“Gatekeepers” of abortion in Australia:
Abortion law and the protection of doctors

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This is to certify that to the best of my knowledge and belief, this thesis contains no material previously published or written by other persons except where due reference is made in the text of the thesis. This thesis has not been submitted for any degree in any other university.

The work in this thesis is my own except where acknowledged.

This thesis is 99, 095 words in length.

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Abstract

Abortion law in Australia is not consistent across the states and territories, but the common characteristic is that an abortion can be lawful where a medical professional is involved. A number of authors have therefore argued that this positions doctors as 'gatekeepers' to abortions (Leslie Cannold 2000, Janet Hadley 1996, Heather Douglas 2009, and de Crespigny & Savulescu 2004). This characterisation of 'gatekeeping' suggests that doctors perform a regulatory function over women's reproductive decisions. However, without examining the emergence and the practice of this gatekeeping role, it only remains an assertion that doctors regulate women's abortion choices.

The design of this thesis draws on the work of Foucault, in particular his approach to studying power. It accepts Foucault's position that power exists only when it is put into action (Foucault 1982, 788). My study of gatekeeping examines the gatekeeping role through this lens, examining how the social *expectation* of regulation for doctors established under the law aligns with how doctors *practice* this regulation. With this in mind, the thesis draws sequentially on multiple sites for investigation, including law, education and medical practice, moving from the framing of abortion legislation through to the decision-making practices of doctors.

This thesis finds that the law in all Australian jurisdictions relies on doctors to perform a function that is not legally or institutionally well-defined, but instead is shaped by and relies upon the values and beliefs held by individual doctors. There is thus a legal expectation of regulation established by the gatekeeping role, but doctors can exercise their own judgement in how they choose to practice the role. The thesis concludes that abortion law in Australia involves balancing the rights and responsibilities of women *and* doctors in the context of the social contentiousness of the abortion issue. The law balances multiple factors, from the protection of women's choices to women's health needs, and the legality of the doctor in facilitating access to the procedure to the rights of doctors to practice medicine according to their own conscience. This results in variable consequences for women seeking abortions, depending on the presiding doctor.

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Chapter 1

Introduction

Abortion law in Australia is not universal across the states and territories. It is contained in both criminal and health statutes, with each state and territory varying in how they approach the issue. Many of the laws historically have been described as being "outdated, confusing and uncertain" (Douglas 2009, 74). Furthermore, as Leslie Cannold (2011, Online) has noted, most women know of a friend, a cousin or a sister who has had an abortion, despite the fact that women are "not lawfully empowered to decide for themselves if they will continue or terminate their pregnancy". The range of different legislative frameworks can create barriers for women to access abortions, with de Costa and Douglas (2015, 349) arguing that the result of the differences in legislation facilitates "extensive abortion 'tourism' from all Australian states to Victoria, and overseas" (de Costa & Douglas 2015, 349). Women are thus able to access abortions, with the most recent comprehensive estimate suggesting approximately 80 000 women per year (Chan & Sage 2005; see also Children by Choice 2017, and de Costa et al 2015, 105), but their capacity to do so is dependent on the law in each Australian jurisdiction. This presents a problem frame for empirical examination of the issue regarding how the provision of abortion occurs in the context of a complex regulatory environment where no two jurisdictions are the same.

Abortion legislation in Australia was originally based on sections 58 and 59 of the United Kingdom's *Offences Against the Person Act 1861* (Rankin 2001, 230). Sections 58 and 59 of the Act stipulated that the intent to procure an abortion was a crime for women and for those assisting them (*Offences Against the Person Act 1861* (UK), 24 & 25 Vict, c 100, ss 58 as enacted). Each jurisdiction in Australia subsequently made changes to the law at different points in time to allow for the performance of abortions, but no two jurisdictions have taken the same approach.

Abortion remains a crime in New South Wales and Queensland where common law rulings provide the basis for a defence of abortion for medical practitioners. In Victoria, Tasmania and the Australian Capital Territory, abortion has been repealed from the Crimes Acts where a doctor is involved. In the Australian Capital Territory there is no reference to abortion in the *Crimes Act 1900* (ACT), but Victoria and Tasmania have retained abortion as a criminal offence if performed by an unqualified person (*Crimes Act 1958 Vic,* s 65 and *Criminal Code Act 1924* (Tas) s

178D). In South Australia and Western Australia, abortion remains in the *Criminal Law Consolidation Act 1935* (SA) and the *Criminal Code Act Compilation Act 1913* (WA) but health law and statutory provisions within criminal law provide legal authority for the performance of abortions by medical professionals in certain circumstances. This was also the case for the Northern Territory until March of 2017, when changes were passed to repeal abortion from the criminal code where performed by a qualified person. The common characteristic across all jurisdictions is the understanding that an abortion can be lawful where a medical practitioner is involved. The involvement of medical practitioners in the provision of abortion is the subject of this thesis, in particular how the role is established in different jurisdictions and how medical practitioners understand their role.

In Chapter 2, the involvement of the medical profession in the abortion context will be problematised, using a range of disciplinary perspectives on abortion and medicine and power to illuminate the complexity of abortion regulation. These perspectives are framed according to the claim from a number of authors that abortion law positions medical practitioners as 'gatekeepers' to women's abortions, arguing that this role delegates the abortion decision to the doctor, rather than the woman (see Cannold 2000, 24-25, Hadley 1996, 187, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004, 202). This literature tends to assume a gatekeeping role for the medical profession based on how the law positions doctors in relation to women, but what we do not know is whether there is an actual gatekeeping function being performed. Therefore we need to look more deeply at what the role is, how it was formed, and how different social actors interpret it.

The use of the word 'gatekeeping' implies a form of regulation based on the legal position of the doctor rather than the actions of doctors. This is based on the fact that the word *gatekeeping* refers to "The activity of controlling, and usually limiting, general access to something" (English Oxford *Living* Dictionaries 2017). Use of the term 'gatekeeping' to describe the role of doctors suggests that doctors occupy a position that controls access to abortion, limiting the capacity of women to exercise reproductive choice. Rankin (2001, 252) has argued "this places little decision-making responsibility with the woman concerned; it merely grants

medical practitioners a quasi-judicial role that they are not necessarily qualified to possess". The term gatekeeping then suggests that there is a potential conflict in the exercise of rights where the legal role of the doctor supersedes the rights of women to control their reproductive future. Thus this characterisation of doctors' role suggests that a woman seeking to exercise a reproductive right in choosing to terminate a pregnancy is subject to the scrutiny of a doctor's judgement. Herein lies the contentious nature of this thesis and its focus of investigation.

What the characterisation of gatekeeping gives us is an assumed regulatory position for doctors to occupy, but it does not provide us with an understanding of how the regulation is applied to women's abortion choices. Metaphorically, there is an assumed gate through which women must pass to access abortions, but the nature of that gate is unclear because, as Chapter 2 will show, abortion is both a moral issue and a medical procedure. The moral dimensions of abortion can impact on the capacity of individual doctors to define the nature of the gate being kept, thus suggesting that the 'gate' might differ from one doctor to the next (see Dworkin 1994, Wertheimer 1971, Joffe 1995, Wainer 1972, and Haigh 2008). There is the possibility then that the role of gatekeeping extends beyond the regulation of a medical procedure to consider the moral dimensions associated with a decision to terminate a pregnancy. The role of the doctor could therefore include the application of medical knowledge and/or the application of an individual doctors' values and beliefs concerning abortion.

This thesis examines this role of gatekeeping by seeking to problematise our use of such a characterisation. It will explore the various ways that gatekeeping has been established and subsequently practiced, framed by the primary research question: *what constitutes the gatekeeping role for abortion in Australia?* Three sub-questions examine how the gatekeeping role has been *established*: How did the medical profession become the legal authority for abortion? What is the legal framework for abortion? What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory? A further three sub-questions explore how the gatekeeping role is *practiced*: How does the education of the medical profession address abortion and the legal role of the doctor? How do

doctors actually perform the gatekeeping role? Do individual values and beliefs influence their abortion decisions?

The role of gatekeeping can be examined from a range of angles, from the subjective expectation of regulatory action to the more objective conduct of regulatory actors. Multiple methodologies are possible in exploring the role of gatekeeping, and Foucault provides a useful framework to undertake such a task. Foucault (1982, 788) argued that the exercise of power is not simply the relationship between individuals or a collective, "it is a way in which certain actions modify others". In this thesis, after examining a variety of possible perspectives, I accept this position, and I will argue that it is more appropriate to consider power as a series of relations constituted through various social apparatuses (see Foucault 2008, 97 & 144, and Foucault 1982, 777-778). In order to understand the constitution of the gatekeeping role, it is therefore necessary to examine the different mechanisms that shape the doctor as gatekeeper, and this can subsequently reveal the nature of the gatekeeping role and what it entails.

In Chapter 3 I outline the research design in greater detail, harnessing Foucault's concept of power. The research design used to capture the gatekeeping role employed three sites of investigation, with each element building on the next. Site 1 used documentary evidence in the form of *legislation, case law and parliamentary debate*. The focus of Site 1 was the legal framework that established the role of gatekeeping, illuminating the intended purpose of abortion law and establishing the scope of authority provided to doctors under the law. Site 2 focused on the *education* of doctors, drawing documentary material from tertiary institutions and interviews with teaching staff. The focus here was how doctors are taught to be gatekeepers and hence taught to exercise judgement over an abortion decision. Site 3 drew evidence from the responses of practicing doctors to a series of *scenarios* for women seeking abortions. The focus here was the decisions each doctor made as to whether or not they would support a woman's request for an abortion, as opposed to whether or not the abortion would be a medical termination or a surgical termination one, and the rationale for their decisions. Each site was chosen to explore different elements in the constitution of the gatekeeping role, specifically how the different sites might support or oppose the

implied characterisation of gatekeeping, determining what the nature of gatekeeping might be and the likely consequences of this for women accessing abortions.

The analysis of each site is organised across four chapters. Chapters 4 and 5 are concerned with the material gathered from legislation and parliamentary debate (Site 1), Chapter 6 focuses on the education of doctors (Site 2), and Chapter 7 examines a range of scenarios associated with abortion decision-making (Site 3). In other words, Chapters 4 and 5 provide the context for gatekeeping and outline what the legislative role is that doctors are *expected* to perform, while Chapters 6 and 7 examine how the law is translated into medical *practice*, and how doctors interpret their role.

This combination of material drawn from multiple sites is designed to acknowledge that the constitution of gatekeeping occurs across a range of social domains, from the law to medicine and from education to ethics. Without considering how each domain contributes to the overall constitution of gatekeeping, there is a risk of assuming, and asserting, that gatekeeping is principally a legal, regulatory, function. Under these conditions, the nature of that regulation would remain untested. Given that the capacity of women to exercise reproductive rights is inherently challenged by the presence of a gatekeeping role, it is necessary to examine the nature of the legal regulation being applied because there appears to be ambiguity as to whether or not the gatekeeping role controls or influences women's reproduction. Indeed in using a Foucauldian frame of analysis, the nature of regulation can be broader than the law and hence an examination of the gatekeeping role in the abortion context will test how the role of gatekeeping facilitates the regulation of women's reproductive choices despite the different jurisdictional frameworks for abortion law.

My analysis begins in Chapter 4 where I examine how the medical profession became the legal authority for abortion, dating back to the early 1800s in the United Kingdom. The discussion spans two sections, the first dealing with the origins of the crime of abortion and the influence of the medical profession in achieving this, and the second section dealing with abortion law reform in

Australia and the influence of the medical profession in the abortion context on legislative debate. By examining the history of abortion law and the influence of the medical profession in this context, we are able to determine why the gatekeeping role was established and how doctors came to occupy a gatekeeping role. This provides the basis for understanding the intended purpose of gatekeeping, which can then be tested against the reality of the practice of gatekeeping.

Chapter 4 suggests that the history of the crime of abortion has involved a close relationship between the actions of members of the medical profession and the enactment of laws concerning abortion. This subsequently led to the legitimacy of abortion being associated with medical practice decision-making, marginalising any other abortion practice which did not occur within the medical domain. Not surprisingly then, the legislative debate that occurred in Australia when changes to abortion laws were debated between 1968 and 2015 tended to accept the legitimacy of the medical profession's involvement in the abortion debate. However, whilst it was generally accepted by the parliaments of those Australian states and territories where abortion law reform has taken place that the medical profession had a legitimate role in abortion decision-making, the scope of the role given to doctors is not universal because of the moral dimensions associated with abortion practice. This resulted in a range of legislative approaches being taken by different states for the regulation of abortion.

Chapter 5 examines the legislative frameworks for abortion in each Australian state and territory from 1968 until 2015, with the aim of highlighting the legal authority given to medical professionals. The analysis explores the scope of authority given to doctors under abortion law in each state and territory. The chapter considers whether or not the law requires that doctors perform a regulatory function, and hence perform a gatekeeping role for women's abortion choices as distinct from the medical procedure of abortion, a possibility to which Chapter 4 eludes. It is important to note that the description of gatekeeping made by a number of authors (see Cannold 2000, 24-25, Hadley 1996, 187, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004, 202) applies to a specific type of legislative framework, one that does not exist in some Australian jurisdictions.

However, because we know that the legal regulation of abortion challenges a woman's capacity to exercise reproductive rights (see Douglas & Kerr 2016, Rankin 2011, and MacKinnon 1991), the role of doctors in the provision of abortion can be problematised regardless of the legal framework. So whilst the description of gatekeeping may not have previously applied to certain legislative frameworks, I have used the term more broadly to characterise the role. Chapter 5 thus considers the position of the doctor according to law and seeks to determine whetherthe position is designed to regulate women's abortion choices or regulate the medical procedure of abortion, or both.

The legal frameworks in different states and territories are assessed according to the following characteristics: the degree of criminality attached to the act of abortion; the legal basis for the doctors'role be it legislated or stipulated at common law; the role of the doctor in shaping the lawfulness of the procedure and whether this requires requisite reasons to be established or not; and the degree of legal recognition for the conscience of a doctor, all issues that emerge from Chapter 4. The first part of Chapter 5 deals with the decriminalised jurisdictions of Victoria, Tasmania and the Australian Capital Territory; the second part deals with the criminal jurisdictions of New South Wales and Queensland; and the third part concerns the hybrid jurisdictions of South Australia, the Northern Territory and Western Australia. The findings from this comparative legislative analysis suggest that there is a distinction to be made between the regulation of abortion procedures and the regulation of a woman's choice to access an abortion procedure. This is because the majority of jurisdictions approach the regulation of abortion based on gestational timeframes, applying different degrees of regulation depending on the length of the pregnancy. The regulation concerns the actions of doctors and the decisions they make, specifically when and where the procedure is performed, and the grounds upon which the procedure is justified.

What my analysis of the law shows is that while the role of gatekeeping positions doctors to regulate the abortion choices of women to varying degrees, the regulation equally applies to the choices that doctors make regarding abortion. In other words, the role of gatekeeping requires that doctors exercise decision-making over abortion choices, but in doing so brings the conduct of doctors under

scrutiny. So whilst the gatekeeping role can be considered problematic for women in being able to exercise their reproductive rights, it can also be a key mechanism for ensuring that women can access abortions and thus exercise their reproductive rights. The legal role of the doctor is thus potentially an enabling force for women to exercise their reproductive rights.

My analysis of abortion law in each jurisdiction also suggests that the law relies on the professional medical judgement of doctors in each case. What this seems to leave as problematic is that doctors may not be prepared to exercise the role that the law has given them because doctors, like all other social actors, possess a set of moral values which can interfere with the decision-making role that the law expects them to perform. The question this now suggests is how doctors negotiate their own moral positions with their medical and legal roles. What happens when these come into conflict? The legislative history outlined in Chapters 4 and 5 explains why people have assumed the medical profession has, and performs, a gatekeeping role. However, as noted above, abortion decisions cross a range of social domains, and so in order to fully understand the significance of this legislative regulatory domain, it is also necessary to explore the way in which the gatekeeping role is practiced in other ethical, educational and clinical domains.

In Chapters 6 and 7 I consider how a doctor learns to apply this regulatory role, starting with how doctors acquire knowledge of abortion law and abortion practice as part of the educative experience, and then looking at how doctors apply knowledge in the abortion context. The education of doctors is discussed in Chapter 6. The chapter is divided in two sections: the first explores the teaching of abortion within the decriminalised jurisdictions; and the second examines how medical students are taught to establish the lawfulness of an abortion procedure in the criminal jurisdictions. The teaching of abortion in the hybrid jurisdictions is discussed as part of the criminal jurisdictions. The purpose of this chapter is to develop an understanding of how the decision-making process for a doctor is established, specifically the types of knowledge that doctors are taught and the training they receive to draw on to provide treatment.

Through exploring medical teaching curricula, Chapter 6 reveals variability in the teaching of medicine, as each institution approaches the curriculum differently and places different degrees of emphasis on clinical and ethical training. The teaching of abortion thus varies, but all approaches recognise that the negotiation of ethical issues in the context of medical practice is a process for individual doctors; one that they can engage in or opt out of, rather than one that can be institutionally defined. As Price (2015, 5) argues, "even in medical schools across Australia, plenty of medical students get no exposure, no instruction, about abortion". The law is thus relying on the professional medical judgement of doctors, but the judgement of doctors is established through teaching that acknowledges that doctors have moral values that warrant them either removing themselves from the abortion decision, or exercising decision-making with due recognition of the potential impact of their views on their patients. The result is that doctors are expected to define the type of encounter that a woman will be subjected to, rather than being taught how the clinical encounter for abortion should be defined. The education of doctors can thus lead to different experiences of decision-making regarding abortion for women. The significance of this for the legal role of gatekeeping is that the practice of the role is not institutionally defined, being left to each individual doctor to determine.

In Chapter 7 I consider the possible consequences of relying on the abortion judgements that doctors make. This chapter examines the responses of practicing doctors to a series of scenarios of women seeking an abortion or considering one. The purpose of these scenarios is to test what criteria and/or characteristics of women determine a particular type of abortion decision. The responses suggest that prior to undergoing an abortion, women are subjected to a range of potential interventions that vary in intensity depending on the doctor. These interventions occur whether or not the doctor supports the abortion decision, and this suggests that a doctor's moral position regarding abortion is not simply about whether or not they believe abortion is right or wrong, but rather how they perceive the woman and her personal circumstances. What this chapter confirms is that doctors draw on information that is not confined to the domain of medicine in order to exercise decision-making regarding abortion, drawing on information from other social domains. The literature that suggests abortion is a moral issue for social

actors (see Dworkin 1994, Wertheimer 1971, Luker 1984, and Cannold 2000) is thus supported, but the findings explored in Chapter 7 extend our understandings to show that the moral dimensions of abortion cannot be disentangled from the professional judgements that doctors make. The reliance of the law on the professional medical judgements of doctors to enable women to access safe and legal abortions is challenged by these findings because they show that doctors can make decisions based on both medical and personal understandings of women's reproduction.

In the final chapter, Chapter 8, I revisit the problem statement (namely, the extent to which the characterisation of gatekeeping for doctors functions to regulate women's reproductive choices), review the findings from my research, and offer some observations for how these findings can help address our understanding of the gatekeeping role. The chapter then tests the utility of my findings and argument through considering the proposed legislative amendments for abortion in New South Wales and Queensland, introduced into each respective parliament in 2016, and the legislative amendments passed in the Northern Territory in March 2017. I examine whether these clarify the function of gatekeeping in those states, and I show how they illuminate the problematic nature of regulation presented in this thesis.

Chapter 8 will also offer summary observations regarding the consequences of the current role of gatekeeping. It argues that the exchange between a woman and a doctor is defined by each doctor as a consequence of the law protecting doctors and their role in the provision of abortion services. This can lead to variable outcomes for women depending on the doctor they visit, but also because they happen to live in one Australian state rather than another. As Dickinson (2015, 104) has argued, "Access to late termination facilities in Australia depends largely upon where a woman resides rather than the indication for the procedure: it is inexplicable that a woman in Victoria can access termination for a fetal malformation in circumstances that a woman in Western Australia may not, solely due to differences in abortion law and not necessarily the fetal abnormality for which the request arose". Douglas (2009 74), drawing from a report of the Office of Women's Policy in Queensland (2000), also highlighted the problematic nature of

abortion law, "the more criminalised abortion is in a jurisdiction, the more difficult it is to ensure that practitioners are properly qualified, regulated and accessible". My research and findings corroborate the positions adopted by Dickinson and Douglas, but what they also show is that regardless of the legal framework, women's abortion choices and their access to the procedure is impacted by doctors because of the influence of personal values on a doctor's decision-making, not just how they understand and apply the law.

Overall, this thesis argues that the gatekeeping role is more complex and fraught with more tension than the word gatekeeping implies, and more ambiguous than the term gatekeeping is often used in the literature. Ultimately, it is characterised by a legislative structure that delivers protection for doctors to perform abortions. However, as a direct consequence of the protection of doctors to provide abortions, or opt out of the abortion context altogether, women are subjected to a form of regulation that is defined by each individual doctor as they see fit. The gatekeeping role can therefore be seen as a mechanism for inhibiting the exercise of reproductive rights, just as it can be seen as a mechanism for facilitating the exercise of reproductive choice by women, providing a mechanism for accessing a procedure that is, in some jurisdictions, considered criminal. What this argument suggests in relation to existing literature on abortion is that the moral dimensions of abortion apply to doctors just as they do other social actors, and that this can have an impact on a woman as part of her medical treatment. My argument also highlights that there is no single meaning of regulation, and that doctors, through their role as gatekeepers, have to negotiate legal, social and medical meanings of regulation.

What my thesis also reveals about the role of gatekeeping is that there is no single approach to an exercise of power. In applying Foucault, I have established that the legal expectation of gatekeeping, and hence the exercise of power, can be translated into practice to both constrain social actors and liberate social actors. This is because the exercise of power has a subjective angle. While the law can establish a defined need for regulation, at the site of regulatory intervention there is a degree of agency for those occupying regulatory roles to choose the type of regulation they wish to apply. What this invariably shows then is that regulation,

when applied, is a variable concept, which holds different meanings for different social actors.

Chapter 2

Literature review: making sense of ‘the abortion debate'

Introduction

The study of abortion is wide-ranging, found in the disciplines of political science, sociology, jurisprudence, philosophy, medicine, history, and theology, just to name a few. The breadth of this work largely addresses the abortion 'issue', in other words the moral and political dimensions regarding abortion, rather than specifically focusing on the physical act of aborting a fetus, and therefore tends to neglect how the moral and political dimensions intersect and thus impact on those undertaking the physical act of terminating a pregnancy. A key component of this body of literature also concerns the role of the medical profession in the abortion context, with some perspectives describing the role of the medical profession as 'gatekeeping' for women's abortions (see Cannold 2000, 24-25, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004, 202). This thesis utilises the breadth of material concerning the abortion issue to problematise this characterisation of gatekeeping for medical practitioners in Australia. As I will suggest in this chapter, the characterisation of gatekeeping is problematic because it is not clear whether this characterisation is the description of a regulatory role in legislation, or a reflection of the actual regulation that occurs. In other words, it is not clear if the description of gatekeeping for doctors is merely a position reflected at law, or whether it reflects a certain type of behavior by doctors defined by the law. To explain this problem statement surrounding gatekeeping, this chapter draws on work that considers medicine and the concept of power, exploring how the assumptions of gatekeeping for abortion are shaped and defined. The primary research question to initially frame this exploration of the characterisation of gatekeeping is *what constitutes the gatekeeping role for abortion in Australia?*

The present chapter commences with an overview of research on abortion. This research collectively reinforces the characterisation of the medical profession as 'gatekeepers' to women's abortions. It covers scholarship across a range of disciplines, as well as drawing on material from doctors themselves who have engaged with the issue of abortion over the past century. What I explore here is how doctors are seen as key regulators for accessing abortion and the nature of the claims of this regulation, particularly in the context of historical literature that suggests doctors have been key proponents for ensuring greater access to abortion for women. A set of general questions emerge from this first part of the chapter,

which are then framed as empirical questions for exploration in Part 2 of the chapter. The chapter concludes with a visual representation of the different research questions that this thesis will examine.

Part 2 of this chapter concerns medicine and the nature of medical power. It draws on literature that considers the concepts of professional power and regulation as a way of exploring the gatekeeping characterisation of the medical profession. I examine whether the gatekeeping characterisation of the profession is indicative of what some researchers have considered a broader shift towards medical control over the body, or if indeed there is something specifically different about abortion that justifies the characterisation of the medical profession as 'gatekeepers' in this context. From this literature I am able to hypothesise that **gatekeeping is constituted through a range of mechanisms that exist to balance the choices of women with the beliefs and interests of doctors, while indemnifying individual doctors who are involved in the provision of abortion services.** This claim will be tested in the research section of this thesis using the empirical questions that emerge from the second half of this chapter. The hypothesis is significant because it also suggests that the notion of gatekeeping exists beyond the domain of medicine and enters into the domain of moral values, even though medicine is utilised as the overarching framework for ascribing legal authority to regulate abortion and define the nature of that regulation.

2.1. Perspectives on abortion

Research on abortion is wide-ranging and complex largely because, as Luker (1984, 1) has argued, the abortion issue itself is highly politicised and has polarised societies throughout modern history whenever the issue has emerged in the public sphere (see also Dickinson 2015, 103). Research that considers the evolution of abortion law and the actions taken by medical professionals because of, and in spite of, the law suggests that historically the medical profession had a role in shaping abortion as a medical issue, thus becoming a key regulator for the procedure (Reagan 1998 and Keown 1988). As Luker (1984, 44) argues, "it was doctors who framed the issue of abortion as a medical matter, to thwart attempts by clergymen, lawyers and, not least, women from having a say in deciding who should be permitted an abortion". This regulatory role for doctors has been

characterised as "gatekeeping" (see Douglas 2009, Cannold 2011, and de Crespigny & Savulescu 2004).

Research that considers the philosophy and morality of abortion, the position of women under law, the role of technology in shaping our understanding of abortion law, the views of women concerning abortion and motherhood, and the perspectives of doctors who have engaged with abortion during periods of criminalisation and decriminalisation provides a contextual basis for understanding the contentious views on abortion (Dworkin 1994, Wertheimer 1971, MacKinnon 1991, Palmer 2009, Rhoden 1986, Hadley 1996, Luker 1984, Cannold 2000, Baird 1990, Joffe 1995, Haigh 2008, Wainer 1972, de Costa 2010, and de Costa et al 2013). It underscores the complexity of the abortion issue and the inevitable involvement of the medical profession in the abortion context, but more importantly I will argue that it also points to a need to consider how this complexity impacts upon the *practices* of the medical profession as regulatory agents. The following sections of this chapter seek to illustrate the complexity of the abortion issue, problematising the characterisation of the medical profession amidst this complexity.

The evolution of abortion law

Significant studies that have looked specifically at the evolution of abortion law include Leslie Reagan's (1998) *When Abortion was a Crime: Women, medicine, and the law in the United States 1867-1973*, and John Keown's (1988) *Abortion, doctors and the law: Some aspects of the legal regulation of abortion in England from 1803 to 1982*. These works demonstrate that the criminalisation and subsequent decriminalisation of abortion were inextricably linked to the actions of the medical profession. Both works provide a useful basis to understand the justification for medical intervention in abortion decision-making.

Whilst Reagan and Keown's studies focused on the United States and the United Kingdom and this thesis concerns Australia, they are both relevant for understanding the contextualisation of the regulatory role for doctors because Australian law originated in the United Kingdom, and some of the key legal concepts were prevalent across both the United Kingdom and the United States.

Reagan's work provided an overview of the period in the US when abortion was considered criminal. Reagan (1998, 8-9) noted that during the eighteenth and early nineteenth centuries abortion was legal during the early stages of pregnancy, noting that the term abortion only applied to procedures performed after 'quickening', quickening being when the fetus is first felt to move in the uterus (Drabsch 2005, 13, see also Reagan 1998). The period of quickening was also an aspect of common law for defining the crime of abortion in the United Kingdom from around 1300 to the earlier part of the 1800s, as it was believed to be the time at which the fetus was infused with a soul (Keown 1988, 3-12 in Drabsch 2005, 13).

Reagan (1998, 10) explored the procurement of abortion during the period of quickening, noting that the most common form of inducing an abortion during this period was through the use of drugs, which in the mid-eighteenth century became a commercial industry. Abortifacients were a profitable product sold by doctors, apothecaries, and other healers (Reagan 1998, 10). The popularity of these drugs gave rise to the first known statutes governing abortion in the United States, which were in fact poison control measures designed to protect pregnant women by regulating the sale of abortifacients which often killed the woman who took them (Reagan 1998, 10). However, despite the laws restricting such drugs, the abortion industry thrived with many successful abortion clinics emerging (Reagan 1998, 10). Access to abortion was thus sought by women despite the law, and further attempts to control the abortion industry were made through interventions from the medical profession.

The expansion of the abortion industry and the continued attempts by women to access abortion irrespective of legal restrictions became the catalyst for the involvement of the medical profession in abortion law reform. In 1857 the newly organised American Medical Association began a crusade to make abortion illegal at every stage of the pregnancy, in an attempt to assert professional control through restricting competition and controlling medical practice (Reagan 1998, 10-11). The American Medical Association worked across the US throughout the late 19th century to achieve passage of new criminal abortion laws, achieving governmental recognition of their views and some state control over the practice

of medicine (Reagan 1998, 11). Reagan's description of the history of early abortion statutes highlights the beginning of an involvement of the medical profession in abortion law, showing how the law was considered their most effective tool by which to achieve such medical control.

John Keown's work examined the evolution of similar sets of laws concerning abortion in England, specifically the relationship between medical practice and the law from 1803 to 1982. He illustrated how the medical profession shaped and influenced legal restrictions of abortion, satisfying both professional and practical health concerns. In discussing the influence of the medical profession on earlier statutes in England from 1803-1861, statutes that formed the basis of criminal law in Australia, Keown (1988, 40) argued: "Increasingly restrictive legislation on abortion and on the obtaining and supplying of abortifacient means would serve not only to safeguard fetal and female life, but would also hinder irregulars from capitalising on the demand for a service which ethical precepts prevented the regulars from satisfying". Thus the criminalisation of abortion was considered to have occurred for the purpose of protecting female and fetal life, but it had the added benefit of reframing medical authority over issues concerning the body and human life. Through this process legitimate knowledge of the human body was shaped as being that which originated from within the medical profession.

Keown's research is important to the study of gatekeeping because it shows how the medical profession has been entangled with the regulation of abortion since the inception of criminal law in the 19th Century, operating to regulate abortion practice and claim it for the medical domain. As Keown (1988, 159) argues with respect to the United Kingdom: "It appears that a central (though not exclusive) concern of the profession in both the restriction of the law and its relaxation in 1967 has been self interest…two central concerns of the profession are freedom from control and prevention of encroachment upon its sphere of influence by the medically unqualified" (see also British Medical Journal 1937 in Keown 1988, 159). This argument is consistent with the idea of 'medical dominance' associated with such authors as Eliot Freidson (1988), Sally Sheldon (1997), Michel Foucault (2008 and 2010), and Michael Thomson (2013).

Keown's study also demonstrated how the medical profession acted to restrict access to abortion, initially through an attempt to curb the destruction of fetal life, but later to provide a safe and viable option for women who were seeking terminations from unqualified practitioners regardless of the law (see Keown 1988). The purpose of the regulation of abortion in this context was thus twofold: first to ensure that abortion was considered a medical issue and remained within the responsibility of medicine to define what is legitimate; and second to protect those within the medical profession to practice abortion. This illustrates how the regulation of abortion is complex, concerning both the defining of professional power for the medical profession as well as the control of a procedure that directly impacts women and their ability to exercise reproductive choice.

Contemporary legal scholarship in Australia has also made a contribution to understanding the evolution of abortion law and the purpose of abortion law, highlighting that abortion remains a complex issue and is more significant than a woman's choice to terminate a pregnancy. Such an understanding is presented through an exploration of the appropriateness of the intervention of external parties such as the medical profession and the justice system in abortion decisions. This research highlights the position of the medical profession under the law and stresses/tests the significance of the role of medical professionals in regulating access to abortion and adjudicating the abortion decisions women make. Such examples include Heath and Mulligan's (2016) "Abortion in the shadow of the criminal law? The case of South Australia", and Mark Rankin's (2001) "Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion" and "The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law" (2011).

Heath and Mulligan (2016) examined abortion law in South Australia, exploring whether the position of abortion under criminal law justifies a continued concern among medical practitioners about the legality of abortion in South Australia. They examined the origins of the legislative changes made in South Australia in 1969, establishing that the intent of the changes "was to preserve women's health through clarifying the contexts in which lawful abortion would be available"

(Heath & Mulligan 2016, 41). What Heath and Mulligan observed in their study is that the current legal framework for abortion in South Australia, originating in 1969, provides sufficient grounds for a surgical termination of pregnancy but does not accurately reflect the contemporary practice of abortion by medication (Heath & Mulligan 2016, 67). They also concluded:

> The continued presence of abortion-related offences in criminal law is undesirable…the presence of abortion offences generates concern in the medical profession and creates potential for the imposition of restrictions on abortion services which the legislative scheme itself does not demand. These circumstances give rise to treatment regimes and restrictions on the availability of abortion that prejudice women's health, rather than protect it.
>
> (Heath & Mulligan 2016, 67)

What Heath and Mulligan's work reveals is the complex relationship between law and medical practice, highlighting how medical practice can evolve in response to the law, but not necessarily as a direct reflection of the law. Their work stresses the importance of examining how the law is translated into practice, a task that this thesis will attempt to do. It also affirms the role of doctors in the abortion context.

While Heath and Mulligan examined South Australia, Rankin on the other hand examined abortion law for all states and territories in Australia, arguing that the law regarding abortion in Australia is varied, and that no approach indicates a woman holding a right to abortion (Rankin 2001 and 2011). In fact despite some legislative changes in Australia between 2001 and 2011, "a woman's right to abortion remains unrecognised in all Australian jurisdictions…in the majority of jurisdictions a woman may be convicted of attempting to procure her own abortion" (Rankin 2011, 47). In at least half of all Australian jurisdictions "the woman must satisfy a medical practitioner that she has sufficient justification for the termination of her pregnancy", and in some cases a woman must convince two doctors (Rankin 2011, 47). This remains the case despite legislative changes made in Tasmania in 2013 and Northern Territory in 2017 (to be discussed in Chapters 5 and 8). Rankin (2001) specifically categorised the role of the medical profession as being regulatory, arguing:

> The medicalisation of abortion undertaken by the judiciary and the legislatures in the 20th century has not granted any rights to women. Of course, this medicalisation

> has meant that it is possible for a medical practitioner to perform an abortion lawfully, thereby providing practical benefits for Australian women seeking abortions. However, this places little decision-making responsibility with the woman concerned; *it merely grants medical practitioners a quasi-judicial role that they are not necessarily qualified to possess*. It also serves to remove from the woman concerned the power to make the reproductive decision about her own body.
>
> (Rankin 2001, 252, my emphasis)

The final two sentences here suggest that, in the legislation, the role of the medical profession has been to regulate access, removing the decision-making authority over reproductive choices from a woman. It is this regulatory role that is specifically described in the Australian context as "gatekeeping" (see de Crespigny & Savulescu 2004, 202, Douglas 2009, 78 & 84, and Cannold 2011). The emphasised words above suggest that there might be uniqueness in the role performed by the medical profession in the abortion context compared to other medical procedures, particularly considering that, as Rankin notes, the role is 'quasi-judicial' and that doctors 'may not be qualified to possess such a role'. Research of this nature poses a question regarding the extent to which doctors perform, and are able to perform, a regulatory role for abortion decisions. This suggests that the law has ascribed authority to the medical profession to perform a role that is legal in nature rather than medical. Therefore the need to explore the regulatory role of doctors seems necessary because it is not clear how a doctor actually performs such a judicial role.

Further investigation is thus needed to explore the operation of abortion regulation and how it is performed, particularly in the context of studies discussed below that have shown the politicisation of abortion concerning women's reproductive rights and the morality of the act of abortion, as well as studies that challenge the appropriateness of the gatekeeping role given the politicisation of the issue. The following two subsections deal with such research. These sections reinforce the complexity of abortion and further problematise the role of the medical profession in this context.

The morality of abortion

Research that addresses the morality of abortion highlights the complexity of abortion as a philosophical, ethical and moral issue, rather than an issue for

shaping medical boundaries. This further problematises the role of doctors in this context because doctors, like all social actors, possess a set of moral values that can impact on their medical practice, and hence the quasi-judicial role that they have been granted can be impacted by a doctor's moral views regarding abortion.

There is extensive research on the subject of abortion and morality, the breath of which cannot be covered within this literature review given the already broad subject focus of 'abortion'. That being said, across the discipline there are some common elements in how the morality of abortion is presented. One text that sufficiently explores the moral question of abortion is Ronald Dworkin's (1994) *Life's Dominion: An argument about abortion, euthanasia and individual freedom*. Dworkin's work examined the moral reasons for and against abortion and euthanasia, specifically examining arguments as to whether abortion and euthanasia violate a fundamental 'right to life'. Dworkin tracked the history of the abortion and euthanasia controversies, particularly in the United States. He characterised the abortion argument as being 'divisive', suggesting that for most people it is an "argument about a moral and metaphysical issue: whether even a just-fertilised embryo is already a human creature with rights and interests of its own, a person…an unborn child, helpless against the abortionist's slaughtering knife" (Dworkin 1994, 30). Dworkin illuminated the moral complexities of the abortion issue and presents a rationale for abortion as being beyond the right of a single pregnant woman to choose: "Theological, moral, philosophical, and even sociological discussions of abortion almost presume that people disagree about abortion because they disagree about whether a fetus is a person with a right to life from the moment of its conception, or becomes a person at some point in the pregnancy, or does not become one until birth" (Dworkin 1994, 30). However, this is only one aspect of the abortion issue.

Dworkin suggested that the moral stance one takes with regard to abortion is not binary, and that 'the abortion debate' is more appropriately considered as one characterised across a spectrum of beliefs where there "are degrees of opinion, ranging from extreme to moderate" (Dworkin 1994, 31). He argued that the crux of the debate concerning abortion has more to do with the intrinsic value of human life than it is about a determination as to whether or not a human fetus is a person

(see Dworkin 1994, 67). What this argument implies is that a person's perspective on abortion is characterised by how they conceptualise a person's whole life and the value they ascribed to such a life. This concerns the quality of life that a prospective child will have, rather than the child simply being a potential life. The range of perspectives in this context will thus vary, leading to various forms of legal and political intervention in a woman's pregnancy decision. Dworkin's work highlighted how the moral dimensions of abortion justify complex legal and political interventions in a woman's abortion decision.

Earlier, in 1971, Roger Wertheimer published "Understanding the Abortion Argument" which explored the moral dimensions of abortion. Wertheimer work is another representation of the typical arguments that emerge in the literature concerning abortion and morality. Like Dworkin, Wertheimer argued that perspectives in the abortion debate are diverse, but his work addressed the emphasis of the liberal debate vis-a-vis the conservative debate. He focused specifically on the extent of moral status attached to the fetus and examined whether this warranted a legitimate exercise of power by the state to restrict abortion access. Wertheimer's work looked at the argument concerning the legalisation of abortion: "the issue is statable as a double-barreled question: At what stage of fetal development, if any and for what reasons, is abortion justifiable?" (Wertheimer 1971, 67). Wertheimer's work differs from that of Dworkin in that it suggests that assuming the controversy regarding abortion is to the value of fetal life in its various stages "seriously misdescribes the actual arguments, and, further, betrays a questionable understanding of morality…we had best take the fundamental question to be: When does a human life begin?" (Wertheimer 1971, 68-69).

In his concluding statements, Wertheimer suggests that the restriction of abortion at law constitutes "an unjustifiable burden and hence an illegitimate exercise of power" by the state because the law cannot demonstrate that the fetus is a human being (Wertheimer 1971, 94). His work reinforces the moral complexity of abortion, and highlights the significance of the ethical and moral issues for the regulation of abortion at law.

Both Dworkin and Wertheimer's works contextualise abortion as being shaped by a moral discourse and suggest that the act of terminating a pregnancy is more complex than a woman choosing not to continue with a pregnancy and hence not become a mother. In other words, it is also about the moral status of a fetus and the social and legal significance of terminating a life. They raise specific questions about the shaping of abortion within the medical domain established by the gatekeeping role, specifically how the moral and ethical arguments that shape the debate within broader society are to be found within the domain of medical practice. If the complexity of the issue is found in broader social and political domains, then it can be hypothesised that the diverse nature of views concerning abortion will be apparent across those actors who practice medicine, and regulate abortion in accordance with the law.

In seeking to explore what constitutes this gatekeeping role in Australia, it is thus necessary to explore the types of decisions that doctors make with regards to abortion, in order to illuminate the extent to which the decisions that doctors make are constituted by medical and scientific knowledge as well as the moral and ethical views of individual doctors. This exploration will help frame the first research question of this thesis.

Women and abortion law

Dworkin and Wertheimer's work pointed to the controversies associated with women's abortion choices because of the moral arguments that shape how abortion is regulated. Dworkin in particular raised the significance of the abortion argument for women, highlighting that there are gendered dimensions to the abortion debate. Wertheimer's work also suggests that there are issues of gender equality in the abortion context, particularly as abortion regulation affects women more so than men. Catharine MacKinnon's (1991) article "Reflections on Sex Equality Under Law" is a useful contribution for framing the issue of gender equality and abortion law. This article is by no means representative of the vast array of literature that is available on the subject of women and the law (see for example Eisenstein 1988 and Easteal 2001), and indeed MacKinnon's views have been described as polarising within feminist spheres (see Munro 2003). What MacKinnon's article gives us though is a perspective on women and the law that

overtly challenges the role of doctors in abortion provision under law because of the direct connection between the law and a woman's capacity to exercise certain rights.

In her article MacKinnon argues that the issue of abortion is closely linked to the position of women generally under law, and that the law regarding abortion specifically continues to subordinate women to men. MacKinnon (1991, 1308-1309) states that it is the social construction of a woman's capacity for and role in childbearing that underpins the subordination of women to men:

> Although reproduction has a major impact on both sexes, men are not generally fired from their jobs, excluded from public life, beaten, patronised, confined, or made into pornography for making babies. This point is not the biological one that only women experience pregnancy and childbirth in their bodies, but the social one: women, because of their sex, are subjected to social inequality at each step in the process of procreation.
>
> (MacKinnon 1991, 1308-1309)

It is because of the subjectification of women to inequality throughout the various stages of reproduction that MacKinnon (1991, 1317) suggests abortion has offered women the only way out of what she considers forced maternity. However, the state-mandated restrictions on abortion disadvantage women in ways that men will never be disadvantaged, as "no man will ever need an abortion, hence be in a position to be denied one" (MacKinnon 1991, 1320). Any form of intervention in abortion thus subordinates women to the person intervening, whether in the realm of law or medicine.

MacKinnon's work emphasises how the complexity of abortion is closely aligned with issues concerning women and their rights to control their bodies and reproductive lives. Her work also contextualises the legal debates regarding abortion through highlighting how the debate reflects gender inequalities. Thus a question emerges as to the scope of the regulatory intervention over abortion, specifically whether the intervention reinforces the subordination of women's abortion choices to the views and beliefs of doctors. A second question for this thesis is the extent to which the legal role of gatekeeping subordinates women's choices to the views and judgements of doctors, given the legal authority they are invested with as gatekeepers.

Women, abortion and technology

In “Seeing and Knowing: Ultrasound images in the contemporary abortion debate”, Julie Palmer (2009) explored the justification for legal and medical intervention in abortion decision-making. Like MacKinnon, her research suggests that abortion has generally been treated as an issue beyond the sovereignty of individual women and has been subject to interference by a range of external actors, with advances in technology providing new platforms for justified intervention in the abortion context.

Palmer (2009, 174-176) discusses the introduction of 3D ultrasound in monitoring fetal development, showing that the use of such images has made its way into the public sphere where an argument has emerged from members of the medical establishment and parts of the anti-abortion movement that scientific development should mandate a reconsideration of abortion law. Indeed, this argument states that the increasing advances and use of technology in understanding fetal development means that fetuses are now considered to be more developed before 24 weeks than previously thought, the period of time that abortion has been generally considered lawful. Thus, it has been argued that abortion law should be reconsidered on the basis that our understandings of abortion before 24 weeks could be destroying 'viable life' (Palmer 2009, 175). Palmer's work highlighted that there is general interest in understanding fetal development across a spectrum of social actors, such as public interest groups both for and against abortion, doctors, and pregnancy advice groups. This interest is then used to justify intervention in abortion regulation through the law and medical practice.

Palmer also demonstrates how technology that allows us to ‘see’ the fetus actually separates the fetus from the pregnant woman (see Palmer 2009, 177-178), where the fetus is the primary patient of a pregnancy and the woman is the "fetal container" (Cannold 2000, 52). For Waldby (1998, 373 in Palmer 2009, 177), this raises the sociological and political concept of power to the fore of the abortion debate, where the "issue of concern is who has the power to render visible and who has the power to look". Palmer's research highlights that there is an ongoing

basis for the justification of parties, other than pregnant women, to have an influence over the decision to terminate a pregnancy. Her research extends our understanding of the legitimacy of medical intervention through illustrating that technological innovations are not neutral, but are part of professional, moral and gendered contestation. This issue of power, specifically the role of power in shaping and defining certain norms and thus maintaining particular discursive practices, needs to be considered in any research into the constitution of gatekeeping in Australia, where there is scope for privileging certain actors' views over others. My thesis will seek to illuminate the extent to which different perspectives, values and interests influence the experiences that women have in accessing abortion procedures.

In 1986, Nancy Rhoden published a similar article to Palmer's regarding the challenge of technology for how abortion law is conceptualised, "Trimesters and Technology: Revamping *Roe v Wade"*. Rhoden examined the relationship between law and scientific advancements, examining the trimester framework established in *Roe v Wade* 1973 with changes to how the lawfulness of abortion might be understood. In *Roe v Wade* 1973, the United States Supreme Court established a trimester framework that "found that during the first trimester, states lack a compelling interest that would justify regulation of abortion" (Rhoden 1986, 639). The ruling was based on the notion that the greater the length of time into a pregnancy when a termination occurs, the greater the risk to maternal life, and hence, "after the time during pregnancy when abortion became more hazardous for women than childbirth, the state's interests in the woman's health became compelling, and it could regulate to protect this interest" (Rhoden 1986, 640). This equated to women having the right to choose abortion during the first trimester, protected by the Constitution of the United States (Rhoden 1986, 639-643).

Rhoden's article demonstrated the complex relationship between law and science, and the inherent tension between medical advances and the legal determination of an appropriate abortion. She examined both the scientific basis for the *Roe* decision and the less explicit ethical elements of the decision, specifically that a viable fetus was like a baby and thus its destruction was forbidden (Rhoden 1986, 643). Rhoden concluded that whilst medical technology is important for shaping

how aspects of the law are understood, it "should not be allowed unilaterally to rule abortion law" (Rhoden 1986, 643). This is because whilst "the law must be responsive to scientific advances, it rightfully must retain control and temper technology with the social values it incorporates" (Rhoden 1986, 691). She argued that whilst the medical profession may have authority to shape and define how abortion is understood and conceptualised, this authority needs to be exercised with due recognition of the social values that established the role in the first place. The scope of the authority given to the medical profession thus needs to be examined in the context of its stated purpose, in order to provide a justification for the performance of the gatekeeping role. This forms a third question for this thesis, specifically is the practice of gatekeeping indicative of the intent of the role of gatekeeping established by the law?

Abortion, motherhood, and women's choices

A number of researchers have explored the perspectives of women in the abortion decision as a way of illuminating the social values that women ascribe to abortion. This research provides a framework for understanding a range of highly politicised issues that medical practitioners navigate in executing their legal role of gatekeeping. Works that address the experiences of women in the context of this politicised debate over abortion include Janet Hadley's (1996) *Abortion: Between Freedom and Necessity*, Kristin Luker's (1984) *Abortion and the Politics of Motherhood,* Leslie Cannold's (2000, first published in 1998) *The Abortion Myth: Feminism, Morality and the Hard Choices women make,* Barbara Baird's (1990) *"I had one too..." An oral history of abortion in South Australia before 1970*, ""The incompetent, barbarous old lady around the corner": The Image of the Backyard abortionist in pro-abortion politics" (1996), and "The self-aborting woman" (1998). These researchers have discussed abortion within the context of decisions about motherhood, women's health care and reproductive rights, and the politicisation of women's abortion choices as popular history for anti-abortion politics, rather than philosophical speculation over the moral existence of a human fetus. A final work, Newton et al's (2016b) "How do women seeking abortion choose between surgical and medical abortion? Perspectives from service providers" deals with the choices women make in relation to the method of

abortion. Collectively, this research has been important for revealing and articulating the varied nature of women's perspectives regarding abortion.

In *Abortion: Between Freedom and Necessity,* Janet Hadley (1996) explored the range of woman's perspectives concerning abortion. She drew material from different countries to examine the context for abortion as it was in the 1990s, and showed what this context revealed about women's access to healthcare. The purpose of her research was to explore what was happening to women around the world who were unwillingly pregnant, and to understand the impact of the abortion controversy on the lives of women by stripping away the "carapace of battle-hardened slogans" (Hadley 1996, xii). Hadley's work emphasised that abortion is, for women, an issue about motherhood. Her research also reveals that women's experiences of abortion are not universal because

> what makes a pregnancy 'unwanted' is not universal…it is not the same all over the world. It is mediated by the social and cultural organisation of the community in which a woman finds herself.
>
> (Hadley 1996, 180-181)

This argument presented by Hadley shows that the range of reasons as to why women would seek an abortion differs according to context. The social and cultural contexts in which the woman finds herself will shape her decision. What this suggests is that medical practitioners are likely to be confronted by requests for a termination of pregnancy for diverse reasons, reasons that they will need to navigate and judge in order to fulfill their legal role. What is not clear however is whether doctors are prepared to navigate such a diverse range of views, and whether their own social and cultural context will impact their views on abortion in the same way as it does women. A fourth question for this thesis is the extent to which doctors are educated to exercise judgement regarding abortion amid such moral and ethical complexity.

Like Hadley, Luker and Cannold examined the abortion controversy and emphasised that the concept of motherhood is central to the abortion controversy for women. Both Luker and Cannold's research explicitly dealt with what they coin 'the abortion debate' as the basis for understanding the choices made by women. The way the abortion debate is framed in the public realm suggests that abortion is broadly either pro-choice or pro-life (Luker 1984, 1-2). However, Luker and

Cannold suggest that the choices of women are not binary and they rarely articulate them in such a dichotomised way. Pro-choice versus pro-life dichotomised discourses contextualise abortion as being based on competing rights, the rights of the woman to control her reproductive life, and the right of the fetus to life (see Luker 1984, 2). The fundamental premise of the pro-life debate is that the embryo is the moral equivalent of the child it will become, a position that the other side of the debate considers highly debatable (Luker 1984, 2). Thus the abortion debate places the abortion decision within a competing rights discourse, suggesting that a woman's decision is based on where they are positioned within that debate. What this suggests is that any research on the role of gatekeepers needs to consider how a doctor's perception of the reproductive rights of women vis-a-vis the rights of the fetus might impact on their medical practice and the decisions they make regarding abortion.

In ''I Would Want to Give My Child, Like, Everything in the World: Issues of Motherhood Influence Women Who Have Abortions", Jones et al. (2008) sum up the significance of Luker's findings:

> women who were strongly opposed to abortion believed that motherhood was a biological and moral imperative. Access to abortion allowed women to forego their "natural responsibilities" and demoted motherhood from a sanctified status to a mere "job." Although pro-choice women valued motherhood, they believed that women and their families were better off when pregnancies were planned and that women needed access to abortion to pursue employment and educational opportunities.
>
> (Jones et al 2008, 81)

Jones et al show that despite the dichotomous discourse implied by pro-choice versus pro-life, the fundamental issue for women on both sides of the debate is motherhood. They compared Luker's work based in the United States with that of Cannold (2000) who examined the abortion debate in the context of Australian women in order to demonstrate that motherhood and abortion are consistently intersecting issues for women who choose to terminate their pregnancy as much as women who choose not to terminate their pregnancy (Jones et al 2008, 80-84). This suggests that motherhood is the central point of the debate for women, rather than the moral status of the fetus implied by the dichotomised discourse of 'the abortion debate'.

Cannold's work specifically provides an overview of the reasons and justifications as to why women were either pro-choice or anti-choice. Cannold (2000, xxv), parenthetically, used the term 'anti-choice' to describe 'pro-life' because she believed that the term 'pro-life' suggested that those opposing the pro-life position in 'the abortion debate' are somehow pro-death. She interviewed women on both sides of the debate and found that sentiments for and against abortion are not focused on terminating a pregnancy but are rather about "what priority women should give to motherhood in their lives" (Cannold 2000, 119). Cannold's research revealed similar results to that of Luker in that the pro-life (or anti-choice) respondents believed that women had a biological and moral obligation to have children, and regarded abortion as the prioritisation of personal aspirations over maternal responsibilities (Jones et al. 2008, 81).

Both Luker and Cannold's studies showed that women's perspectives in the abortion decision were more aligned to determinations of motherhood than it was linked to the philosophical question of a fetus being considered to have a right to life. The advantage of both Cannold and Luker's framework lies in how their research focuses on women, exploring the justifications for and against abortion and the link to notions of appropriate 'motherhood'. Their research introduces a useful angle onto the determination for the abortion decision, specifically how concepts of motherhood are often a determinant factor during the decision-making process for women. This leads to a corollary point that needs to be considered in my study of gatekeepers. Given the regulatory role of doctors as gatekeepers to women's abortions, it is pertinent to understand whether the significance of motherhood as a determinant factor for a woman's abortion decision is also considered in the decision-making process of doctors. This reinforces the need to understand the decision-making process of a doctor as more than a medical decision, and even more than a moral decision (as I noted earlier). Drawing on the findings of Luker and Cannold it can also be hypothesised that the impact of doctors' perspectives regarding motherhood, and what a doctor might perceive constitutes an appropriate mother, influence doctors in their gatekeeping role. This is a fifth question that this thesis will examine, specifically are doctors

influenced by their own views regarding motherhood when exercising abortion decision-making?

Like Luker and Cannold, Barbara Baird's (1990) oral history of women seeking abortions prior to 1970 in South Australia illuminated the lived experience of women seeking abortions. Her work outlined the illegal abortion industry in South Australia and showed how the politicisation of motherhood and the various impacts of external parties in the abortion decision leads to different social and health outcomes for women. During this period of illegality in South Australia, women underwent procedures performed by unqualified persons colloquially known as 'backyard abortionists', or attempted to practice abortion themselves using a range of techniques (see Baird 1990, 73). Those that could afford the care of a respected medical professional would undergo surgical treatment in a medical facility, despite the fact that abortion was illegal (Baird 1990, 63). Her work presented a variety of different experiences of women accessing abortions, and the great lengths that some women went to in order to gain access to a termination.

For the purpose of my research in this thesis, the importance of Baird's work lies in the behaviour of the medical profession under these circumstances:

> ...the world view of the medical profession (with the exception of some individual doctors) was not sympathetic to women's autonomy and self determination. The interests of women wanting abortions were quite different from the interest of the medical profession, except for those who chose to make money from women's unwanted pregnancies.
>
> (Baird 1990, 21)

Baird's work showed that for those who could afford it, an abortion procedure would take place with little to no complications, but for poorer women exploitative practices of backyard abortionists left many with long-term heath care issues, often following near death experiences. Her work also showed however, that regardless of abortion being criminalised, women sought terminations. In some situations doctors performed the terminations, but doctors were also involved in treating complications after abortions. Her work is valuable because it emphasised the need for safe abortion services. For my concerns in this thesis, it also shows the inevitable participation of the medical profession in treatment concerning terminations of pregnancy, regardless of the legality of abortion.

In Baird's articles "The Incompetent, Barbarous Old Lady Round the Corner': The image of the backyard abortionist in pro-abortion politics" (1996) and "The self-aborting woman" (1998), the role of the medical profession in the provision of abortion is further problematised. Baird suggests that abortion politics in Australia is influenced by a popular history that mobilises images of abortion providers as "powerful currency in the discourse of the contemporary pro-choice movement in Australia, and selective experiences of self-aborting women as *victims,* "whose problem is solved by law reform and thus medicalisation" (1990, 323-324 & 331). Baird analyses the narrative of the self-aborting woman and the backyard abortionist and considers how images of both figures have framed our politics and historical narratives, the basis of which has lead to an understanding of safe abortion being inextricably linked to external medical intervention in the reproductive process. Baird (1998, 323) argues that in the popular history of abortion "self-abortion stands in for, or is prioritised among, those images which represent the illegal past to which we must not return". This is despite the fact that there is evidence to suggest that women have safely aborted their own pregnancies on mass over the same historical period (see Baird 1998, 324).

Baird's work shows how women's experiences can be mobilized in different ways to create a discursive narrative, one that Baird suggests reproduces a class-based distinction in how abortion is understood (Baird 1998, 324). This is because lower, working class women have tended to reproduce narratives about abortion through a woman-centered framework, where as middle-class professionals from the "mid-nineteenth century increasingly promoted foetus- and child-centred understandings of pregnancy and stressed the virtues of prevention of conception over abortion" (Baird 1998, 324). The class-based distinction has meant that women's experiences of abortion are viewed through the lens of middle-class perspectives, which "at best privileges contraception over abortion and medically performed abortions over other kinds, and at worst is clearly anti-abortion" (Baird 1998, 334). The inevitable engagement in abortion by the medical profession is thus likely to marginalise the experiences of individual women in favor of an extrinsic analysis of a woman's pregnancy experience. It therefore devalues the experiences of women and how women understand their own pregnancies,

privileging the role of doctors in being able to define the appropriateness of an abortion.

In seeking to understand the constitution of the gatekeeping role, another question thus emerges from Baird's work. This involves the extent to which different approaches are taken by different doctors, leading to different applications of this regulatory role. This sixth question for my thesis involves how much scope there is for doctors to differentially perform their gatekeeping role. A corollary to this question involves the scope of authority for the medical profession to apply different approaches to an abortion. Thus in establishing what constitutes the role of gatekeeping, Baird's research points to the importance in my thesis of considering the scope of authority provided to doctors, and the discursive foundation upon which this authority is built. .

Newton et al's (2016b) work, "How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers", offers another perspective for understanding the experience of women seeking terminations of pregnancy. Their work focuses on the decisions women make regarding the method of abortion, be it a medical or surgical termination. What Newton et al (2016b, 525-526) found was that the decisions women make regarding the method of abortion includes subjective factors (perceiving medical abortion to be more natural, a perceived increase in privacy for a medical option, and choosing the option that has the least emotional impact) and also practical and pragmatic factors (the time and location of the procedure, the availability of support, and the level of awareness of medical abortion). What this suggests is that even when women make decisions that they will undergo an abortion, there are internal and external drivers that impact their decision-making regarding the method of procedure, including the information provided by medical professionals. So, while Newton et al's work addressed abortion decision-making regarding the method of termination, *that is how it will occur,* and my thesis is focused on decision-making as to whether or not a pregnancy will be terminated, *that is if it should occur,* it nevertheless highlights the significance of external factors on the abortion decisions that women make. My thesis will thus attempt to

address similar questions to that of Newton et al, in particular whether or not external factors impact on the decisions that doctors make regarding abortion.

The research of Newton et al, Baird, Luker and Cannold demonstrated a variety of views amongst women regarding abortion, but for my purposes it also highlights the inevitable involvement of the medical profession in *being able to exercise those views*. Furthermore, their research suggests that there might be similar variability in views regarding abortion within the medical profession. This is important as it alludes to the different ways that doctors can understand the gatekeeping role, despite the fact that the characterisation of gatekeeping is accepted within the law and throughout society as being a consequence of the legal role of the doctor, whose authority is based on exercising a 'medical' decision, rather than an ethical one.

Medical practitioners and abortion

As suggested above, research undertaken on the medical profession itself in the abortion context demonstrates that the views of the medical profession can be varied, and sometimes in dispute with the law (see Haigh 2008, Wainer 1972, Joffe 1995, de Costa 2010, and de Costa et al 2013). This should not come as a surprise, given that doctors have been key providers of abortion services regardless of the law that it is in operation, as Baird's historic research showed. While the research above acknowledges this, there is less understanding of the multiple ways in which this power is exercised.

There are, however, useful studies on doctors in this respect. Carole Joffe's (1995) *Doctors of Conscience: the struggle to provide abortion before and after Roe v Wade*, provides a comprehensive examination on abortion from the historical experience of doctors in the United States. *Roe* refers to *Roe v Wade,* 410 U.S 113 (1973), the US Supreme Court Decision that gave women a constitutional right to privacy during the first trimester of their pregnancy, and subsequently the capacity to access terminations of pregnancy during this period. Joffe's work shows how some members of the medical profession have been key facilitators for accessing abortion. She interviewed medical practitioners, some of who had performed

abortions before the legalisation provided by *Roe,* and all of who had provided abortions after the *Roe* decision.

Joffe labels the medical practitioners who provided abortions before and after *Roe* as a "conscience" generation, who were driven to provide abortions to women because of their experience of the consequences of illegal abortions prior to the *Roe* decision (Joffe 1995, 183). Joffe was concerned that the future of health care for women in the United States was in jeopardy because the retirement of the "conscience" generation provides a gap to be filled by a new generation of doctors that did not experience the trauma of abortion before legalisation (Joffe 1995, 183). Her research placed great importance on the medical profession in facilitating abortions; a role that Joffe believes may disappear with a new generation of health care professionals. Her concerns also reinforce how there are varied approaches to abortion among doctors, regardless of the gatekeeping role of the medical profession, whether under illegal conditions, such as Baird studied in Australia, or the post-Roe conditions studied by Joffe. The latter work suggests that the gatekeeping role of the medical profession can indeed benefit women in facilitating safe abortion, just as it may hinder their access to the procedure. Therefore without a greater appreciation of the constitution of the gatekeeping role, there is a risk that the blanket characterisation of gatekeeping is interpreted to be simply inhibitive or supportive, rather than it being reflective of a practice of gatekeeping that might lead to either outcome for a woman seeking an abortion, depending on the individual doctor.

One key historical piece of research that revealed the role of the Australian medical profession in providing access to abortion and shaping the law regarding abortion was Gideon Haigh's (2008) *The Racket: How abortion became legal in Australia*. Haigh explored the history of abortion law and the effect of the prohibition of abortion prior to the Menhennitt ruling of 1969 in Victoria. This ruling permitted the performance of lawful abortions at common law by medical practitioners provided that they could demonstrate that there was a serious danger to the life or physical or mental health of a woman (Haigh 2008, 135). As Haigh notes: "It is a big story: abortion is a raw subject, precisely because it turns what society celebrates as life's most fulfilling experience into a problem at best, a crisis at

worst…It is a tale of cavernous silences and conspicuous absences – history it was in nobody's interests to record, statistics it was in no-one's power to keep, and events few willingly relive" (Haigh 2008, 11-12). Haigh's history of abortion during the period of prohibition reveals that doctors were performing abortions despite the law, but that the motivations of doctors in doing so varied. This was similar to the observations made by Baird.

Haigh examined how this hidden abortion industry operated prior to the 1970s, and how it only surfaced during periodic inquiries into police corruption. However, he argues that these inquiries did very little to address the systemic and social problems surrounding abortion (Haigh 2008, 198):

> Yet, if investigations of police corruption scarcely delved deep enough, they went far further than those into medical corruption. It's arguable that the behavior of doctors, in their rapacity and recklessness, was every bit as unconscionable as those of law enforcement officers…Illegality served not the ends of morality but the need of greed…nobody ever met a poor abortionist.
>
> (Haigh 2008, 220)

Like the research discussed above (Joffe 1995, Keown 1988, Reagan 1998 and Baird 1990), Haigh's work highlights how different parts of the medical profession were intimately involved in shaping legitimate and illegitimate practices concerning abortion during its era of prohibition. He shows how the medical profession could be either the providers of abortions for those that could afford their services, or were the predominant treating physicians when abortions had taken place by qualified and unqualified persons resulting in unforeseen medical calamities for individual women. What this research demonstrates is that the medical profession has always been active in the provision of abortion services in Australia, resulting in both positive and negative consequences for women depending on the doctor who treated them. Therefore, any attempt, such as that which will be undertaken in this thesis, to understand what constitutes the role of gatekeeping in Australia needs to be aware of how the decisions and practices of doctors can potentially impact negatively on women by subordinating their choices to those of the doctor, just as the decisions and practices of doctors can positively impact on women.

In this respect, it is worth noting Haigh's description of the activities of one of Australia's most renowned abortion campaigners, medical physician Dr Bertram Wainer. This helps to reveal how individual doctors can act to assist women and hence reform restrictive abortion practices. In the 1960s and 1970s Wainer was the predominant figure campaigning for abortion law reform in Australia. In 1972 he published an autobiography titled *It isn't Nice,* in which he recounted the activities he had participated in to seek changes to Australian abortion law. This included staging an abortion where he announced his intention to perform the procedure at a certain location and challenged the police to come and arrest him (see Wainer 1972, 215-216). Wainer sought to show that the complete prohibition of abortion by the law was unenforceable by testing the boundaries of what could be considered a lawful procedure. In response to a series of questions from writer Virginia Freeman detailed in his book, Wainer stated:

> Abortion for me was never a cause or an issue any more important than anything else I might have been involved with…I am always reluctant to say this, but I do not believe abortion is a good thing; it is the lesser of two evils…The issue was one of inequality of rights – the rich have, the poor do not. It is not a question of whether abortions are going to be performed or not, but where, by whom, and how safely and cheaply. At no stage did I have to decide whether abortions were a good or bad thing – I had simply reached the conclusion that they were happening and no law would ever stop them; it was an unenforceable law.
>
> (Wainer 1972, 180-181)

Wainer's views expressed here are indicative of the tenuous relationship between the law, women's desires to abort a pregnancy, and medical practice. It highlights that regardless of the moral and ethical arguments surrounding abortion and abortion law, abortions occur, and that there will inevitably be involvement from a medical professional either to perform the procedure safely or treat a woman in the case of complications after an abortion procedure. What Wainer drew to attention to was that the issue of abortion was not whether they should occur, but how safely they would occur and how cheaply they would be provided so that all women could access a safe abortion regardless of their personal circumstance. He drew attention to issues of social equity.

Wainer's autobiography helped shed light on another problematic aspect of gatekeeping and demonstrated that doctors can engage in abortion for different

reasons. There were doctors who sought to provide abortions and allow access to abortions for women, and some doctors were committed to reforming abortion law, targeted at improving the health care provided to women. Other doctors wanted to hinder access to the procedure or capitalise financially on women's attempts to access the procedure. Wainer's actions helped to reform abortion law and reveal the unethical conduct of some doctors who were exploiting their position by charging women unconscionable amounts of money for abortion procedures, because as long as "politicians, police, doctors and others with power, money and the right connections could obtain safe abortions, while only those with no influence had to face unqualified operators or the possibility of prosecution, then the law was not going to be changed" (Wainer 1972, 185). Thus Wainer's autobiography provides another lens through which to understand the experience of medical professionals regarding abortion, an experience that indicates a complex relationship between the legal regulation of abortion, the desires of patients, and the obligations of doctors to provide healthcare for women.

While Wainer's work explored a doctor working under conditions of prohibition of abortion, Caroline de Costa is a contemporary doctor who has published on the subject of abortion access and abortion law in Australia. In her book *Never, ever, again: why Australian abortion law needs reform* (2010), de Costa, like Wainer, queries the practice of gatekeeping as inhibiting women because "medical practitioners…want (mostly) to be able to refer their patients to safe and accessible abortion services" (de Costa 2010, 2393). de Costa's book tracks the history of abortion law and practice in Australia largely as it pertains to Queensland.

de Costa (2010, 2501) points to the health dangers of abortion being labeled a crime, arguing that women "always and everywhere, have sought, and often found, abortion, when they have made that decision for themselves, and until 1970, many died in the attempt". She presents a similar appreciation of the historical experience of abortion law in Australia as that presented by Baird (1990), Haigh (2008), and Wainer (1972) in which there emerges a progressive narrative regarding the evolving legal struggle for safe medical intervention. For the purposes of my research in this thesis, this narrative shows how medical

professionals have justified the role of gatekeeping as being in the interests of women, and suggests that this role has been necessary for ensuring that women have access to abortion. The narrative limits consideration that the gatekeeping role can be inhibitive of women's rights. I argue that research on the constitution of the gatekeeping role needs to consider that the gatekeeping role can have multiple functions, and that the desire of medical professionals to hold a gatekeeping role may not necessarily be to restrict the decisions that women make.

de Costa's study is representative of arguments from within the Australian medical profession aimed at providing women with safe and legal access to abortion procedures. However as de Costa notes, the failure to reform Australian law in some states means that abortion practice remains an ambiguous area for many doctors, and "they are hesitant about being involved in the practice of abortion themselves" (de Costa 2010, 2493). Whilst her study demonstrates the positive sentiments of many medical professionals towards providing women with access to abortions, it does so on the assumption, like that of Haigh, that the place of the doctor in the abortion decision is generally accepted. This place of the doctor involves doctors providing abortion procedures and thus being involved in the decision-making process for abortion. de Costa herself reiterates that abortion should be a matter for a woman, her partner and her doctor (2010, 2534), indicating that the choices women make should not occur in isolation of external actors, particularly a treating doctor. Such a position reinforces an uncritical acceptance of the doctor as gatekeeper.

However, despite this assumption of the acceptability of a gatekeeping role, de Costa's work does pave the way for a more expansive exploration of the function of gatekeeping and the performance of gatekeeping by doctors. While she accepts that doctors have a role in the abortion process, she does not seem to consider the impact of the doctor in the decision-making process for women, or how doctors come to make their own decisions about abortion cases. If I hypothesise, as done above, that abortion views among doctors are wide ranging and varied just as they are among women (see Luker 1984, Hadley 1996, and Cannold 2000), then the provision of abortion is not simply going to occur because a woman has chosen

this path; there is likely to be some engagement with and by the doctor in the abortion decision. What this requires then is an exploration of the decision-making process for a doctor. In this thesis, a seventh question I will explore is how are doctors educated about abortion and thus taught to exercise abortion decision-making? Findings relating to this question will help us to understand if doctors' decisions are driven by medical knowledge or if they are influenced by the ethical or other non-medical views that doctors hold regarding abortion, or a combination of both.

Preliminarily research into this question is available and helps inform my own research. In 2013, de Costa published the results of a study with Heather Douglas and Kirsten Black which explored aspects of the decision-making process for doctors in New South Wales and Queensland, "Making it legal: Abortion providers knowledge and use of abortion law in New South Wales and Queensland". The study explored the knowledge of medical professionals with regard to abortion law, "their views of this law…and…their descriptions of how they applied that knowledge to their day to day practice" (de Costa et al 2013, 185). The study found that:

> All practitioners were fully aware that abortion remains a crime in their own state and that if they were charged with performing an abortion they would need to provide a defence based on existing legislation and case law. All were aware of the need to conduct consultations, make decisions and perform procedures, and to document all these actions, to conform as closely as possible with the wording of state law. All found this requirement unnecessary, unpleasant, and restrictive of their practice. Many stated in one way or another that they would like to see the law reformed or abolished for these reasons. Most also reported finding the requirement to identify emotional distress demeaning to the women they cared for.
>
> (de Costa et al 2013, 188)

The results of the study demonstrated clear recognition by doctors of their legal gatekeeping role, but also revealed a desire by the medical profession not to have to perform this role as it operates under current legal conditions. In other words, what the doctors' wanted was the ability to engage with women seeking abortions within the confines of their own medical practice. de Costa et al's study draws on similar questions that my own thesis proposes, but without the scope to consider some of the wider social and ethical complexities regarding the abortion debate

presented earlier in this chapter. Hence whilst de Costa et al's study considered some elements of the gatekeeping role, such as how doctors understand the law and then translate this into their medical practice, it did not critically explore all the elements that allowed the constitution of the role, nor how the role is framed in different Australian jurisdictions. Such a study needs to be understood in the context of broader considerations of abortion and the possible differential application of abortion law resulting from individual doctors' values and beliefs, rather than simply from their different interpretations of the law. The former concerns how a doctor negotiates the law and their own values and beliefs to exercise decision-making, where as the latter concerns how a doctor applies the law as it is written to determine the legality of an abortion decision. This distinction is important for my work because my earlier discussion revealed the importance of the social context of abortion decision-making rather than just a legal interpretation.

The research presented in this chapter so far shows the contentious nature of the abortion debate in various domains, from the social to the medical, and from the legal to the ethical. I have attempted to problematise the characterisation of gatekeeping and the published accounts of the actions of doctors in seeking to reform abortion law. Much of this research argues that abortion law can subordinate women's choices to the decisions of doctors, and that the issue of abortion is more complex than the binary 'for or against' suggested by much abortion politics. The literature also shows that doctors have acted to criminalise abortion as well as legalise abortion. Despite this though, the literature has characterised the medical profession as gatekeepers to women's abortions, while others implicitly recognise it, suggesting broad recognition and acceptance of a regulatory role to be performed by individual doctors.

Cannold, quoting a report by the Australian National Health and Medical Research Council, aptly captures this gatekeeping characterisation of the medical profession by stating:

> the legal status of abortion places an obligation on doctors (and others) to play a gate-keeping role. The intention of the legislators and judge who established this role was precisely to ensure that the decision rested finally in the hands of the medical practitioner, rather than the woman.

(1996, 35-36 in Cannold 2000, 25)

However, if we consider the wide-ranging research on abortion in connection to the gatekeeping role, then there emerges a need to consider the constitution of the role of gatekeeping, beyond it being the description of the medical profession under abortion law. This section of the chapter has illustrated that we need a broader sociological understanding of how this regulatory role is practiced and understood. Seven general questions emerged from the literature regarding abortion: to what extent are the decisions that doctors make constituted by medical and scientific knowledge as well as the moral and ethical views of individual doctors (q1)? To what extent does the legal role of gatekeeping subordinate women's choices to the views and judgements of doctors, given the legal authority they are invested with as gatekeepers (q2)? Is the practice of gatekeeping indicative of the legal intent for the gatekeeping role (q3)? Are doctors educated to exercise judgement regarding abortion amidst moral and ethical complexity (q4)? Are doctors influenced by their own views regarding motherhood when exercising decision-making (q5)? How much scope is there for doctors to perform the gatekeeping role in different ways (q6)? How are doctors educated about abortion and thus taught to exercise abortion decision-making (q7)? The next section suggests that literature regarding social and medical power is useful for framing this role of gatekeeping and understanding the performance of gatekeeping in Australia. It also establishes the empirical questions that will guide my exploration of the gatekeeping role to address these general questions, and my specific concerns with the gatekeeping role.

2.2 Perspectives on medicine and power

As noted in the first part of this chapter, the characterisation of the medical profession as gatekeepers to women's abortions presents an assumption that doctors have power over women through their role of regulating access to abortion procedures, but from the research analysed we also know that doctors have a choice as to whether or not they will exercise this power (see Rankin 2001 and 2011). This description of the legal role of doctors implies that gatekeeping operates as a distributive or collective form of power, considering power in the context of what legitimates it and how the structures of legitimisation shape social power (see Heiskala 2001, and Foucault 1982, 778). As we have seen in the first

section of this chapter, however, it is not clear whether the exercise of power by the medical profession is professionally defined with standards and frameworks for ascertaining lawfulness or whether this power is more complexly defined in relation to how an individual doctor understands lawfulness.

Given that we know from the research presented in the previous section that views regarding abortion are varied and contentious, the difference between a professionally defined gatekeeping role and a role defined by the personal political views of a doctor could produce variable outcomes for women seeking abortions, regardless of the law. Therefore there is a need to explore the gatekeeping characterisation of the medical profession in greater depth to determine how it is *intended to* operate within specific jurisdictions, to then compare this with how it *actually* operates. There are existing approaches to the sociological study of power and medical knowledge that are useful frameworks for exploring the intention, and operation, of gatekeeping, and these approaches add a more critical dimension to the understanding of the role.

For the purposes of this thesis, Foucault's approach to studying power is of greater utility than works that consider power to be distributive or collective. A distributive form of power is aligned with the work of Weber where "'power' (*Macht)* is the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests" (Weber 1978, 53 in Heiskala 2001, 242). Power in this context tends to be treated as a zero-sum game where *a* has power over *b*: "an increase in *a's* power means a corresponding decrease in *b's* power" (Parsons 1960, Mann 1986 and Giddens 1995 in Heiskala 2001, 243). On the other hand, a collective form of power also takes the distributive form and suggests that power can be an emerging resource for *a* and *b* through co-operation to enhance their joint power over third parties and over nature (Mann 1986 and Giddens 1995 in Heiskala 2001, 243). However, both forms of power assume that power is given and taken, and that power is the operation of control or persuasion from one person or institution to another. Power in this context is useful for exploring the legal framework of gatekeeping and the shaping of that same legal framework, for example by studying the impact of a doctor's decisions on the abortion choices of

women. However, it does not provide a mechanism for understanding the constitution of the gatekeeping role and its practice. This is because it cannot account for how the gatekeeping role might lead to both positive and negative outcomes for women depending on how the role might be defined by individual doctors. To understand this, it is therefore necessary to go beyond distributive notions of power.

Foucault's approach to power on the other hand shifts our focus in understanding the effect of power from one person to another, to the effect of power on the shaping of the human subject. Power is not an attribute held by an individual, or wielded by one person over another. For this reason I consider Foucault's work to be of greater utility for exploring and comparing not only the intended operation of gatekeeping but also more importantly, the reality of how gatekeeping is practiced.

Foucault himself drew on this distinction. In "The Subject and Power", Foucault (1982, 777) stated that the goal of his work was not to analyse or elaborate on the foundations of power, but rather to "create a history of the different modes by which, in our culture, human beings are made into subjects". It was not 'power' that was the central theme of his work, but rather how power contributed to the shaping of the subject, or more accurately the objectivising of the subject (Foucault 1982, 777-778). This approach is consistent with the wider sociological concerns I outlined in the previous section regarding the shaping of 'the abortion debate'. As Foucault (1982, 788) argued:

> The exercise of power is not simply a relationship between partners, individuals or collective; it is a way in which certain actions modify others. Which is to say, of course, that something called Power, with or without a capital letter, which is assumed to exist universally in a concentrated or diffused form, does not exist. Power exists only when it is put into action.

In the context of this thesis, such an understanding of power provides that gatekeeping can only exist when it is acted upon; the mere characterisation of the role is not indicative of the medical profession exercising power, nor is it sufficient for its exercise. Using this as a framework, we are able to go beyond the characterisation of the doctor as 'having power over women' to shape or alter their abortion decisions, to exploring the techniques of power that operate to construct

the authority of the doctor and the types of approaches to women that may eventuate. A Foucauldian approach is thus interested in the operation of power to shape human subjects, whether doctors or women seeking abortions, rather than studying power within the confines of an exchange where one person exercises power over another and thus overtly alters the latter's behavior or decisions. Utilising such an approach allows me to examine the characterisation of a gatekeeper and to understand the operation of gatekeeping in contemporary society, comparing the assumed regulatory function of gatekeeping with the reality of how gatekeeping is practiced.

The origins of the involvement of the medical profession in abortion law in Australia provide an avenue for exploring this assumed regulatory function of gatekeeping, addressing the first empirical sub-question of this thesis, *how did the medical profession become the legal authority for abortion?* A general question to this effect emerged from Part 1 of this chapter (q3) following an examination of abortion and technology in the work of Palmer (2009) and Rhoden (1986). This question also emerged in the historical work undertaken by Reagan (1998) and Keown (1988), which indicated the involvement of the medical profession in shaping abortion regulation in both the United States and the United Kingdom. Both suggested that the purpose of regulating abortion lay beyond the technical act of terminating a pregnancy, problematising the power held by the medical profession over matters that were beyond the clinical domain.

Foucault's *The Birth of the Clinic* (2010, originally published in 1963 in French and then English in 1973) provides a useful frame for understanding the origins of medical authority as understood by Reagan and Keown, and hence the origin of the regulatory function of the gatekeeping role performed by medical professionals. *The Birth of the Clinic* explored the evolution of medicine, in particular the evolution of the medical gaze. Foucault examined the emergence of the medical clinic in the eighteenth century, establishing how the development of medicine involved a transition from people being accidental to a disease to becoming constituent parts of the disease. He studied the transition from seeing the whole person as an affliction to seeing the subject of the affliction, utilising the distinction where the 18th century patient-doctor question "'What is the matter with you?'

was replaced with another question: 'Where does it hurt?'" (Foucault 2010, xxi). For Foucault, medicine emerged in the later half of the eighteenth century as a positive science, where the person became the object of study (Foucault 2010, 244-246):

> The possibility for the individual of being both the subject and object of his own knowledge implies an inversion in the structure of finitude. For classical thought, finitude had no other content than the negation of the infinite, while the thought that was formed at the end of the eighteenth century gave it the powers of the positive: the anthropological structure that then appeared played both the critical role of limit and the founding role of origin. It was this reversal that served the philosophical condition for the organisation of a positive medicine; inversely, this positive medicine marked, at the empirical level, the beginning of that fundamental relation that binds modern man to his original finitude. Hence the fundamental place of medicine in the over-all architecture of the human sciences: it is closer than any of them to the anthropological structure that sustains them.
>
> (Foucault 2010, 244)

The Birth of the Clinic is a useful tool to begin my own research as it provides an understanding of how medicine has come to hold such social and political significance and, for my interests, therefore legitimises the role of the medical profession as gatekeepers. It also explains the reliance on medical knowledge to manage abortion, shaping abortion as a medical issue. These were the assumptions that we observed in the literature in Part 1 of this chapter, and Foucault's work on power and discourse lends insight into the establishment of the gatekeeping role.

As noted above, Foucault approaches the concept of power as a broader societal phenomenon and rejects its narrow use as a political phenomenon that is wielded by some people over others. As a corollary, Foucault also reconsiders the concept of regulation as being beyond the politico-legal sphere, residing everywhere in society as a way that modern people act out and understand their social relationships. This transformation in the nature of power and regulation is helpful for analysing the problematic nature of the gatekeeping role performed by doctors that is established by abortion law. It allows the researcher to bridge the legal and the social, and the medical and the ethical. Regulation, in other words, does not reside solely as a legal phenomenon, but as a social practice that exists between specific people in each particular interaction.

Viewing the gatekeeping role through this lens shows that by shaping abortion as a medical issue, it is possible that the reproductive rights of women are secondary to the medical interpretation of an abortion decision. As Mackinnon (1991) showed in Part 1 of this chapter, abortion is closely aligned to issues concerning the rights of women to control their bodies and reproductive lives. Hence, any form of legal regulation or medical intervention in abortion is likely to impact on a woman's capacity to exercise certain rights, such as her ability to exercise reproductive rights in her decision to continue with or terminate a pregnancy. This conflict over rights warrants further exploration of the nature of medicalised intervention to determine the likely impact of intervention on women.

Sally Sheldon's *Beyond Control: Medical Power and Abortion Law* (1997) provides a useful framework for examining the privileging of medical views over the choices of women. Sheldon's work draws on Foucault to explore the role of the medical profession in shaping abortion law in the United Kingdom, in particular the medical profession's impact on the decriminalisation of abortion in the United Kingdom with the passing of the *Abortion Act 1967* (UK). Quoting Foucault, Sheldon states that modern society is a "society of normalisation, a society governed less by legal rights than by the authority of the human sciences" (Foucault 1980 in Sheldon 1997, 10). Sheldon then argues that an exploration of the *Abortion Act 1967* (UK) needs to question in more detail "to what extent the lifting or restriction of criminal prohibitions entails an increase in human freedom" (Sheldon 1997, 10). The work conducted by Sheldon problematises the notion that abortion law reform has provided women with an increase in reproductive rights, showing instead that the supposed increase in reproductive freedom has been grounds for medical control and supervision over women (Sheldon 1997, 5). Her work thus raises the paradox that a medical professional's involvement in abortion is likely to lead to greater, unrestricted access for women.

This same question, whether contemporary abortion law reform provides women with an increase in reproductive freedom or a prospective decrease, was also raised in Part 1 of this chapter through the work of Joffe (1995), Baird (1990), and Wainer (1972). All three authors showed that the application of medical authority

can differ between individual medical professionals, with some acting to assist women in procuring safe abortions and others acting to inhibit them. This suggests that despite certain legal frameworks, doctors do act according to what they personally consider to be appropriate medical practice. These findings warrant further exploration of the legal frameworks operating in Australia to understand whether the scope of authority given to the medical profession mandates a regulatory role or provides sufficient scope for a doctor to interpret the nature of the regulation as they see fit. Any preliminary exploration of the scope of legal authority can be framed using a second and third empirical question for this thesis: *what is the legal framework for abortion? and what is the scope of authority over abortion and in what sense is the role regulatory?*

Foucault's *The History of Sexuality Volume 1* originally published in French in 1976 and then in English in 1978, provides a useful basis for exploring these legal frameworks operating in Australia and the scope of legal regulation for abortion. In *The History of Sexuality Volume 1*, Foucault discussed how the various institutions within society operate within a continuum to create a range of devices whose functions are largely regulatory. This continuum goes from the law and state sanctioned intervention in certain areas of social concern to a medical or educational intervention in the lives of individual social actors. The first set of interventions establishes legal regulation, and the second operates as social regulation, but the issue for Foucault was how the two types of regulation combine, or more accurately, how the two operate in connection with one another. In seeking to explore the various institutions Foucault designed an approach that sought to understand how issues concerning reproduction were inextricably linked to a science of sexuality that focuses on analysing desire rather than increasing pleasure:

> in a specific type of discourse on sex, in a specific form of extortion of truth, appearing historically and in specific places (around the child's body, apropos of women's sex, in connection with practices restricting births, and so on), what were the immediate, the most local power relations at work? How did they make possible these kinds of discourses, and conversely, how were these discourses used to support power relations?
>
> (Foucault 2008, 97)

These questions can be useful for my study of gatekeeping in the sense that they highlight the significance of the exchange between a woman and her doctor for establishing particular social discourses concerning sex and sexuality. For Foucault, the discourse of sex was constituted through a range of social interventions and scientific strategies that sought to categorise sexuality and study the science of desire. A key element of this was the practice of restricting births, and whilst Foucault himself did not study abortion at any great length, his framing of the questions shows that abortion belongs to the discourse of sexuality, a discourse that Foucault suggested lead to a shift in the nature of regulation (see Foucault 2008, 144).

In describing the transition Foucault (2008, 144) argued: "I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory". Again, this framing of the issue is a useful way of broadening the abortion debate raised in the opening section of this chapter, where the wider social attitudes and norms need to be considered. Foucault (2008, 142-143) suggested that the shift in regulatory intervention could be considered as a transition towards the operation of 'bio-power', where power would have a mastery over living beings at the level of life itself; "it was the taking charge of life, more than the threat of death, that gave power its access even to the body". This further suggests that the law expanded in scope and influence to affect medical and administrative practices, and that these practices would be defined by various apparatuses to regulate the existence of living beings.

The operation of bio-power, for Foucault, has two broad elements: one is the requirement for some form of regulation and the other is a site for regulatory intervention (see Foucault 2008, 146-147). One such example was "the hysterisation of women, which involved a thorough medicalisation of their bodies and their sex…carried out in the name of the responsibility they owed to the health of their children, the solidity of the family institution, and the safeguarding of society" (Foucault 2008, 146-147). From this perspective, the clinical encounter

between a woman and her doctor is a site for regulatory intervention, and the legal positioning of abortion in the medical domain establishes the requirement for regulation. What this means is that regardless of whether there is legal specificity for regulation, and hence a legally defined gatekeeping role, the position of abortion as a medical procedure ensures that social conduct can be regulated, and hence ensures that a degree of gatekeeping occurs. From this it is possible to suggest that **the constitution of gatekeeping in Australia regulates social norms concerning abortion and reproductive choice through the apparatus of medical practice.**

This Foucauldian approach to regulation means that there is a need for researchers to consider the practice of the operation of gatekeeping, so as to better appreciate the nature of the regulation of abortion established through the characterisation of gatekeeping. If we consider that the shaping of abortion as a medical issue leads to a justified medical intervention for abortion, then it would be plausible to assume that a doctor's knowledge of abortion would be characterised as being within the medical domain. The medicalisation of abortion thus assumes that medical intervention will occur through the application of medical knowledge, requiring that the education of medical professionals be examined to consider the following, fourth empirical question: *how does the education of the medical profession address abortion and the legal role of the doctor?* The general questions that emerged in Part 1 of this chapter (q4 and q7) also showed this to be an important avenue for investigation because the gatekeeping role positions doctors to exercise decision-making amid moral and ethical complexity (see Luker 1984, Cannold, 2000, Hadley 1996, and Dworkin 1994), and it is not clear whetherthey are adequately prepared to exercise decision-making in this context. This was a reality that was shown in Part 1 of this chapter to be characteristic of the medical profession's involvement with abortion over the last century (see Joffe 1995, Baird 1990, Haigh 2008, de Costa 2010, and Wainer 1972).

Exploring the education of the medical profession involves considering the process by which medical professionals acquire knowledge of abortion, and examining whether the process for acquiring medical knowledge teaches the application of legal regulation. This is an important element for understanding the practice of

gatekeeping because it seeks to explain how and why individual members of a body of medical professionals might approach abortion decisions differently. Elements of Eliot Freidson's study *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (1988) provide a useful frame for exploring the problematisation of medical education vis-a-vis the application of acquired knowledge to be able to practice as a medical professional. Freidson (1988, 338) argues "the professional is an expert because he is thought to possess some special knowledge unavailable to laymen who have not gone through his special course of professional training". However, he also claims "the practice, expertise, or application of expertise is analytically distinct from expertise or knowledge itself" (Freidson 1988, 337). This is because the use of knowledge by a significant social actor such as a doctor is brought into the social domain when they engage in a particular abortion decision, and this can change the characteristics of knowledge from known to applied. Freidson's work thus describes the authoritative nature of medical knowledge, but problematises its application on the basis that medicine includes both the scientific knowledge of medicine and the practical knowledge of individual clinicians to personally apply their knowledge, defined as 'judgement' or 'wisdom' (Freidson 1988, 346-347).

If we accept Freidson's proposition that medicine is both the acquisition of technical knowledge and the application of personal knowledge, there is a further need to explore the nature of the operation of gatekeeping to ascertain whether the medicalised intervention over abortion is an applied judgement of medical knowledge by a medical professional or a judgement by a medical professional irrespective of their medical knowledge. In other words are doctors' decisions the application of a defined knowledge base, or are they influenced by both technical knowledge and their own personal knowledge. Hence there is a fifth and sixth empirical question concerning the role of the individual doctor in the abortion context, specifically: *How do doctors actually perform the gatekeeping role? Do individual values and beliefs influence their abortion decisions?* These questions emerged from the general questions identified in Part 1of this chapter (q1, q2, q5 and q6), questions that I identified as being a necessary aspect for my study of gatekeeping. They are also consistent with a Foucauldian perspective, as they provide an opportunity to examine how power is conceptualised at the level of the

exchange between a doctor and a woman, exploring how the power established through law is played out at the level of the individual and thus used to define and shape human conduct.

The gatekeeping role of medical professionals for abortion in Australia is a complex interplay between the law and medical practice, warranting an exploration of how the various elements intertwine to constitute that role. The theoretical perspectives and existing literature on medicine and power explored in this section provide useful frameworks to explore the abortion debate noted in Part 1 of this chapter, generating six empirical questions to be explored: *How did the medical profession become the legal authority for abortion? What is the legal framework for abortion? What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory? How does the education of the medical profession address abortion and the legal role of the doctor? How do doctors actually perform the gatekeeping role? Do individual values and beliefs influence their abortion decisions?* In particular, this section suggests that between the legal assumption of regulation and the practice of regulation, there is a legitimised intervention in women's reproductive choices that reflects a doctor's own views of abortion instead of the application of legal definitions of abortion, or the application of medically scientific knowledge. Using Foucault's conceptualisation of techniques of power, regulation and the operation of bio-power as being constitutive for the shaping of a human subject, it is now possible to analyse the various elements of the gatekeeping role and assess the sites of power that operate to define and shape the gatekeeping role. Figure 1 shows the relationship between these different research questions, highlighting where each set of questions will be examined in the thesis. The main research question is presented on the left hand side and each box shows the empirical questions to be addressed in each chapter.

Conclusion

Part 1 of this chapter showed the complexity of abortion, and problematised the characterisation of gatekeeping for medical professionals. The research showed how abortion regulation was defined by a professional struggle of the medical profession to define legitimate medical practice and justify restrictive abortion practices or protect doctors who perform abortions. The regulation of abortion

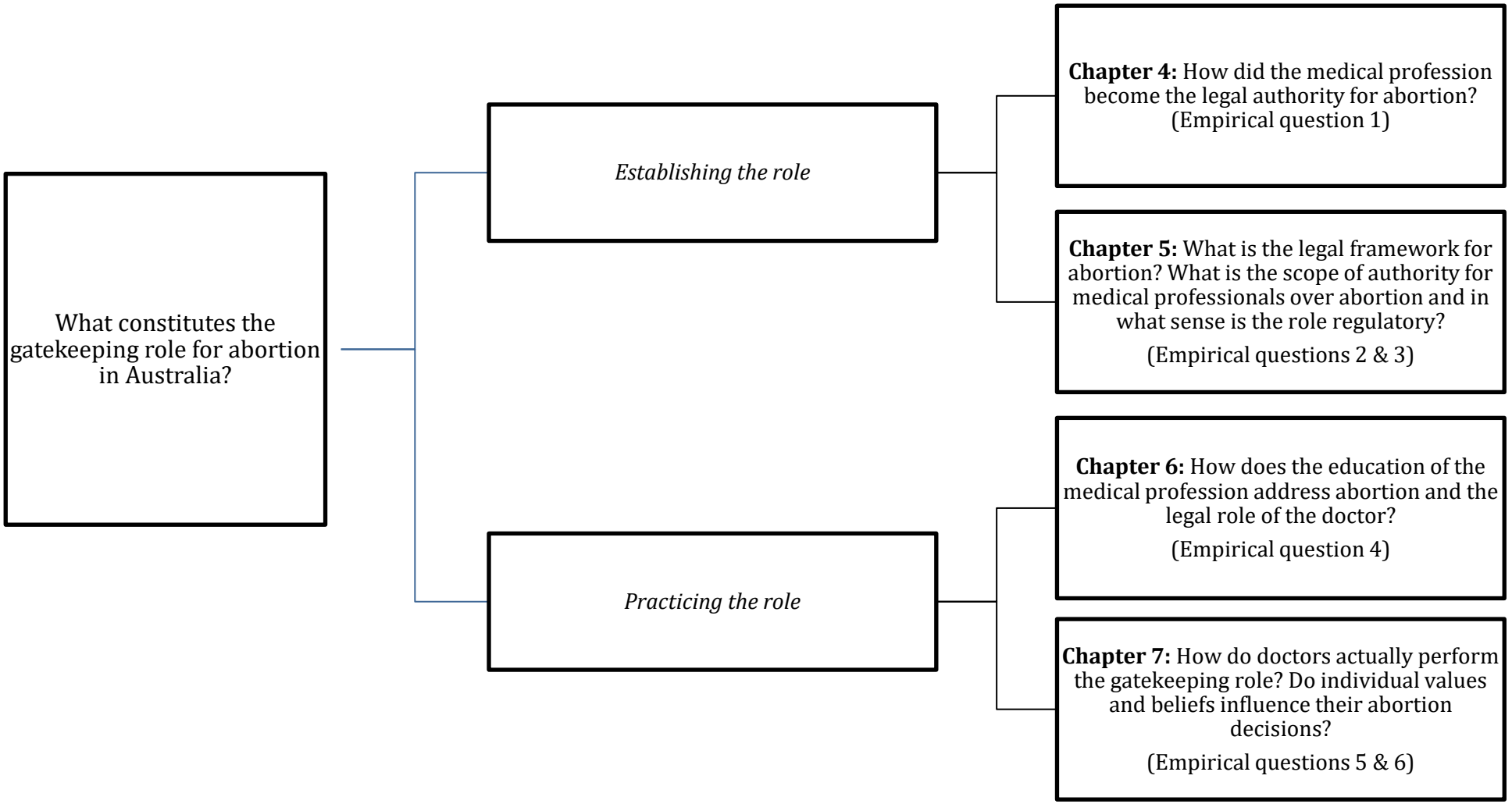
was also shown to have taken place against a backdrop of moral and political arguments as to the appropriateness of abortion, including arguments concerning women's rights and their capacity to control their reproductive freedom. The latter further problematises the role of gatekeeping for the medical profession because the regulatory position of the doctor places them at the site of regulatory intervention where the practical exercise of reproductive rights by women is likely to occur, therefore placing them as potential regulators of women's reproductive rights. From this I established seven general questions.

Part 2 of this chapter used existing literature to develop a useful framework that could be used to understand the site for regulatory intervention in the abortion decision and helped establish a set of empirical questions to focus and explore the general questions that emerged from the literature in Part 1. The involvement of the medical profession in shaping abortion as a medical issue legitimising medicalised intervention leads to an assumption that medicalised intervention is justified because doctors use medical knowledge and apply this knowledge in their clinical encounters. However, the application of medical knowledge was shown to be problematic because it requires that a doctor utilise both clinical and ethical knowledge, with the ethical knowledge being characterised by multiple and competing discourses. In the context of my research topic, this issue is particularly pertinent considering the moral and ethical contexts for abortion described in Part 1 of this chapter. The crux of the issue is that what a doctor brings to abortion decision-making as a gatekeeper can be both scientific and moral, meaning that their decision-making can vary depending on the individual gatekeeper. This problem necessitates greater exploration of the practice of the gatekeeping role so as to expand our understanding of the complexity of abortion regulation in Australia and illuminate the space between arguments for professional legitimacy of abortion regulation, and moral and ethical debates concerning abortion, including women's rights.

Without such an understanding of the gatekeeping role there is a risk that untested assumptions are made about the actions of the medical profession, rather than seeking to explore how the regulatory position of the medical profession affects both the woman accessing an abortion and the doctor having to regulate access to

the abortion procedure. Basically, if we assume that doctors are gatekeepers and accept that characterisation, we then logically assume that there are standards and frameworks for gatekeeping to occur, suggesting that there is some type of regulatory framework and educative process to define the role. The next chapter discusses how Foucault's approach to studying power, which formed the basis of my research design, helped in operationalising the questions raised in this chapter (shown in Figure 1) and also helped in designing a methodology to generate the research findings.

Figure 1: Outline of research questions



Chapter 3

Methodology

Introduction

As noted in the previous chapter, the characterisation of the medical profession as gatekeepers to women's abortions suggests that doctors have power over the reproductive choices that women make (see Cannold 2000, Douglas 2009, and Sheldon 1997). Some authors have argued that abortion regulation has been a consequence of campaigns of the medical profession to advance its own professional agenda (see Reagan 1998, Keown 1988, Baird 1990 and Sheldon 1997). Individual doctors however, have described their attempts as promoting equality for women, providing safe and legal access to abortion procedures irrespective of the law (see Wainer 1972 and de Costa 2010). Regardless, there is no question in the literature that the medical profession has a role in the provision of abortion in Australia, but the nature of this role is contested.

We are thus presented with a gatekeeping characterisation of the medical profession that has not been substantially tested, one that suggests a regulatory expectation for medical professionals but does not necessarily define how doctors are to practice this regulatory role. We are also presented with the possibility that abortion regulation holds different meanings, in the legal, sociological and medical contexts; where the meanings attached to the function imply different expectations of doctors and leads to different outcomes for doctors and their patients. This necessitates a greater exploration of the gatekeeping characterisation in order to better understand the different ways that regulation is established and enacted, from the legal framework of gatekeeping through to the practice of individual doctors making decisions related to abortion requests.

In this chapter I will argue that such an exploration is best approached using a multi-modal method, framed by the primary research question *what constitutes the gatekeeping role for abortion in Australia?* While the previous chapter illustrated the relevance of Foucault for theoretically framing this question, the present chapter commences with an exploration of the utility of Foucault for developing a methodological approach that seeks to understand the characterisation of gatekeeping. Part Two of this chapter discusses the design of the research, specifically the use of three sites from which the data is drawn.

The empirical sub-questions, established in Part 2 of the previous chapter, require different sites of investigation and Site 1 utilises documentary evidence in the form of legislative material, case law and parliamentary documentation, which will be discussed in Chapters 4 and 5; Site 2 uses documentary material from tertiary institutions and interviews with teaching staff, to be discussed in Chapter 6; and Site 3 uses responses from practising doctors to a suite of scenarios of women seeking, or considering, abortions, to be discussed in Chapter 7. My thesis combines a range of research methods focused on these three sites, because in the context of being able to understand/ 'know' the role of gatekeeping, what defines it and how it is sustained, there was not one site of investigation but rather a combination of sites that provided the greatest possibility for exploring the characterisation of the medical profession in this context. Such an approach is unique to the study of abortion because there has not been a study completed in Australia that utilises all three sites of investigation.

3.1 The utility of Foucault

Chapter 2 showed that studies of power and medical knowledge were useful frameworks for establishing a set of empirical questions to explore the role of gatekeeping by the medical profession. Foucault's work in particular was shown to be valuable for understanding how the gatekeeping role is originated, shaped, defined, and practiced. Foucault's approach to studying power and human subjects requires that power and regulation is studied from the effect that it has on individuals and institutions, rather than studying power and regulation within the confines of a single exchange where one person exercises power over another and thus overtly alters behavior or decisions (Heiskala 2001, 242-243). As this thesis is concerned with what constitutes the gatekeeping role, how it is defined, maintained and practiced/enacted, Foucault's approach to studying power was also considered to be the most informative for designing a methodological approach.

Foucault's approach to the study of society and philosophy can be characterised as being both poststructuralist and 'deconstructivist', with his exploration of particular societal phenomena being "concerned with how the development of discursive practices and interactive conventions produce truth and knowledge and

so shape and define subjects and subjectivity" (Prado 1995, 21-24 & 11). His approach to studying power did not focus on the study of power itself, but rather sought to explore the process by which "human beings are made into subjects" (Foucault 1982, 777). Foucault argued that in order to understand how human beings are made into subjects, which in our case would be the process which defines and shapes gatekeepers and those approaching the gate, one must take the forms of resistance against different forms of power as the starting point:

> To use another metaphor, it consists of using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, and find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies.
>
> (Foucault 1982, 780)

To use such an approach, Foucault (1982, 792) determined that five points needed to be established to adequately analyse power relations:

- The system of differentiations which permits one to act upon the actions of others;
- The types of objectives pursued by those who act upon the actions of others;
- The means of bringing power relations into being;
- Forms of institutionalisation; and
- Degrees of rationalisation.

Analyzing power relations thus requires consideration of a range of factors, where the focus of analysis operates across multiple social domains. In the context of this thesis, it requires that we first understand the origins of the gatekeeping role and then examine the various ways that it emerges to regulate abortion access, to then be able to discern the type of regulatory function that operates.

In using Foucault, I am undertaking an approach that seeks to understand how the function of gatekeeping maintains certain truths that shape and define individual doctors and the actions they take in treating women who seek abortion procedures. This provides an opportunity to understand how the "subject is either divided inside himself or divided from others" (Foucault 1982, 777-778). What this means is that we are given an opportunity to understand the form of power that operates to create and sustain gatekeepers, a power that "applies itself to immediate everyday life which categorises the individual, marks him by his (sic)

own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognize in him" (Foucault 1982, 781). The advantage of this approach is that it does not begin by assuming that power is vested in 'gatekeepers'. In other words, the approach seeks to understand the form of power that shapes the gatekeeper and permits the performance of gatekeeping to operate as a constitutive element for either providing women with reproductive rights, or acting as an inhibitor for women seeking to exercise reproductive rights by seeking an abortion.

Such an approach to the study of gatekeeping facilitates the development of a methodology that takes the construction of gatekeeping as its central focus rather than assuming a priori that the power of gatekeeping exists. Hence, in this thesis, it is the process of shaping the role of gatekeeping that is of concern, not the asserted power that a gatekeeper holds; it examines how power operates, rather than what power is (see Deacon 2002, 91). Foucault's approach to studying the operation of power provides the basis for a methodology that seeks to examine the role of gatekeeping beyond the expectation of a regulatory function - an expectation that is implied by the characterisation of gatekeeping presented in Chapter 2 - and moves towards the practice and reproduction of the gatekeeping role.

This thesis is thus concerned with understanding the origins of the gatekeeping role, the definition of the gatekeeping role, and the sustained practice of gatekeeping, all of which are likely to combine to constitute the role of gatekeeping over abortion access by medical professionals in Australia. All three elements informed the research design for this thesis, necessitating the use of three sites for investigation.

3.2 Research design

My dissertation utilised three sites to underpin a broader methodology to analyse the various power relations that constitute gatekeeping in contemporary Australia. Site 1 focused on the law and its origins, Site 2 examined the education of medical professionals regarding abortion law, and Site 3 explored the responses of practicing doctors to abortion scenarios. The research design combined these three sites to understand the various social spaces and institutions that might

contribute to the shaping of a gatekeeping role for medical practitioners. The broader methodology examined the interrelatedness of the various sites, using discourse analysis to understand whether the characterisation of gatekeeping is translated to the reality of the operation of gatekeeping in everyday medical practice. Data collection occurred between March 2013 and concluded in April of 2015.

Discourse analysis was chosen as an appropriate method because it is "primarily a qualitative method of 'reading' texts, conversations and documents which explores the connections between language, communication, knowledge, power and social practices" (Munci in Jupp 2006, 74). My approach utilised discourse analysis to explore the linkages between the various sites of investigation. This provided an opportunity to establish an overarching picture of gatekeeping, from the expectation of gatekeeping compared to the operation of gatekeeping. It helped link my three chosen sites.

The research design was executed iteratively, informed by Foucault's approach to studying power, in particular how power relations shape the subject rather than studying what power is, or identifying who holds power in any given situation. As Foucault suggests (1982, 780), to analyse power relations one must examine it through the lens of an antagonism of strategies, rather than assuming that power exists, analysed from the point of view of its internal rationality. So while the empirical sub-questions identified in Chapter 2 informed the overall research design from the outset, the process of developing the operationalised questions was iterative so as to explore power from the perspective of various strategies, rather than assuming that power identified in one site would automatically demonstrate the same characteristics of power in the subsequent sites. Therefore the findings from Site 1 helped to inform the analysis of the findings from Site 2, and the analysis of the findings from Site 2 informed the analysis of Site 3. The following discussion describes the focus of each site and the deployment of this iterative approach.

Site 1

The legal frameworks for abortion in Australia and the discussion that gave rise to their existence were the central focus of Site 1. The central theme for this site was derived from the literature explored in Chapter 2 concerning the evolution of abortion law (see Keown 1988, Reagan 1998, and Sheldon 1997), specifically how the medical profession came to hold legitimacy in the abortion context and thus hold a legitimate gatekeeping role. Site 1 sought to establish how doctors had come to hold a specified legal role for abortion in Australia, despite abortion being a complex social, moral and political issue, not just a medical procedure to terminate a pregnancy (see Dworkin 1994, Hadley 1996, Luker 1984, Palmer 2009, Baird 1990, and Haigh 2008). The empirical questions investigated in Site 1 were: *How did the medical profession become the legal authority for abortion? What is the legal framework for abortion? What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory?*

What I was seeking to explore in Site 1 was the process of justification for the role of gatekeeping, examining both the intent of the role and the structure of the role established by the law. This formed the basis for understanding the scope of power ascribed to the medical profession, which could then be utilised to examine how doctors are shaped to exercise decision-making regarding women's abortion choices. Historical treatise, legislation, case law, parliamentary documents and Hansard transcripts formed the basis of the research. Historical works were initially gathered from the 1800s through to the early 1900s in the form of historical treatises on the evolution of abortion law. This material was important for illuminating the origins of medical involvement in Australian abortion law. All other material (legislation, case law, parliamentary documents and Hansard transcripts) was gathered for the time period of 1968 until 2015, with 1968 being the year that the first legislative changes to abortion law were debated in Australia, while 2015 was the notional end of my research fieldwork. Material was also gathered in 2016 and 2017 when legislative changes were presented in three Australian jurisdictions, New South Wales, Queensland and the Northern Territory. This material is examined in Chapter 8 in the context of future research.

The information gathered in Site 1 was designed to understand the legal framework of gatekeeping for abortion, which involved not only the law as it was written but documents that explained how the law had come into existence. In other words how power was brought into action through the establishment of particular legal frameworks. For the period prior to the 1960s in Australia, historical treatise formed the basis of my analysis given that the law had not been changed since the inception criminal law in the 1800s and its origins were likely to provide an understanding of the influence of the medical profession on abortion in criminal law. Post 1960, I took the legislative process as being the mechanism for examining this history, as the legislature has a fundamental role in debating the merits of proposed changes before a law can be enacted. In Australia the most appropriate place to find the origins of law was through parliamentary reports and Hansard transcripts.

The use of historical treatise, Hansard material and parliamentary reports addressed my sub question, *how did the medical profession become the legal authority for abortion?* The research was focused on examining how the medical profession came to be an authoritative figure for abortion law. Using historical material, material from the legislature itself in the form of parliamentary debate (published as Hansard transcripts), and multiple versions of proposed legislations that were amended during passage through parliament also provided an opportunity to explore the role of the medical profession in making changes to the legislation. It provided an opportunity for examining power-in-action, drawing on Foucault's approach to how we understand power more broadly. The examination of this first sub-question sought to explore the extent to which the medical profession was involved in shaping abortion as a medical issue, and hence the extent to which the use of medical knowledge regarding abortion is privileged over the knowledge that women hold regarding their reproductive choices. This provided the basis for analysing the likely consequences of the medicalisation of abortion, which was defined as being problematic in Chapter 2 because of the scientific and personal dimensions of decision-making by doctors described by Freidson (1988), and also evident in the work of Wainer (1972), Haigh (2008) and Joffe (1995).

The historical material was derived from key historical texts on abortion law and the medical profession, in particular John Keown's (1988) *Abortion, Doctors and the law: Some aspects of the legal regulation of abortion in England from 1803 to 1982*. This text was chosen in particular because of its focus on the United Kingdom, noting that Australian law originated in the United Kingdom, and its use in other abortion related works as a key authority for the history of abortion law (see Grubb 1990, Thomson 2013, and Drabsch 2005). Hansard material was derived from websites of the state and territory parliaments across Australia, with the exception of South Australia. The material for South Australia was drawn from the official record of the minutes of the *Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968*. I was not able to obtain the Hansard transcripts for South Australia when this report was debated, and so the use of the South Australian Committee's report is limited to the sentiments of different groups, not the overall sentiments of the South Australian parliament.

Two keyword searches were used to find parliamentary material that was relevant to abortion law reform, "abortion" and "termination of pregnancy". Where this yielded limited results, I browsed the various databases starting with the date of legislative change, working backwards until I was able to find parliamentary debate relating to abortion. Material was gathered for the jurisdictions of the Australian Capital Territory, South Australia, the Northern Territory, Western Australia, Victoria and Tasmania, as these were the only jurisdictions where legislative change had occurred prior to 2015. There was no material for New South Wales and Queensland because no legislative reform had taken place in these jurisdictions, and hence no change to the specific legislation regarding abortion.

It should be noted that while legislative debate was obtainable for these five jurisdictions, the Northern Territory's 1974 legislative change was not obtainable and is therefore not included. However, it is unlikely that the Northern Territory changes of 1974 would have had a substantial impact on the findings because these changes brought the legislation in line with the changes made in South Australia (see Rankin 2001, 244). This was not surprising given that the Northern

Territory was governed by South Australia until the 1940s, when it was given the administrative power to make its own laws (see Legislative Assembly of the Northern Territory, 2015). The fact that the debate was missing from the analysis was not, therefore, considered to be of material impact to the broad nature of the findings.

The transcripts were analysed using two operationalising questions: *Did the medical profession have any involvement in defining abortion as a crime? What debate occurred in the legislature when abortion law was changed and did this debate legitimate the role of 'gatekeeping'?* To analyse the material I looked for any reference to 'doctors' or the medical profession, and any indication of where doctors had made appeals to parliamentarians, highlighted these terms and then examined the subsequent passages of discussion around these key words. What I was looking for in the Hansard transcripts was any reference to the medical profession being an authority for abortion regulation, and the types of justifications that would have been made to allow for this, if it proved to be apparent in the transcripts. Such an approach leveraged Foucault's theories of power, seeking to understand how the medical profession might have deployed power to achieve certain actions. This would help in my search for answers to the questions that arose in Chapter 2; specifically how the medical profession had come to hold status in regulating abortion in Australia despite abortion being considered to have both scientific and social dimensions (see Rhoden 1986, Keown 1988 and Reagan 1998). As Keown (1988) and Reagan's (1998) work suggested in the previous chapter, the purpose of regulating abortion lies beyond the technical act of terminating a pregnancy, and thus problematises the power held by various social actors.

The second issue relating to Site 1, specifically abortion law and the precursor legislation to abortion law, sought to examine the legal power that is held by the medical profession. It considered the legal frameworks for abortion in Australia from 1968 until 2015. Each jurisdiction was examined separately because the performance of abortion in Australia is governed according to state and territory legislation. The legal frameworks for abortion, the precursor legislation, and case law addressed two empirical questions that emerged from Chapter 2: *What is the*

legal framework for abortion? What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory? These questions framed the contextual part of the research project and established the basis for highlighting the scope of medical power over abortion.

Legal material was found in the legislative databases of each Australian jurisdiction located on the attorney-general's website of a particular jurisdiction or the parliamentary library of a given state or territory for legislative data. The material was found in criminal law and/or health law. Again, I used the keywords "abortion" and "termination of pregnancy" when searching each website to elicit the material, as abortion was the term used in the United Kingdom's statutes of 1861 upon which Australian law is based, and termination of pregnancy is the medical term used to describe the act of aborting a fetus. Through this approach I was able to obtain some indication of where the legal framework for abortion currently resided, which I then used as the basis for creating a more holistic picture of the evolution of abortion law. This was possible because of the way that law is presented in Australia, specifically the way in which legal documents and/or legal databases contain references to the laws that have preceded them.

Abortion law in each state and territory was analysed using three operationalising questions: *Is abortion governed by criminal law or health law? Are there specified legal criteria for lawfulness and what role do doctors have for establishing if the criteria have been met? How does the law describe the role of the doctor?* Current and historical legislation was recorded in an excel spreadsheet, and the sections were listed against each of the components outlined in the operationalising questions. Each of these questions explored the scope of expected conduct for a doctor that is implied by a characterisation of gatekeeping under each particular legal framework for abortion, and this provided a basis for a comparison of the various frameworks. The operational questions also meant that I had a mechanism for grouping the jurisdictions according to the characteristics of 'criminal', 'decriminalised', and 'hybrid', which also meant that I had a way of comparing the findings of the various sites according to the law that operated in each state and territory. This was important because I was seeking to examine the various ways that power relations are established, exploring how power is ascribed to doctors,

how it shapes the way that doctors conceptualise regulation, and then how power is transmitted through them, rather then seeking to demonstrate how power is used. My purpose necessitated a comparative framework across the three sites.

Through building Site 1, what I was seeking to explore was how the law might constitute a strategy for shaping power, rather than pursuing an approach that assumed the medical profession held absolute power. In this sense, I was examining the position of doctors vis-à-vis women seeking abortions, establishing whether or not the role of gatekeeping gave doctors power over women's abortion choices, or whether it might also define power over the decisions of doctors in relation to women. Answers to these questions thus provided a way of examining whether the power ascribed to the medical profession as gatekeepers went beyond the scope of medicine, thus defining a role for doctors in regulating a social, political and moral issue.

The analysis of both current legislation and the debate that gave rise to it in the legislature in Site 1 was important for understanding the constitution of gatekeeping for abortion because it provided the foundation for examining the scope of legal authority given to the medical profession. Once I had built this basis I could then establish Sites 2 and 3 to explore how this authority might shape and define the views and actions of doctors when confronted with an abortion request. Thus, an understanding of the authority, and the legitimacy of the authority, became the foundation for examining the material gathered in Sites 2 and 3, exploring how an expectation of regulation might compare to the practice of abortion regulation.

Site 2

Site 2 was concerned with exploring the education of medical professionals regarding abortion law, and sought information from tertiary institutions. The purpose of this material was to understand how medical professionals were taught about abortion. I sought to examine whether this teaching reflected the legal frameworks for abortion and whether it contributed to the shaping of a gatekeeper. The sub question that framed the exploration of material at Site 2 also emerged from the literature in Chapter 2, established as an empirical question:

how does the education of the medical profession address abortion and the legal role of the doctor?

Site 2 drew on the focus of Site 1 by asking how a doctor is educated to enact abortion decisions as required under the appropriate legislation. This approach was subsequently taken because my findings from Site 1 revealed that common law understandings of lawfulness for an abortion procedure and certain legislative approaches required that a medical professional, or in some cases two doctors, could perform an abortion where there was a genuine belief/evidence that there was a psychological or physical risk to the mother's health (see Rankin 2001, 231-235 & Rankin 2011). I sought to explore what constituted a psychological or physical risk and to understand how medical students were taught to exercise judgement in determining risk when making decisions regarding a woman's request for an abortion. In the context of trying to understand the constitution of the role of gatekeeping, Site 2 provided a way of understanding how legal power is operationalised by the medical profession, revealing how the power given to the medical profession shapes doctors and thus defines a particular type of conduct. Site 2 was, therefore, a means to examine the nature of power in the abortion context, examining how the medical profession translates power rather than assuming that legal power equates to a particular type of action by doctors.

Site 2 used both course materials concerning abortion and interviews with teaching staff. Information was sought through formal engagement with tertiary institutions to outline where abortion was taught in the curriculum, and the content of that teaching. The operationalised questions were derived from my broad concern addressed in Chapter 2 (*how does the education of the medical profession address abortion and the legal role of the doctor?)* and focused on: the time during a medical student's study when abortion emerged as a topic for discussion; whether or not abortion was a course of its own merit or part of a broader subject area; whether or not students were taught about the law and the key aspects of that teaching; whether students were taught how to apply the law; and whether medical educators believed that the education was sufficient to enable a doctor to practice lawfully (see Annex F). I also wanted to understand the context of abortion teaching and its relative importance within medical curricula. I

considered this to be a necessary aspect of my questions because it would reveal the quantum of teaching that students were exposed to. It would also overcome a potential limitation of the research. This limitation was that a focus on abortion teaching alone could negate an appreciation of teaching that addresses other issues that may be relevant to abortion practice like professional or ethical practice training. In pursuing this approach, I wanted to understand how an understanding of the law acquired during medical training might inform the practice of medical professionals. Participants were given the option to participate in person, via phone interview, through Skype, or by completing an electronic questionnaire.

Interviews with teaching staff used semi-structured interview techniques largely because in the case of my research project, qualitative interviews inevitably demanded interpretations, where participants were meaning makers rather than passive conduits for retrieving information (see Warren 2001, 83). Such an approach acknowledged the professional status of medical educators and respected that, as professionals, they could be reflexive of their own teaching. It also meant that the complex social, political and moral issues associated with abortion could be reflexively explored by interviewees. As a result, the research design intentionally left the interviews open in order to respect the professional knowledge and capability of the interviewees to explain medical education, and to explain their own views of that education in a non-confrontational setting.

The decision to use interviews in Site 2 was also influenced by their value in previous research on abortion related issues. Previous use of interviews has provided a rich source of information, particularly pertaining to women's experiences of abortion and the attitudes of medical professionals during periods of criminalisation and legalisation (see Baird 1990, Messer & May 1988 and Lee 1969). Ryan et al (1994) in particular recorded women's experiences of seeking an abortion in the context of a public discussion about abortion that focused on abortion being a moral issue (see Ryan et al 1994, ix). The authors emphasised the importance of the primary material they gathered through the interview process, contrasting the findings of the interviews against the various discourses on abortion that dominated the public sphere. This revealed the value of interviews in

being able to show how a discourse is not only what is documented but how people come to understand and interpret written material. Thus, the focus of my research in using course material and interviews considered the content, process and practice of education. If I had only examined the content of medical education, this would have ignored how students actually acquire knowledge and the process whereby they come to learn to practice that knowledge. The latter is a key element in understanding how the legal expectation of gatekeeping is translated through education into medical practice.

The collection of material for Site 2 commenced in July of 2013, when I wrote to the Deans of Medical Schools in Australia requesting access to course material and approval to speak with teaching staff (see Annex C). The names of the Deans of Medical Schools were found by first establishing a list of medical schools in Australia using the Australian Universities webpage (http://www.australianuniversities.com.au/schools/medical), and then confirming the list with the Australian Medical Council (webpage http://www.amc.org.au/index.php/ar/bme/schools), the professional body that provides accreditation for medical programs across Australia. Through this process I was able to confirm that there were 18 institutions accredited to teach medicine in Australia. These institutions are spread across all jurisdictions in Australia with the exception of the Northern Territory. There is no medical school based in the Northern Territory; a university from South Australia provides the teaching of medicine there. I sought input from all 18 institutions so that the material gathered could be analysed in line with the majority of legal frameworks (criminal, decriminalised and hybrid) explored in Site 1.

Of the 18 institutions, 4 provided no response, 1 stated that they would not allow third party access to their materials, and 6 agreed to participate on receipt of my ethics approval documentation. Of the 6, 1 required that I have ethics approval from their institution and another 3 sought approval from their research and education committees. Once I had provided the information and had gained the necessary approvals, the institutions provided the names of people with whom I could liaise. The material gathered in Site 2 was drawn from 10 out of a possible 18 tertiary institutions, with 13 teachers participating in interviews and three

institutions providing course material. All participants interviewed were involved in the teaching of abortion from different parts of the curriculum, and included obstetricians, gynecologists, lawyers, ethicists and nurses. My use of the term 'tertiary educators' thus includes five different professional groups. The range of institutions was representative of the groupings I applied to the analysis in Site 1 (criminal, decriminalised, and hybrid), and hence provided a basis for comparing the legal role of gatekeeping with how the role is translated into the education of doctors.

The structure of the phone interviews and the face-to-face interviews did not always follow the interview script, as is expected in semi-structured questionnaires. The flow of conversation usually meant that many questions in the protocol were addressed as the conversation flowed. I often found myself taking notes of questions that appeared towards to the end of the protocol, gauging elements of the previous questions as flexibly as I could. In this context, the semi-structured nature of the interviews gave participants space to elaborate on issues and provide their perspectives on the complexity of the teaching for abortion in medical schools in Australia. This flexibility added depth and richness to my fieldwork, allowing me to take into consideration issues that the participants felt were important and relevant.

In this way, my engagement with the participants followed the ongoing conversation rather than the questions, facilitating a flow of information where interesting and unexpected new information emerged: the word “maniacs” was used by one participant to describe those doctors who refuse to provide certain health treatments because of moral or religious grounds; and the word “underlings” was used to describe the clinical teaching of medical students. The emergence of these phrases during conversation gave insight into the sentiments that participants bring to their practice, sentiments that I had to take into account when considering the constituent parts of the gatekeeping role. They also reinforced the value of discourse analysis. These sentiments that emerged from the more free-flowing interviews therefore helped inform my analysis of the education of gatekeeping at Site 2 and gave me preliminary insight into the practice of

gatekeeping for Site 3, specifically the extent to which individual values and beliefs enter the clinical encounter to define the abortion gatekeeping role.

During my fieldwork, I also maintained flexibility in relation to my use of terminology, specifically my use of the word 'abortion'. Formal documentation retained the word, but when speaking with participants and prospective participants I adopted the term 'termination of pregnancy', as this was the phrase that I discovered was used by specialist obstetricians and gynecologists working in the field. In fact on at least two occasions, clarification was sought from participants in tertiary institutions that I was seeking information on termination of pregnancy in the broader sense, rather than purely the physical act of aborting a fetus. At least one practitioner in the field noted that the medical term 'termination of pregnancy' was more appropriate to use when speaking with participants, as this is the clinical term and is used in everyday medical discourse. It was thus more appropriate to discuss 'termination of pregnancy' instead of abortion, as this heightened my credibility in being able to engage with the participant population.

The change in terminology also informed how I examined the material in Site 1 as it flagged the likelihood that abortion law would characterise the act differently depending on the legal domain, that being criminal law or health law. I found that the term 'termination of pregnancy' tends to be used in the context of lawful medical terminations of pregnancy performed by medical professionals, where as the term 'abortion' appears in the legislation that governs the act as being criminal in some jurisdictions (*Crimes Act 1900* (NSW) s 82-84, and *Criminal Code Act 1899* (Qld), ss 224-226). Abortion is however, the term used more broadly across the academic research domains discussed in Chapter 2. I have thus maintained the use of abortion throughout my thesis, but it is important to note that practitioners themselves often use the term 'termination of pregnancy'. In this context it refers to the same procedure (including both medical and surgical options) as the words are often used interchangeably, but the characteristics of medical terminations of pregnancy are the subject of this thesis given the legal role of doctors in providing access to abortions.

The evidence from Site 2 was designed to extend an understanding of the scope of regulatory conduct, specifically through examining how the education of a doctor related to the regulatory conduct that was defined by the legal material gathered from Site 1. The material was collated in an excel spreadsheet, broken down by participant and survey question, providing a mechanism for comparing the different responses for each question, and also a basis for examining each participants response in their entirety. The analysis of the data was framed using the questions: *What education do medical students receive regarding abortion? Are doctors taught certain criteria to determine the appropriateness of an abortion procedure?* What I was seeking to understand here was how the law was brought into action, and thus how the power of the law might be applied to medical education, and hence applied to doctors to shape them into regulatory actors. Participant quotes were selected based on how their responses addressed these questions, and the context in which they gave their answers was formed the basis of my findings. The questions also emerged from the literature in Chapter 2 concerning abortion and motherhood, where it was shown that a woman's rationale for an abortion can be based on a diverse range of views (see Hadley 1996, Luker 1984 and Cannold 2000). This raised the question whether or not doctors would be prepared to exercise judgement amidst the moral and ethical complexity that is inherent in abortion decision-making.

Site 3

Site 3 explored how practicing doctors approached abortion cases, specifically to understand how a doctor might translate the regulatory expectation of gatekeeping and the educative experience that defines a type of regulation. The empirical questions developed to frame the investigation of Site 3 were: *How do doctors actually perform the gatekeeping role? Do individual values and beliefs influence their abortion decisions?* The analysis was focused through the use of the following sub-questions: *What reasons do doctors provide for supporting an abortion or not? Are judgements about women's choices made in making a decision to support the request?* These questions were focused on the findings generated in Sites 1 and 2, combining the law and the educative experience of gatekeeping with an appreciation of the operation of gatekeeping at the level of the exchange between a woman and her doctor.

What I was exploring specifically in Site 3 was the extent to which individual values and beliefs entered the clinical encounter. Here I was exploring whether the moral and ethical complexity of abortion shown in Chapter 2 (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984 and Cannold 2000) impacted on doctors when exercising judgement in abortion cases. This information could then be compared to the findings of Sites 1 and 2 in order to understand if there was an acceptance that individual beliefs could impact the decisions that doctors make. From the findings of Chapter 2, the approach taken hypothesised that gatekeeping was a consequence of both the establishment of a particular regulatory function and the practice of that same regulation, where the power invested in doctors as gatekeepers to women's abortions would define a particular context for decision-making.

Site 3 used responses from practicing doctors to a range of scenarios of women considering a termination of pregnancy. There were 8 scenarios in total; 7 were hypothetical and the final an actual abortion case that occurred in 2009 which was prominent in the public sphere. The questionnaires were distributed to participants as Microsoft Word documents (see Annexes G and H). Participants were asked to respond to the scenarios, as well as to a series of questions regarding their educative experience. Regarding the scenarios, participants were asked whether or not they would have supported the abortion request, how they might have reacted or felt about the situation, and what advice they would have given to the woman. I combined this with a series of questions regarding education, which referred to the extent of the respondent's abortion education, what participants remembered about the education, whether the education concerned abortion law and how to apply the law, and finally if participants felt confident in their understanding of the law. Participants were asked about their education in order to link their education concerning abortion with their medical practice, thereby allowing me to examine the translation of abortion law into medical practice through the educative experience from the perspective of practicing doctors. In this way I was able to link my findings from Sites 1, 2 and 3.

The use of the 7 hypothetical scenarios came about as a result of ethical concerns regarding doctors having to discuss real abortion cases. The first iteration of my research involved interviewing practicing doctors who had provided abortion services since 1969 in Australia, the year that the first common law ruling on the grounds upon which an abortion might be considered lawful was introduced. I was seeking examples of the types of engagements that doctors had been involved in. In taking such an approach, I was looking at how doctors performed the gatekeeping role by understanding how doctors themselves understood the process for allowing women to access abortion procedures as well as the characteristics these woman would need to demonstrate to be able to access abortion services. However, in designing the questions about doctors' experiences in recommending abortion services, I became concerned that the approach might require that doctors admit to a potentially illegal act, because the criminality of abortion remains variable across Australian state jurisdictions. As the law allows for a medical practitioner to establish reasons/defences to constitute a lawful abortion, the risk of uncovering any illegal activity was considered to be low, but it was nevertheless real. The consequence of my initial research design would potentially open doctors to legal scrutiny. Therefore, an alternative approach to understanding the performance of gatekeeping was designed. Participants were asked to respond to hypothetical scenarios of women requesting an abortion rather than providing the details of personal experiences.

My alternative approach was designed to elicit a doctor's understanding of the various issues pertaining to the provision of abortion services without placing them in a position of increased legal risk. An added advantage was that this approach allowed me to control for certain variables, including legal, clinical, ethical, and social considerations, ensuring that responses would be focused on the doctors rationale for their decision.

In designing the approach for Site 3, I came to appreciate in greater depth the nuances of my research project. I found that the change in my research design did not result in a loss of value for my research by moving away from descriptions of actual cases. I found that my evidence was strengthened through the utilisation of a method that was more aligned to an exploration of the professional values and

judgements that doctors make and the basis for certain types of judgements. As noted in Chapter 2, despite abortion being a complex moral and ethical issue, there is a role for the medical profession in regulating access to its use (see Wertheimer 1972, Dworkin 1994, Keown 1988, Reagan 1998, Hadley 1996, Wainer 1972, Haigh 2008, Joffe 1995, Baird 1990 and de Costa 2010), thus warranting an examination of the extent to which the individual values and beliefs of doctors enter the clinical encounter. The use of the hypothetical scenarios also opened up the prospective field of participants to include any person who has practiced medicine in Australia between 1969 and 2012/2013, rather than simply those who had encountered actual abortion scenarios.

The hypothetical scenarios presented a range of abortion situations. The women described were fictional characters except for one, but the circumstances they found themselves in correlated to the many stories of women seeking abortions in Australia recounted in the rich body of oral history and archival research on the subject (see Baird 1990, Wainer 1972, Ryan et al 1994 and McCalman 1998). It should be noted, however, that the scenarios were only a sample of the many different circumstances that women can face when seeking an abortion; there is no single reason as to why women seek an abortion, nor is there a common characteristic among all women seeking abortions (see Rosenthal et al 2009 and Guttmacher 2013). However, the development of the scenarios as representative of possible abortion cases was reaffirmed during the course of the fieldwork, with one participant stating "I have had a quick read through them and they all sound very familiar and fit with the sort of women and situations I encounter every day in my abortion practice" (Anne, 26 February 2014).

The scenarios sought to examine the extent to which the decisions made by doctors were influenced by a doctor's moral and ethical beliefs, or whether the decisions were constituted by medical and scientific knowledge. This was a question that emerged in Chapter 2 following my examination of literature concerning the morality of abortion (see Dworkin 1994 and Wertheimer 1971), and also literature concerning abortion law, where the lawfulness of abortion has historically been ascribed to situations where there is deemed to be a physical or psychological risk of harm to a pregnant woman (see Rankin 2001, Haigh 2008,

and Wainer 1972). Each case focused on a different situation, bringing to the fore different elements of a woman's personal circumstances that might contribute to a particular abortion decision. The range of cases was designed to test how a woman's personal circumstances and psychological health might impact on the decision-making process for a doctor, examining whether different circumstances would elicit a different response. My hypothesis was that there would be certain characteristics of women that would define a diagnosis of psychological risk for the abortion to occur, but that different doctors would also respond differently to the women presented because of the ethical complexity of abortion. The hypothetical scenarios were designed to test whether this was the case.

The first scenario explored responses to abortions that occur as a result of sexual assault. This type of scenario has been considered to be a legitimate justification for an abortion by persons on either side of the abortion debate, be they pro choice or pro life, and thus have generally been considered to be lawful (see McAllister & Pietsch 2011, 120, and Cameron & McAllister 2016; see also Wainer 1972). The case sought to test this assumption, examining whether a doctor's response to sexual assault would alter how they react to abortion cases. The issue being tested was whether a person's moral view of abortion would dictate a particular outcome or whether the presence of sexual assault would change their moral stance.

Scenario 2 presented the case of a married woman who had several children, and sought to highlight how doctors considered variables such as age, family circumstance and economic viability in their decision-making process. This case was similar to many of the stories told by women in the oral history of abortion in Australia (see Ryan et al 1994, Baird 1990 and McCalman 1998). Scenario 3 on the other hand, removed elements of a woman's experience that might invoke empathy and compassion. This scenario sought to examine whether a woman's career had an impact on the decision-making process for a doctor.

The fourth scenario sought to explore how views regarding particular careers, in this case prostitution, entered the clinical encounter. The contrast in career choices between the third and fourth scenarios was used to test the extent to which a doctor's values regarding prospective motherhood might influence their

decision-making process. This was an issue raised in Chapter 2 following my examination of literature regarding abortion and motherhood (see Luker 1984 and Cannold 2000), where it was shown that a person's views regarding abortion can often include how they perceive motherhood and what might constitute an appropriate mother, just as it can be a reflection of how they understand the moral status of a fetus (see Dworkin 1994 and Wertheimer 1971).

Scenario 5 examined the impact of personal relationships on the decision-making process for a doctor. The case presented a woman who had fallen pregnant within a problematic relationship, with the pregnancy now being the catalyst for increased psychological distress. In this scenario, I again sought to explore how doctors make determinations of psychological stress, determining whether relationship issues would impact this. Scenarios 6 and 7 further explored the impact of significant psychological stress on decision-making. In these cases, I wanted to explore whether religious beliefs would be a factor for doctors making a particular decision. These three latter scenarios sought to examine the extent to which recognition of individual values and beliefs outside of the medical domain, in this instance personal relationships and religion, might impact on the decision-making process for a doctor. This was important because as I pointed out in Chapter 2, the literature concerning abortion, morality, and motherhood revealed that a person's perspective on abortion could be shaped by a range of factors (see Luker 1984, Cannold 2000, Dworkin 1994 and Hadley 1996), suggesting that doctors, like all social actors, could be shaped by these same factors and thus hold different views regarding abortion.

The final scenario involved an actual case, that of Tegan Leach and Sergie Brennan, a young couple who faced abortion-related charges in 2009 in Queensland and were tried in 2010 (see *R v Leach and Brennan* (2010) QDC 74). This scenario provided participants with an opportunity to comment on a real life situation, and allowed me to explore how doctors used their professional judgement in relation to a contemporary case. I also used this case to explore how doctors conceptualise the relationship between law and medical practice as Tegan was the first woman in Australia in 50 years to be charged with procuring a miscarriage, and abortions have been occurring in Australia throughout this period (Betts 2009, de Costa

2005 and Cannold 2011). The case therefore provided a way to link my various research sites, as it gave an appreciation of how the law is understood by individual doctors. In trying to understand the role of gatekeeping this was important because as I discussed in Chapter 2, whilst the medical profession may have authority to shape and define abortion practice, the exercise of this authority should be with due recognition of the social values that establishes the medical profession's role under law (see Rhoden 1986). Doctors' perceptions of the law were thus a key element for understanding what constitutes the role of gatekeeping, and the use of an actual case attempted to achieve this.

Participants for Site 3 were sought using a range of channels. Initially, the call for participants (see Annex A) was sent to Sexual Health and Family Planning organisations in Australia and also to medical practitioners who were known to me. This yielded a total of three research participants. A subsequent call for participants was made in September of 2013 through a number of peak bodies for medical practitioners in Australia, including GP Victoria (now Networking Health Victoria), CheckUp: Advancing Primary Healthcare, Western Australian General Practice Education and Training, the Royal Australian College of General Practitioners, Marie Stopes International Australia, Aspen Medical, Royal Darwin Hospital, Rural Doctors Association of New South Wales, New South Wales Rural Doctors Network, Central Queensland Rural Division of General Practice, West Belconnen Health Coop, Fountain Corner Adelaide, Globe Medical Practice in Adelaide, and two family practices in South Australia. I sought contacts for each Australian jurisdiction in order to recruit participants that would be working within the legal frameworks that were to be investigated in Site 1.

Three groups responded that they would add the request to their monthly or weekly newsletter, and 1 other group stated they could not distribute the call, though they suggested that the Australian Medical Association (AMA) might be better placed to make the request. The AMA declined to distribute the request stating that the "AMA is not in a position to distribute this material as our various publications are not generally used as a conduit for PhD projects" (Email correspondence with the AMA Dated 12 November 2013). Following this second attempt, I had one individual participant contact me to participate in the research,

whom I had initially contacted through New South Wales Rural Doctors Network. In January of 2014, I sent the request to a further 7 medical entities through an online search for "Abortion service providers". I obtained an additional participant through this recruitment method. The final research participant came to me through a mutual contact.

In this manner, a total of 6 practising doctors formed the basis of analysis for Site 3. The small sample size did present a challenge in being able to extrapolate the research findings that pertained to Site 3. However in analysing the data, particularly in relation to the findings that arose from my analysis of Sites 1 and 2, I did not consider that the sample size would be an insurmountable barrier in presenting a picture of gatekeeping. This was because the research focus was the constitution of the role of gatekeeping, and hence I was not seeking to prove the existence of any specific regulation rather I was seeking an indication of the type of regulation. Had this been my purpose, a greater sample size would have been warranted because the range of regulatory frameworks would need to be aligned with a sufficient number of doctors from each jurisdiction to show the direct relationship. However, what I was seeking to understand was whether or not individual values and beliefs regarding abortion were apparent within the medical domain, just as they are within broader lay community, and hence the small sample size did not alter my capacity to ascertain if this was the case. That being said, it did alter my ability to understand the extent to which individual values and beliefs impact on the clinical encounter, and as such these findings need to be viewed with the caveat that they are indicative of the presence of individual values and beliefs, not necessarily representative of the impact of individual values and beliefs on women seeking terminations of pregnancy.

During the course of my fieldwork, I received feedback from a research participant of Site 2 regarding my overall research project. The information I received was of direct relevance for the execution of fieldwork in Site 3, and hence influenced how I carried out my fieldwork. The participant stated:

> Focusing responses on the medical professions personal values and judgements is the main focus of your thesis. Given the limited training received by medical students on abortion, patients are seeking advice from a medical profession that is largely untrained. Personal values appear to be the only tools available for clinical

> decision-making. And yes, whilst GPs are gatekeepers for many clinical and social issues (e.g. Centrelink entitlements, etc), these decisions are usually informed, evidence-based (and shouldn't rely on, or are prevented from relying on value judgements). Not the case with abortion unfortunately.
>
> (Lucy, 3 October 2013)

The point Lucy was making was that the emphasis of my instructions to the research participants should be on soliciting the values and judgements of doctors, rather than seeking their decision as to the clinical options for abortion. Clinical options would refer to either a medical or surgical termination, or other treatment to manage the woman's situation. A medical abortion refers to the administering of pharmaceutical substances to bring about a miscarriage and surgical refers to a procedure undertaken by a practitioner to remove the contents of the uterus. Whilst the clarification of a medical or surgical abortion does concern a decision-making process, it focuses the participant's attention on the clinical aspects of abortion and not the broader moral and ethical elements that may come into play when a doctor considers whether or not to perform an abortion, or assist a woman in procuring one, rather than how to perform the abortion. As my research design was focused on the influence of individual values and beliefs on the decision-making process for a doctor compared to their knowledge of abortion law and the legal requirements for a lawful termination, I considered the change to be necessary.

In response to Lucy's suggestion, I amended the instructions. The instructions provided to participants initially read:

> INSTRUCTIONS: The following scenarios are descriptions of different women who have requested an abortion. Please read each scenario and provide comments as to whether or not you would support the abortion. Describe how you might react or feel towards the woman and whether, if supported, the abortion would be medical or surgical. Scenarios 1 through 7 are fictional; scenario 8 is based on a litigated case of abortion that occurred in 2009. For the purpose of the scenarios, assume that all women are physically and clinically fit to undergo treatment.

The instructions were changed and emphasis added:

> INSTRUCTIONS: The following scenarios are descriptions of different women who have either requested an abortion or may be candidates for one. Please read each scenario and provide comments as to whether or not you would support the

abortion. Describe how you might react or feel towards the woman. What advice would you give?

Scenarios 1 through 7 are fictional; scenario 8 is based on a litigated case of abortion that occurred in 2009. For the purpose of the scenarios, assume that all women are physically and clinically fit to undergo treatment.

The change in instructions helped clarify the type of response I was looking for. I was seeking to elicit the types of values and judgements made by practitioners with regards to women seeking an abortion. The suggested changes were made in October of 2013, and the revised approach was used for the final three participants. The responses of the participants did not differ in detail from the previous three, but there was a greater emphasis on the advice that would be provided. This meant that the research findings were focused on the behavior of the doctor and the decision-making process, rather than whether or not they would agree to facilitate access to an abortion and the type of abortion that they would recommend. The impact of this change on my findings was not significant, as it did seem to alter how doctors explained their decisions. It did, however, require greater explanation of the decision made. As such, the difference in findings did not have a material impact on the overall findings of my thesis, and hence all six responses are used in Chapter 7.

The material gathered in Site 3 was analysed using a combination of key word searches and tabular comparisons. The data was entered into an excel spreadsheet, listed by participant for each scenario. This allowed me to visually compare the response of each participant to the same case, as well as each participant across the cases. It also allowed me to appreciate the temporal aspects of abortion education and current practice, particularly when comparing the length of time that individuals practiced and their responses concerning abortion education and abortion law. Through this process, I determined that the material gathered in Site 3 concerning the educative experience of practicing doctors was not required. This was because what I was examining was not a causal relationship between the law, medical education, and medical decision-making, but rather the contribution of multiple factors to a characterisation of gatekeeping. In other words, I was not trying to demonstrate that one site lead to another site, but rather that the various sites combine to create an overall characterisation of gatekeeping. The questions that I used to operationalise my examination of Site 3 also focused

on the impact of individual values and beliefs on the decision-making process, and as such the material concerning education was not relevant for this purpose.

In executing the research design, the approach considered the interrelatedness of the three sites for investigation, namely the *law*, *medical education* and *abortion decision-making*, and as such was completed iteratively and in parallel rather than being executed sequentially. Sites 2 and 3 were progressed in parallel with one another, and Site 1 was progressed following recruitment of participants for sites 2 and 3. The analysis of my research findings was undertaken sequentially commencing with Site 1, then Site 2, and then Site 3. I approached my research analysis by looking at the common themes across the sites, which included any justification of medical decision-making for abortion and the positioning of the medical profession's decision-making capacity over that of women. I also looked for any reference to the legitimacy of medical knowledge and medical practice. These themes were a consequence of the general questions raised in Chapter 2, which largely question whether the ethical, moral, and political complexity of abortion is applicable to the decisions that doctors make. This approach was taken because the role of gatekeeping had been assumed and/or described by previous research in this field (see Cannold 2000, de Crespigny & Savulescu 2004, and Douglas 2009), but it had not been substantially tested.

Conclusion

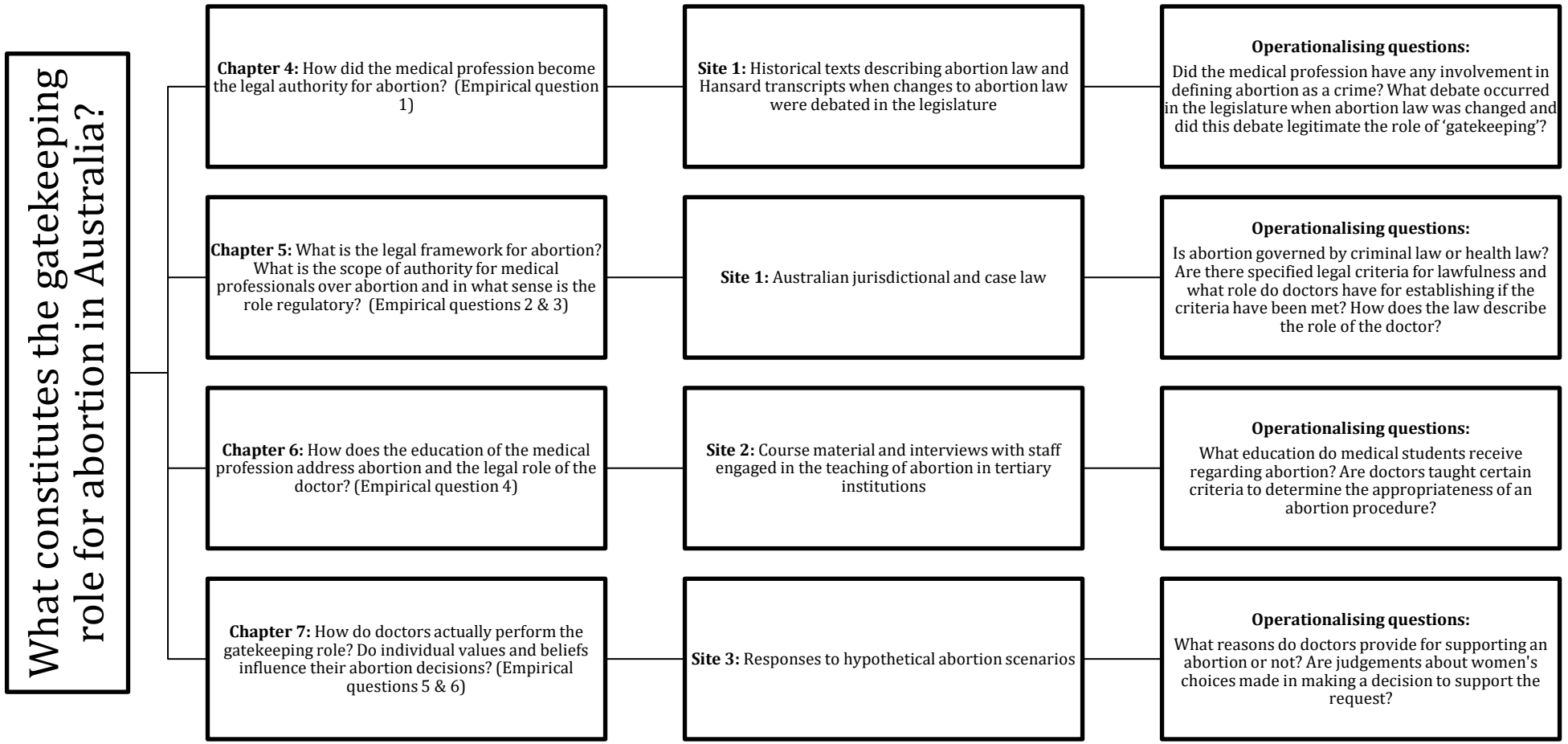
The research design used for this thesis used discourse analysis across three sites of investigation: Site 1 explored abortion law, case law, parliamentary material and Hansard transcripts; Site 2 examined the education of doctors regarding abortion and abortion law; and Site 3 sought information from practicing doctors confronted by abortion cases. Examination of these three sites for investigation, coupled with an iterative approach to the execution of the research, provided scope to appreciate the nature of the role of gatekeeping for abortion, and the process by which it is legitimated and maintained. The methodology examined the characterisation of gatekeeping by exploring the various sites where gatekeeping is mobilised to create an expectation of regulatory conduct, which might then legitimate the regulation of women's abortion choices.

Figure 2 is a graphical representation of the overarching methodology, identifying how each site contributes to our understanding of the next site. It reveals how each site contributes to answering the primary research question, namely *what constitutes the gatekeeping role for abortion in Australia?* The diagram is a visual representation of this thesis and it is intended to guide the reader through the material that follows. The main research question is presented on the left hand side and each row represents the thesis chapters: the empirical questions derived from Chapter 2, an outline of the applicable site of investigation, and then on the far right an indication of the questions that operationalised my analysis of the research material. The next chapter commences our analysis of Site 1, specifically addressing the origins of the gatekeeping role. Chapter 5 will examine the legal framework of gatekeeping, Chapter 6 the teaching of abortion, and Chapter 7 the reality of the gatekeeping role as evidenced from the responses provided by practicing doctors to abortion cases. This graphical representation of my thesis provides a compass for understanding my research project and my overall approach to the thesis question.

Importantly though, while the methodology provides a sufficient basis for examining the constitution of the gatekeeping role through the use of three sites of investigation, there are limitations in the approach that limit the conclusions that are able to be drawn. Collecting data from three different sites resulted in sample sizes for the empirical sections that were small, meaning that there is not a sufficient sample in Site 3 to be able to state that the findings are representative of the performance of gatekeeping by doctors, and likewise for Site 2, there is no student data collected. The absence of student data in Site 2 limits the ability of the data to be considered as a holistic picture of abortion education, because it does not answer whether or not students practice what they are taught. Therefore the results are, at best, indicative of aspects and/or concerns of the gatekeeping role, rather than being indicative of a wholesale form of gatekeeping. The use of three sites also limited the ability of the findings from the two empirical sections to be extrapolated beyond that which is contained within this thesis because the data collection was limited to how doctors are taught about abortion law, and how they make complex decisions amidst the legal framework, not how they understand abortion more broadly nor how they . This invariably limited the doctors' potential

response options, and thus potentially excluded other determinant factors for how doctors approach abortion scenarios. It is therefore important to understand that the findings of this thesis can only be representative of a picture of gatekeeping and the relationships between law and practice; they cannot be representative of individual cases of gatekeeping.

Figure 2: Relationship of research questions and Sites of investigation



Chapter 4

Legitimising the 'gatekeeper': constituting the authority of the medical profession

Introduction

As we saw in Chapter 2, the medical profession holds legal authority over access to abortion procedures in the majority of Australian jurisdictions, occupying what observers have called a gatekeeping role under abortion law for women accessing terminations of pregnancy (see Cannold 2000, 24-25, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004). In Chapter 2 we also saw that abortion is a morally and politically contested issue (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984 and Cannold 2000), that it was a site of contestation for the shaping of medical power (see Keown 1988 and Reagan 1998), and that the application of medical knowledge can include knowledge that is considered both scientific and moral (see Freidson 1988). From this I suggested that the role of gatekeeping could be problematised because its purpose is contestable, and therefore its consequence can be variable. This is particularly the case when we consider that the gatekeeping role can have an impact on the capacity of women to exercise reproductive decision making not as a consequence of the application of medical knowledge *per se*, but rather the interpretation of knowledge by individual doctors (see Rankin 2001, Baird 1990, Sheldon 1997, Joffe 1995, Freidson 1988, Miola 2004 and Palmer 2009). The present chapter commences our analysis of the purpose of gatekeeping by examining the origins of the gatekeeping role and exploring the legislative debate which shaped its existence in Australia. This explores the first sub-question of this thesis, *how did the medical profession become the legal authority for abortion?*

An exploration of the origins of the gatekeeping role provides the contextual basis for understanding why medical professionals are considered to be gatekeepers. It also illustrates the rationale for broad societal acceptance of medical intervention in the abortion process, rather than women exercising their own choice alone. Two sub-questions operationalised my exploration into the origins of medical intervention for abortion: *Did the medical profession have any involvement in defining abortion as a crime? (sub-question 1) What debate occurred in the legislature when abortion law was changed and did this debate legitimate the role of 'gatekeeping'? (sub-question 2).*

The first part of this chapter is a historical overview of the criminalisation of abortion, examining the role of the medical profession in shaping our understanding of abortion and abortion regulation. This section answers sub-question 1 of this chapter and highlights how the criminalisation of abortion was linked to a professional struggle for legitimacy by the medical profession, with the medical profession being active in defining abortion as a crime and then subsequently shaping the grounds for a defence of abortion, or the requisite reasons for an abortion, to qualify for a claim of lawfulness in the later parts of the twentieth century (see also Keown 1988, Reagan 1998, and Rankin 2011).

Part Two of this chapter concerns the process of abortion law reform in Australia from 1968 to 2015, specifically the legislative discussion that resulted in changes to abortion law from its original versions of the late nineteenth century and early twentieth century. It answers sub-question 2 of this chapter and examines the extent to which the medical profession held significance in defining our legal understandings of abortion during this period. It is thus the debate that led to legislative change that is the focus here, with the resulting legislative frameworks to be discussed in Chapter 5. The section utilises parliamentary debate in South Australia, Western Australia, the Australian Capital Territory, the Northern Territory, Victoria and Tasmania. New South Wales and Queensland are not included here because they have not enacted substantial legislative reform for abortion. The Northern Territory's debate of 2006 is discussed here, but the debate that occurred in 1974 is not included because whilst they did enact legislative change in that year, evidence of the debate was not accessible. The legislation did however imitate that of South Australia (see Rankin 2011, 3 & 18), and hence any observations made in relation to South Australia can apply to the Northern Territory. The order of discussion pertains to the historical timeline in which the Australian debates occurred, with the exception of the Northern Territory's change of 1974, and these jurisdictions were chosen because they reflected the major legislative reforms that have occurred in Australia since the late 1960s when the first legislative change and judicial ruling as to the lawfulness of an abortion in Australia was made.

The discussion is not intended to be an exhaustive treatise on the content and nature of legislative debate, and nor does it span all periods of debate. Rather, it draws out the key statements and patterns of conversation that pertain to the medical profession in order to establish how the medical profession has come to hold a legal role as 'gatekeepers' to women's abortions, despite the moral and ethical complexity associated with abortion more broadly (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984 and Cannold 2000). It also establishes the intent of abortion law, a necessary point for examination proposed by Rhoden (1986) in Chapter 2 where it was argued that while the medical profession may hold authority to shape and define how abortion is understood and conceptualised, the authority needs to be exercised with due recognition of the social values that initially established it.

The present chapter will show that the significance of the medical profession in shaping abortion as a crime continued as abortion was decriminalised, positioning doctors as regulatory agents under abortion law. In each jurisdiction, the role of the doctor is presented as being necessary to ensure that there is an adequate balance between the rights of women, the rights of doctors, and the appropriateness of abortion choices. Thus the involvement of the medical profession in the criminalisation of abortion and then the subsequent decriminalisation of abortion, suggests that the gatekeeping role for doctors is authoritative and justified on the grounds of a doctor's capacity to apply the scientific knowledge of medicine as members of a profession. However, their role as doctor also grants them the capacity to hold views beyond the domain of medicine that could impact on the reproductive choices of women.

4.1 The origins of the crime of abortion and medical intervention

Australian abortion law originated in the United Kingdom in the earlier part of the nineteenth century as a direct result of Australia's colonial history, where the legal frameworks of the United Kingdom became the foundation upon which British colonies established legal governance. In this section, I will show that the history of abortion practice, and the establishment of legal frameworks for abortion in the United Kingdom, highlights a correlation between the actions of the medical profession and the establishment of law. This connection enforced medical

authority over issues concerning abortion practice, and became the foundation upon which Australian abortion law was developed. The present section concerns the history of abortion law in the United Kingdom, including a brief summation of the judicial ruling that occurred in 1938 (a ruling that was similar to that made in Australia in 1969 to allow for the performance of lawful abortions at common law), and then summarises the subsequent enactment of the *Abortion Act 1967* (UK).

Abortion was not always considered to be a crime, and prior to the introduction of statutory provisions governing abortion in the nineteenth century abortion was governed by common law. The legality of abortion in this context, however, was largely uncertain (see Keown 1988, 3). This legality has been contested, but most authors accept that at least during the eighteenth and early nineteenth centuries there was a period during a woman's pregnancy where she could restore the menses and thus induce abortion (see Reagan 1998, 8, Luker 1984, 4, Dickinson 2015, 103, and Keown 1988, 3). The point in time during a pregnancy has been referred to as 'quickening', the point at which the woman feels the fetus stir in her womb. The notion of quickening was linked to religious concepts of life where it was believed that this was the point at which the fetus was infused with a soul (Drabsch, 2005, 13). As Reagan (1998, 8) has argued, at "conception and the earliest stage of pregnancy before quickening, no one believed that a human life existed; not even the Catholic Church took this view".

Post quickening, it was widely believed that the procurement of an abortion was a crime, with the term 'abortion' applying to the period after quickening, as early induced abortion was considered to be simply the restoration of the menses (see Dickinson 2015, 103, and Reagan 1998, 8). Common law descriptions of abortion applied criminality post quickening, illustrated by the following statement made by Sir William Blackstone, a British legal practitioner of the eighteenth century (Kerr 1876 in Drabsch 2005, 13):

> Life is the immediate gift of God, a right inherent by nature in every individual; and it begins in contemplation of law as soon as an infant is able to stir in the mother's womb. For if a woman is quick with child, and by a potion or otherwise, kills it in her womb; or, if any one beat her, whereby the child dies in her body, and she is

> delivered of a dead child; this, though not murder, was by the ancient law homicide or manslaughter.

Whilst the above indicates that criminality was attached to the termination of pregnancy post quickening, what is of significance here is that the concept of quickening gave women a degree of power in regulating their bodily functions, as the proof as to when quickening had begun was arguably theirs alone. This gave women a broadly accepted right to control their bodies in the earlier stages of pregnancy.

As the law began to change in the early nineteenth century, legitimate acceptance of women controlling their bodily functions gradually diminished. The first statutory provision of abortion in the United Kingdom was enacted in 1803, *Lord Ellenborough's Act 1803* (see Keown 1988, 28). Keown (1988, 12) has argued that whilst no definitive explanation for the restriction of abortion by this Act has been provided, there are three possible reasons for the restriction: "the desire of the Chief Justice, Lord Ellenborough, to clarify the law; a perception of abortion as a social problem; and condemnation by eminent medical practitioners of the moral significance attached to quickening". Regarding the popularity of abortion, Keown (1988, 21) has argued of the situation in the United Kingdom "it is clear… that at least in certain quarters, abortion was regarded as of frequent occurrence and the common law as having failed to suppress it". The significance of quickening was an issue challenged by the concern of prominent male physicians that "fetal life should be protected by law at all stages of gestation" (Keown 1988, 22), with several physicians suggesting that fetal life began before quickening (see Keown 1988, 31).

In 1828 the United Kingdom enacted *Lord Lansdowne's Act 1828,* which prohibited instrumental abortion after quickening (see Keown 1988, 28-29). In 1837 *The Offences Against the Person Act 1837* was enacted, abolishing the "distinction between interference before and after quickening" (Keown 1988, 29). The 1837 Act also removed any reference to quickening (Dickinson 2015, 103). Keown (1988, 27-33) has suggested that medical opinion influenced the shaping of the law throughout this period, with the influence of the medical establishment gaining capacity as each new piece of legislation was enacted. Regarding the use of

quickening in legal statutes, the opinion of Professor Thomson, a leading authority on medical jurisprudence in 1836, captures the evolving importance of medical science in shaping the law:

> This distinction with respect to the periods in which criminal abortion is effected, demonstrates, very strongly, the necessity of lawyers and statesmen consulting medical men, prior to framing Acts which have physiological questions.
>
> (A.T. Thomson, 'Lectures on medical jurisprudence' (1836-1837) 1 *Lancet* 625, 626 in Keown 1988, 32)

The increasing significance of medical opinion at law throughout the earlier part of the nineteenth century is indicative of the increasing importance of scientific medical knowledge for understanding the body, as opposed to recognising the experiences of individual women (see Keown 1988, 32 and Turner 1995, 84-109). Utilising the perspectives of Foucault and his study of sexuality, Turner (1995, 99) suggests that the shaping of medical knowledge is a consequence of the fact that modern "human societies are faced by a problem of order which involves reproduction of populations and their regulation in space and time, but it also involves the restraint of singular bodies and their representation in time and space". Turner views the regulation of the body as part of the management of sexuality and as such the issue "of regulation is in practice the regulation of the sexuality of women by a system of patriarchal or patristic powers" (Turner 1995, 99). Therefore the significance of changes to the importance of quickening at law in the United Kingdom can be seen, from this perspective, to be a consequence of the increasing power of medicine to define and redefine understandings of the human body, understandings that were inherently patriarchal because of a social need to control reproduction. From this perspective, legal and medical epistemologies were thus inherently patriarchal, and privileged the perspectives of male legal practitioners and medical physicians over the perspectives of women. MacKinnon's argument, canvassed in Chapter 2, that abortion law subjectifies women to inequality because of the inherently patriarchal nature of the law is consistent with this claim (see MacKinnon 1991).

Interest in abortion from the medical sphere served not only to increase the recognition of medical knowledge at law, but also to shape the legitimacy of medical practice more broadly. Thomson (2013) and Reagan (1998) have argued, similar to Turner (1995), that interest in abortion from the medical sphere

reflected a struggle to legitimate medical knowledge and therefore marginalise practices that were not endorsed by medical practitioners. The origins of the authority for the role of gatekeeping by the medical profession was thus linked to a broader struggle for medicine to achieve legitimacy in defining human conduct and the character of illness and, as discussed in Chapter 2, this was a process that Foucault (2010) suggested was a defining characterisation for the application of medical knowledge. The legal authority of the medical profession for abortion was based on the success of the medical profession in being able to define the legitimacy of practices that impact the human body, which in this case was the act of aborting of a fetus.

In the United States, the struggle for medical legitimacy was characterised as a professional conflict between "regulars" and "irregulars" (see Brief 281 American Historians as Amici Curiae Supporting Appellees Webster v. Reproductive Services 1988 in Rubin 1994, 15), a similar scenario that Thomson argued occurred in the United Kingdom (2013, 191-192). The regulars were those who became the practitioners and proponents of scientific medicine, a professional group that at the time was white, middle class and male (see Reagan 1998, 10-11), whereas the irregulars ranged from herbalists to midwives. As James Mohr describes:

> Practically, the regular physicians saw in abortion a medical procedure that not only gave the competition an edge but also undermined the solidarity of their own regular ranks. If a regular doctor refused to perform an abortion he knew the woman could go to one of several types of irregulars and probably receive one…As more and more irregulars began to advertise abortion services openly, especially after 1840, regular physicians grew more nervous about losing their practices to healers who would provide the service that more and more American women after 1840 began to want…The best way out of these dilemmas was to persuade state legislators to make abortion a criminal offense. Anti-abortion laws would weaken the appeal of the competition and take the pressure off the more marginal members of the regulars' own sect.
>
> (James Mohr in Brief of 281 American Historians as *Amici Curiae* Supporting Appellees *Webster v. Reproductive Services,* 1988, Document 5 in Rubin 1994, 15)

Thomson (2013, 191-192) argues that a similar scenario occurred in the United Kingdom, suggesting that the campaigns of the medical profession to criminalise abortion were instrumental in the shaping of abortion as a matter of public

concern. Members of the medical profession mobilised abortion in the nineteenth century as an issue that served the emerging profession's social and economic interests (Thomson 2013, 191-192). This became one of the foundations for medical authority over the choices of women, hence positioning the medical profession as a constitutive element for defining the legal appropriateness of abortion.

A key consequence of the mobilisation of abortion as an issue of concern for the medical profession in the United Kingdom was that the practice of abortion became attached to the actions of irregulars only (see Thomson 2013, 195-196). The practice of abortion thus became linked to illegitimate medical practice. The regulars' campaign was evidenced in press and medical journals, and in lobbying materials for Parliament (see Thomson 2013, 197). The central premise of the medical argument was the claim that regular physicians hold scientific knowledge regarding embryonic life, which was "not shared by uneducated practitioners" (Thomson 2013, 196). Thomson (203, 195 & 208) suggested that the medical profession utilised campaigns for the criminalisation of abortion as a means for shaping the professional boundaries of medicine, excluding all others who could potentially make a claim to understand women's reproduction, including women themselves (Thomson 2013, 195 & 208).

In the midst of social and medical discourse concerning the legitimacy of abortion practice in the United Kingdom, there remained legal confusion as to the existence and definition of the offence of abortion (Keown 1988, 12). Definitions for what constituted proof in abortion cases varied, and variations continued throughout the nineteenth century as the courts and legislature grappled with defining the offence of abortion at common law (see Keown 1988, 12-13).

In a major revision to the law in the United Kingdom, the *Offences Against the Person Act 1861* (UK), it was made clear that it was an offence for a woman to procure her own abortion, that "pregnancy was not a necessary element of the offence when committed by a third party", and that "obtaining or supplying means knowing that they are intended to be used to procure miscarriage" was a statutory

misdemeanor (Keown 1988, 33). Abortion was contained in two sections of the Act, sections 58 and 59. Section 58 of the Act read:

> Administering drugs or using instruments to procure abortion.
>
> Every Woman, being with Child, who, with Intent to procure her own Miscarriage, shall unlawfully administer to herself any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, and whosoever, with Intent to procure the Miscarriage of any Woman, whether she be or be not with Child, shall unlawfully administer to her or cause to be taken by her any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, shall be guilty of Felony, and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for Life or for any Term not less than Three Years,—or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour, and with or without Solitary Confinement.
>
> *(Offences Against the Person Act 1861* (UK), 24 & 25 Vict, c 100, ss 58 as enacted)

Section 59 of the Act dealt with those who assisted the woman:

> Procuring drugs, & c. to cause abortion.
>
> Whosoever shall unlawfully supply or procure any Poison or other noxious Thing, or any Instrument or Thing whatsoever, knowing that the same is intended to be unlawfully used or employed with Intent to procure the Miscarriage of any Woman, whether she be or be not with Child, shall be guilty of a Misdemeanor, and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for the Term of Three Years, or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour.
>
> *(Offences Against the Person Act 1861* (UK), 24 & 25 Vict, c 100, ss 59 as enacted)

Both of these sections indicated that the procurement of an abortion was a crime and that the statute applied both to women who sought their own abortion and women who had abortions, as well as those individuals assisting them. The Act of 1861 guaranteed the position of abortion as a criminal act, justifying legal intervention. Abortion law in Australia, found in criminal law of each Australian jurisdiction, was based on sections 58 and 59 of the United Kingdom's Act of 1861 and remained unchanged until the later half of the twentieth century.

However, despite the blanket criminalisation of abortion in the Act of 1861, there is evidence to suggest that some United Kingdom medical practitioners performed abortions both before and after criminalisation (see Keown 1988, 59-60 & 66). As

Keown (1988, 22, 31, 59-63) argued, whilst there is evidence that some eminent medical practitioners condemned any action that went against the preservation of fetal life, there is an equal amount of evidence in obstetrical writings that the procedure was known within the medical profession. This performance of abortions by medical practitioners supports the proposition that the criminalisation of abortion was more about the regulation of abortion outside of medical spheres as argued by Thomson (2013) than it was about changing the authority of the medical profession to shape and define abortion practice. It also provides evidence of the consequences of medical practitioners holding contrasting ethical positions on the issue of abortion.

In fact, the subsequent introduction of the *Infant Life Preservation Act* in 1929 in Britain "decriminalised abortion if it was carried out in good faith, for the sole purpose of preserving the life of the mother" (Dickinson 2015, 103), and common law gave greater recognition to the role played by medical professionals as opposed to attempting to stop the practice altogether. According to Keown (1988, 84)

> the [Offences Against the Person Act 1861] did not explicitly permit therapeutic abortion but…this did not prevent the performance of the procedure by medical men: abortion was openly induced according to indications established not by the law but by the profession. When these indications expanded, so too did the performance of abortion, even though the law remained unchanged in its apparent restrictiveness. Only in 1938, after the law was challenged by a member of the medical establishment was legal theory unequivocally brought more into line with the realities of clinical practice. It is apparent, therefore, that medical men exerted significant influence not only on the restriction of the law in the nineteenth century but also on its subsequent relaxation.

What this suggests is that the medical profession's involvement in defining abortion as a crime in the United Kingdom resulted in doctors having an accepted role in the provision of abortion, even though they did not hold a legally legitimate one. The change referred to by Keown in 1938 involved the case of *R v Bourne*, the first judicial ruling in the United Kingdom as to the meaning of the word 'unlawful' in the abortion statute, and this gave legal legitimacy to the role performed by the medical profession that had been acceptable despite the blanket criminalisation of the act according to the *Offences Against the Person Act 1861* (UK). The case

prosecuted a United Kingdom medical professional who had performed an abortion procedure on a 14-year-old rape victim (Dixon 2003, 7).

In this case of *R v Bourne*, Justice Macnaghten upheld a defense submission that the use of the word 'unlawfully' in the statute required that the Crown would have to prove that the use of an instrument by Dr Bourne was unlawful. Justice Macnaghten ruled that

> the burden rests on the Crown to satisfy you beyond a reasonable doubt that the defendant did not procure the miscarriage of this girl in good faith for the purpose of preserving her life… if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuation of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.
>
> (Macnaghten, J 1938 in Keown 1988, 51)

This establishment of what constituted 'lawfulness' in 1938 clarified the authority of the medical profession, giving doctors a role in being able to shape the lawfulness of an abortion procedure. It also resulted in doctors having to navigate and understand both the medical knowledge needed to perform abortions, the legal knowledge needed to satisfy a defence for a lawful abortion procedure, and the social knowledge concerning a woman's circumstances. Thus there emerged a common law understanding of the capacity for medical professionals to establish grounds for arguing the lawfulness of the procedure based on their own medical knowledge and decision-making process, but also a common law expectation that doctors understand legal knowledge and the concept of lawfulness. This reinforced the acceptance of medicalised intervention for abortion as it permitted the medical profession to perform abortions despite the criminalisation of the act, but it also placed doctors in the precarious position of having to justify medical action in the context of criminal law.

From the judicial ruling of *R v Bourne* in the United Kingdom we can problematise the authority of the medical profession as follows. The 1938 United Kingdom ruling recognised that doctors can legitimately exercise decision-making authority over abortion choices, and that the authority of the doctor could be defined by

individual judgement and a doctor's understanding of the law, rather than needing to be medically or legally defined. However, Chapter 2 pointed out that abortion is a moral and ethical issue (see Dworkin 1994 and Wertheimer 1971), and from this premise it becomes apparent that the recognition of the role of the doctor, because of medical authority, also meant that they had to exercise judgement over a moral and ethical issue. This gave medical professionals the authority to exercise judgements that could impact the reproductive choices of women, privileging the decision-making of a doctor in the abortion context rather than the woman. However, as Brookes (1988, 155) argues, if "abortion is a moral issue, then it is not clear what qualifies doctors, and not women themselves, to make the decision". Hence we are presented with the dilemma that doctors were accorded the legal role of establishing reasons/defences for the lawfulness of an abortion procedure, but there was not any certainty what would qualify a doctor to exercise such a decision, particularly when abortion is a complex moral issue.

This problematic authority given to the medical profession at common law by the judicial ruling of *R v Bourne* guided the practice of abortion in the United Kingdom up until the late 1960s (see Dixon, 2003, 7). In 1967, the United Kingdom introduced the *Abortion Act 1967* to clarify the law relating to the termination of pregnancy by medical practitioners (*Abortion Act 1967* (UK) CH. 87). The *Abortion Act 1967 (UK)* stated that

> (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith-
>
> > (a) that the continuance of the pregnancy would involve risk to the life of the, pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or
> >
> > (b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
>
> (*Abortion Act 1967* (UK) CH. 87 as in force)

The Act gave the medical profession statutory authority to terminate a pregnancy provided that two doctors could certify the existence of reasons for an abortion. It enshrined the authority of the medical profession to decide who could access an

abortion and the clinical and personal circumstances for a pregnant woman that would justify one. Through this process the choices of women remained marginalised in place of medical and legal knowledge, as the evidentiary conditions for determining lawfulness needed to be based on a legal judgement as to the validity of the medical assessment of her mental and physical health, not a woman's interpretation of what may impact her health or reproductive future. The authority of the medical profession to define abortion practice was thus legally recognised, and therefore the influence of the medical profession in shaping abortion as a crime under the *Offences Against the Person Act 1861* (UK) was transformed to provide a legal basis for doctors to perform abortions, with all other attempts being criminal. The medical profession did therefore have a role in defining abortion as a crime, with legal legitimacy for an abortion in the United Kingdom being attached to the actions of doctors only.

In this section I sought to examine if the medical profession was involved in defining abortion as a crime, in order to understand the context in which the medical profession became 'gatekeepers'. This was considered to be necessary following my examination of Rhoden (1986) and Foucault (2010) in Chapter 2 where I argued that the authority of medicine in any context needs to be empirically tested so as to understand its scope and authority. The history of abortion law explored here suggests that the medical profession in the United Kingdom was involved in the criminalisation of abortion and the subsequent relaxation of restrictive abortion laws. The medical profession came to hold authority over matters concerning reproductive choice by defining the practice of abortion and abortion choices as medical issues, to be managed within the medical domain. This meant that doctors became the authoritative entity for defining abortion practice and regulating access to the procedure. The authority of the medical profession also resulted in a medical understanding of abortion holding greater significance than that of any other social group. My examination of the origins of medical authority for abortion thus also supports the possibility that abortion law subordinates women's abortion choices to the judgements of doctors, a possibility that was suggested in Chapter 2 following my examination of women and abortion law, and also women, technology and the law (see MacKinnon 1991, Palmer 2009, and Rhoden 1986).

4.2 The medical profession, the legislature and abortion in Australia

From the history of abortion law examined above, we can ascertain that the medical profession had a key role in defining the legitimacy of abortion, initially through the criminalisation of abortion, and then through judicial rulings and legislative changes that recognised the accepted role of medical professionals in establishing reasons for the lawful termination of pregnancy. The authority given to the medical profession has meant that medical views of abortion hold greater significance than those of other social groups, including pregnant women themselves. What is not clear from the above, however, is whether or not this was the intent of legislative changes, an understanding of which matters in the context of trying to understand the constitution of the gatekeeping role in Australia. We have not been able to infer intent in the previous section because much of the historical material suggests that the rationale for abortion law was a combination of factors, factors that had varying degrees of significance. These factors included clarification of the law, the perception of abortion as a social problem, condemnation of the moral significance of 'quickening', and action to define the boundaries of medical practice (see Keown 1988, 12-25 and Thomson 2013, 191-192).

I have determined this to be an important point for examination because the role of the medical profession in shaping the history of abortion law could be a consequence of the shaping of political and professional boundaries, just as it could be about the intent of the legislature or the medical profession to police and regulate women. This is central to my thesis question because it shows that the role of gatekeeping could have several purposes, which may or may not be indicative of the assumed regulatory function required of doctors implied by the characterisation of 'gatekeeping'. Also, while we know that the criminalisation of abortion in Australia was the same process for criminalisation in the United Kingdom, because Australian law originated in the United Kingdom, the process of decriminalisation evolved in different circumstances. Thus it is necessary to examine if the process of decriminalisation in Australia reveals a similar authority for the medical profession as that which emerged in the United Kingdom.

The present section examines abortion law reform in Australia, specifically the debates that occurred between 1968 and 2015 in the Parliaments of certain Australian states and territories when the law was changed; South Australia, Western Australia, the Australian Capital Territory, the Northern Territory, Victoria and Tasmania. The section looks at the debates that occurred in these legislatures to understand how Parliaments legitimated the 'gatekeeping' role. This addresses the process by which the medical profession became the legal authority for abortion in Australia, determining if the debate specified a role for the medical professionals and thus provided an indication of what this role should entail. From this we are able to understand how medical knowledge of abortion was conceptualised and thus privileged above other forms of knowledge, resulting in a privileging of the role of the doctor as the gatekeeper to a complex moral and ethical issue like abortion (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000 discussed in Chapter 2).

South Australia

The first substantial legislative debate concerning the lawfulness of abortion in Australia occurred in the late 1960s in South Australia. In December of 1968, the *Criminal Law Consolidation Act Amendment Bill 1968* was referred to a Select Committee (the Committee) to examine the implications of proposed legislative changes to the crime of abortion. The proposed Bill was developed in order to clarify the meaning of the word "unlawful" contained in the statute, similar to the United Kingdom legislation of 1967. As the Committee stated in its Final Report:

> At present the law is not settled. The Committee is of the opinion therefore that the law should be in statutory form. This has the advantage, subject to the inevitable limitations of drafting, of clarification and of certainty.
>
> (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968 1969, 4)

This statement implies a recognition that the law regarding abortion was problematic, particularly given the suggestion that the law should be in statutory form. What this suggests is that the practice of abortion at common law may not have been sufficient to provide clarity as to the lawfulness of an abortion procedure.

The deliberations of the Committee considered moral concerns regarding abortion. Those opposed to abortion broadly proposed that life began at conception, with those in support of abortion arguing that abortion was a decision for a woman and her doctor (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 3). There was general consensus that abortion should not be freely available but that some relaxing of the current law would acknowledge that despite there being a general rule that pregnancy should not be interfered with and hence terminated, "there are, and always have been qualifications for various reasons" (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 4). These qualifications came to be understood by the legislature as being only those that were defined by medical knowledge, like the 1967 United Kingdom legislation, reaffirming the authoritative role of the medical profession in shaping legitimate abortion practice.

One such qualification was fetal viability, and the Committee considered the timeframe for fetal viability in establishing a definition for abortion. Abortion was broadly taken to mean an act undertaken to terminate a pregnancy prior to fetal 'viability', which in this case was suggested to be at 20 weeks gestation (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 3; also section 1 of the current version of the *Abortion Act 1967 (UK)* includes a gestational threshold of 24 weeks). The suggestion that 'viability' was 20 weeks came from the testimony of doctors, and the rationale for this time was attributed to the experience of the medical profession in managing births at various stages of pregnancy (see Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 3). The concept of viability applied a boundary between pre-and post-viability periods within a pregnancy, assigning the labels of 'lawful' and 'unlawful' to a clinically-determined timeframe. Thus, the very definition of abortion became a scientific determination of the division between fetal viability and lawful termination, suggesting that once a fetus was viable, abortion would be unlawful. The concept of 'viability' placed abortion firmly within the domain of medicine, enhancing the legitimacy of medical knowledge of abortion.

The shaping of medical knowledge regarding abortion and the role that the medical profession came to hold as an authority for abortion was not an unsurprising consequence of the Committee's deliberations given the composition of the witnesses that appeared. Of the 34 witnesses, 17 were medical professionals, one of which was the nominee for the Archbishop of Adelaide (see Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 6). Two witnesses were social workers, one was a police officer, two individuals were women annotated as having "Home Duties", and the remaining witnesses were public servants, representatives of religious bodies and representatives of political parties. Further, of the 16 written submissions and documents provided to the Committee, five came from medical professionals (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 7).

The deliberations of the Committee also reflected the authority of the medical profession in the abortion discussion, reinforcing the capacity of the medical profession to define legitimate abortion practice and hence ensure that abortion was understood and conceptualised as being the domain of medicine. The specific legitimacy of a medical professional's involvement in abortion practice can be found in a statement made to the Committee by the then Inspector of Police in Adelaide, Mr Paul Turner. When asked about the frequency of practitioners being charged and tried for procuring an abortion, Mr Turner noted that trials were rare and that "if a medical practitioner performs such an operation I do not think there is any possible way of proving that it is illegal" (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 18). At no point during the course of Mr Turner's statement did any member of the Committee ask why this was case, implying that should a medical practitioner provide an abortion then it would be deemed by the police to be on defensible grounds. In other words, a medical professional performed the pivotal role of shaping what could be considered a legal or illegal procedure.

The sentiments of one medical professional reinforced this medical authority in shaping abortion and defining legitimate abortion practice. Lloyd Woodrow Cox, Professor of Obstetrics and Gynaecology, University of Adelaide, stated:

> I believe a change in law is required because the medical situation is undefined, and it is wrong that a situation should be undefined. I believe the present law, as far as preventing illegal practice, is ineffective, and I am certain the Committee will have to call evidence regarding the difficulties the Police Force suffer. I do not know how you can get over that.
>
> (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 24)

This statement made by Professor Cox emphasises how abortion was considered to be a medical procedure and it highlights his belief that the practice of abortion should be defined in a medical context. It also shows how sentiments put forward by a medical practitioner in describing the relationship between the law and clinical practice held status in articulating abortion as a medical issue. The role of the medical practitioner in giving testimony therefore gave weight to the role of doctors as 'gatekeepers' to abortion procedures.

A statement made by a housewife and mother of 7 children, Margaret Clare Pilkington, as well as the Committee's response to her statement, also spoke to the role of doctors as 'gatekeepers' to abortion procedures. This response also introduced the notion that doctors could overstep their medical authority as a direct consequence of the moral dimensions associated with abortion. Margaret Pilkington argued that women wishing to terminate their pregnancies could be susceptible to the persuasion of a doctor, stating that "mothers in the early stages of pregnancy are often not in a fit state to judge rationally about their own and their family's future…pregnant women are most susceptible to influence at this stage" (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 64). She believed that abortion should remain criminalised because of the likelihood of women being coerced and/or influenced by individual doctors into having an abortion procedure (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 64). Her claims acknowledge that there is always the possibility that doctors can overstep their medical authority and enter the realms of morality, demonstrating the problematic nature of the gatekeeping role. As I

suggested in Chapter 2, the ethical and moral dimensions of abortion are likely to be applicable for doctors just as they are for social actors, and therefore Margaret Pilkington was expressing the view that the role of gatekeeping potentially gives authority to doctors to utilise moral views in exercising judgement over abortion cases.

In their response to Margaret Pilkington, the Committee recognised the danger of doctors entering into moral decision-making, but suggested that the danger can be overcome by having two doctors, rather than one, make the decision. Their response was framed as a question, specifically "Seeing that this Bill gives the protection of two legally qualified medical practitioners forming an opinion about the matter, do you not think there is little likelihood of pressure being brought on women by the medical profession to abort?" (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 66). This suggests that medical professionals, by virtue of their qualifications and thus professional status, are in a position to exercise decision-making capacity *without* allowing any moral issues to impact the decision-making process.

The interchange between Margaret Pilkington and the Committee highlights an ethical tension between women, doctors and the law. Women's reproductive choices were to be considered in the process of decision-making, rather than being the determinant factor for accessing an abortion. This means that women's reproductive choices remained the subject of medical judgements. The legal positioning of the doctor thus privileged a medical assessment of a woman's reproductive choice, and possibly their moral position, over the reproductive choices of the woman herself.

The submission made by the Abortion Law Reform Association of South Australia (ALRASA) further illustrated the legitimate role of the medical profession in adjudicating a woman's abortion choice, despite acknowledgement that a doctor's decision-making capacity could be influenced by their moral position. The ALRASA's submission to the Committee stated:

> We in ALRASA do not advocate abortion *per* se. We seek a situation in which a pregnant woman will have a right to approach her doctor to discuss the termination of her pregnancy if it is unwanted in the expectation that an abortion can be

> considered, and performed if she and her doctor agree that this is in her interests and in accord with her conscience and with his… For a woman the problem is direct and simple – pregnancy is often welcome, but sometimes it is unwelcome and disrupting to healthy well-being and future life plans. Here she should have a right to consult a doctor who can act according to his conscience in advising her. We regard this as a basic human right that every woman should have.
>
> (Appendix B pages 94 and 99 in Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968, 1969, 2)

ALRASA argued that the reproductive choices of women could be appropriately managed during the exchange between a woman and her doctor. The Association also recognised that during the clinical encounter for an abortion request, the doctors' conscience could legitimately impact on their decision-making capacity. The preceding paragraph to the ALRASA's submission contained in the Committee's report supported this claim:

> The Committee points out that as in so many matters, conclusions on this subject are not reached by the exercise of reason alone. Individual belief and conviction, either religious or otherwise, colour a person's views.
>
> (Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968,1969, 3)

By recognising that views on abortion are influenced by individual belief and conviction, but that the decision is appropriately managed within the domain of medicine, the Committee reaffirms that a doctor's moral views regarding abortion can influence the decisions they make. The gatekeeping role for doctors is thus accepted as being both the use of medical knowledge and the moral views of a doctor.

The final report of the Committee in South Australia examined here showed that the role of the medical profession in the abortion context was accepted. The testimony of Mr Turner and Professor Cox showed that abortion was accepted as a medical issue despite it not being legally legitimate. Their arguments suggested that the accepted role for doctors should be reflected in law. However, the statements made by ALRASA and Mrs Pilkington pointed to the problematic nature of the role doctors perform, specifically that the authority of the doctor over abortion access provides an opportunity for a doctor's moral position to influence abortion decisions. The Committee suggested that this problem could be overcome

by having two doctors involved. What this debate revealed was that there was an accepted role for doctors in the provision of abortions, and that doctors could perform this role using medical judgement provided that their moral judgements were managed appropriately.

Western Australia

The trigger for abortion law reform in Western Australia in 1998 was the introduction of a Private Member's Bill brought forward by the Honorable Cheryl Davenport to remove abortion from the criminal code, and a series of events that saw two medical professionals charged with abortion-related offences. The circumstances surrounding the Bill in Western Australia resulted in "one of the most remarkable parliamentary debates in Western Australia's history", because of the moral tone of the discussion and the divergence of views that emerged both within and outside of the government (Phillips & Black 1998, 94). Like South Australia, the role of the medical profession in defining abortion practice was influential in shaping changes to abortion law.

On 10 February 1998, the police in Western Australia issued a summons to two medical professionals charging them with attempting to procure an abortion on a mother-of-three in 1996 (Phillips & Black 1998, 595). The charges were the first to be laid in over thirty years (Phillips & Black 1998, 595). Under section 199 of the criminal code, the charges carried a penalty of up to fourteen years in goal and "provoked immediate pressure on the State Government to reexamine the state's abortion laws" (Phillips & Black 1998, 595). Phillips & Black (1998, 595) have argued that whilst the Honorable Cheryl Davenport had in fact been working on a Private Member's Bill prior to the charges being laid, it was the charging of the doctors that brought the issue into the public sphere and generated significant impetus for clarification of the law. The context for the changes in Western Australia was thus different to what triggered changes in South Australia in 1968 and the United Kingdom in 1967. It was a context that was more morally charged as it was based on current events rather than hypothetical legal situations.

Prior to the announcements that the doctors were to be charged, it was broadly assumed that Western Australia came under the same ruling as Victoria, *R v*

Davidson (1969), which determined that abortions could be considered to be lawful where a medical professional deemed that the procedure was necessary to save the life of the woman or to prevent serious harm to her physical or mental health (Phillips & Black 1998, 595; *R v Davidson* (1969), the Menhennitt ruling, will be discussed in Chapter 5). The charging of the two medical practitioners indicated that this may not in fact be the case and "mounting pressure from medical professional representatives for the abandonment of the prosecutions and/or government action to bring about change in the law culminated in an ultimatum by medical staff at King Edward Memorial Hospital giving the government six weeks to act before all abortion services were withdrawn" (Phillips & Black 1998, 595). The Bill was debated in Parliament from March to the last week of May. The promptness with which it was debated was influenced by the ultimatum, showing the influence of the medical profession to drive the nature and timing of legislative debate.

Yet, similar to the deliberations of the Committee in South Australia, the Western Australian Parliament showed that there was a difference between the law of abortion and the contemporary practice of abortion. The Western Australian discussion highlighted that the practice of abortion was occurring under the auspice of medical treatment, despite the fact that abortion was a crime, and that the situation needed to be resolved one way or another or else medical practitioners would remain under threat of criminal action. A statement made by the Honorable Cheryl Davenport indicated the urgency of the situation:

> The Western Australia community needs certainty about its abortion laws…The story about the charges against Dr Victor Chan broke on 4 February and community debate, as we all know, has raged for many weeks…Clearly a significant majority of Western Australians want this change…Clearly Western Australian women need to know that they can access abortion services that are medically safe and that they are not breaking the law in doing so.
>
> (Western Australia Legislative Council Hansard 1998, 2797)

This statement suggests that abortion was accepted as being a part of medical practice regardless of the law. It also suggested that both the medical profession and public opinion were on the same side. The medical profession's role as 'gatekeepers' was thus a consequence of current medical practice rather than it being a consequence of their position at law. Similar to South Australia, the debate

in Western Australia indicated that the role of the medical profession in the provision of abortion service was already considered acceptable and that the law needed to recognise this state of affairs.

However, while the role of the medical profession in providing abortion services was accepted given public and medical opinion on the matter leading into the legislative debate, the scope of the role performed by doctors was not. Legislative debate in Western Australia thus examined the nature of the role for doctors, in particular the extent to which a doctor's personal beliefs could impact their engagement in abortion practice. Two examples from the Western Australian abortion debate illustrate this. The first was a statement made by the Honorable E.J. Charlton:

> No person, medical centre or provider of health services in this State should be obliged to participate in anything to do with procuring an abortion if they do not want to. This has nothing to do with a health service. This is about a person's choice to be involved in a procedure.
>
> (Western Australia Legislative Council Hansard 1998, 2805)

The second was a statement made by the Honorable Tom Stephens:

> I see in so many areas of health administration the natural suspicion of people from the medical fraternity, yet in this abortion area suddenly doctors' solution and their involvement in the abortion process is somehow separated out from all the other suspicions…In reference to abortion somehow or other the medical solution, the doctors' right to be involved and their right to have no-one else involved in the abortion process, is championed, yet in all of the other areas of medical practitioners' activities and interface with patients, there is regularly pressure for the involvement of the State by ensuring that the rights of individuals – women, children and others – are protected by Statute.
>
> (Western Australia Legislative Council Hansard 1998, 2847)

The first statement clearly articulated that a member of the medical fraternity should be able to choose whether or not to be involved in an abortion procedure and that this choice is separate from the decision as to whether or not an abortion should be performed. The second statement problematises the role of the doctor in the decision-making process for an abortion, suggesting that the role is different to that which they perform for other medical procedures like elective surgery and treatment for disease. These statements present different understandings of the role that doctors occupy in relation to abortion, with the first suggesting that a

doctor can choose not to occupy the role on ethical grounds and the second challenging a doctors primacy in abortion decision-making because of the moral complexity associated with abortion practice. What underlies both these comments, however, is that the role of the doctor in abortion cases is accepted, with acknowledgement that a doctor's values and beliefs can impact on a woman's capacity to access abortion procedures.

During the course of the debate, the role of a doctor was accepted by the Parliament because it was a central aspect of current medical practice; indeed it was the significance of the medical profession's role in providing abortion services that brought the legislative situation to the fore of public and political debate. What this debate revealed, though, was that while the medical profession has a role in the provision of abortion services, the moral complexity of abortion warrants a doctor being able to remove themselves from abortion cases. This is despite the fact that the moral complexity of abortion also encompasses the moral complexity of the potential for women to die if abortion is refused, not to mention the moral issues surrounding reproductive autonomy. According to Mr Stephens the complexity of abortion also warrants exclusion of any other form of scrutiny of the abortion decision, which means that a doctor's decision-making is free from external scrutiny. This is significant because it suggests that the abortion encounter is closed to a woman and her doctor, and therefore, the individual values and beliefs of doctors can impact on a patient and not be called into question. The debate in Western Australia thus accepted the role of the doctor as gatekeeper and showed that this role is an element of medical practice, which is practiced according to the beliefs of individual doctors.

Australian Capital Territory

Like Western Australia, the Australian Capital Territory debated elements of abortion law reform in 1998, but it was not until 2002 that substantial changes to the law were proposed. The changes in 2002 proposed decriminalisation of abortion. The role of the medical profession in regulating abortion procedures was a point of discussion during this period of legislative debate, as were the moral dimensions of the abortion issue, with the inherent tension between the two characterising the debate. Parliamentary debate in the Australian Capital Territory

again shows that abortion is an accepted part of medical practice despite its moral complexity, and there is a legitimate role for doctors in navigating this complexity.

Abortion law reform first appeared in the Australian Capital Territory with the passing of the *Health Regulation (Maternal Health Information) Act 1998*. The Act required that information be provided to women seeking abortions, but it did not remove abortion from the criminal code and made no attempt to clarify the circumstances under which an abortion would be considered lawful. The Act stated that the "Legislative Assembly also wishes to ensure that neither complying nor failing to comply with these requirements to provide information will affect whether or not an abortion or other act is lawful for the purposes of sections 40 to 45 (inclusive) of the *Crimes Act 1900*, which deal with abortion and related matters" (*Health Regulation (Maternal Health Information) Act 1998,* ACT, repealed on 10 September 2002). In enacting the legislation, the Australian Capital Territory prescribed in statute the requirements to be met by medical practitioners, specifically that balanced medical advice be provided to women seeking abortions and that procedures be performed in appropriate medical facilities (see *Health Regulation (Maternal Health Information) Act 1998,* ACT, repealed on 10 September 2002).

While the legislation of 1998 provided that the medical profession had a legal obligation to provide information to women seeking abortions, it retained the position that the determination of the lawfulness of the procedure was an issue for criminal law. This passage of law recognised the role of the medical profession, but unlike South Australia and Western Australia, it did not try to dictate how the role was to be performed. It left the decision as to whether or not an abortion should occur with doctors under a common law ruling, where as the law in South Australia and Western Australia provided more detail of the process by which an abortion decision would be lawful. However, by legislating requirements for medical practitioners, abortion was shown to be an issue for the medical domain to manage, similar to South Australia and Western Australia.

The Australian Capital Territory progressed abortion law reform in 2002 with the passage of a suite of legislation that removed abortion from the criminal code and

regulated the procedure under the *Medical Practitioners Act 1930* (ACT). Like the debate that occurred in Western Australia, the Australia Capital Territory saw aspects of the debate focus on the moral dimensions of abortion and the legitimacy of the medical profession's role in this context (see Stefaniak, Australian Capital Territory Hansard 21 August 2002, 2502).

The moral dimensions of abortion were highlighted in the majority of testimony captured in the Hansard transcripts of the Australian Capital Territory legislature in 2002. Much of the testimony considered the role of the medical profession in regulating access to abortions, largely in the context of either challenges to the notion of abortion being solely a medical procedure or the argument that abortion is an issue for a woman and her doctor. One Member of the ACT Legislative Assembly (MLA), Ms Dundas, argued that abortion should be a matter for a woman and her doctor and that this was a widely held view in Australian society: "the complete lack of convictions for abortion in the Australian Capital Territory shows that the judiciary and successive governments have rejected the concept of abortion as a crime…This is an outdated law that contradicts Australians' overwhelming belief that the decision about abortion should be left to the individual and their doctor" (Australian Capital Territory Hansard 21 August 2002, 2548).

A statement made by Mr Hargreaves however, challenged the notion that abortion should be a matter for a woman and her doctor and therefore managed within the medical domain:

> I do not consider an abortion is merely a medical procedure. I understand a medical procedure to be, for example, the removal of a diseased or unwanted organ. It can in fact be the transplantation of any organ. But, to me, "medical procedure" talks about surgical intervention on parts of the body, a pathology issue. It doesn't talk about there being two lives. And I cannot get away from this. We are talking about two lives, and I can't apply the thought of terminating a life as just a medical procedure.
>
> (Australian Capital Territory Hansard 21 August 2002, 2508)

Mr Hargreaves then argued that the decision to terminate a pregnancy was a challenging one for women and that elements of the criminal code should be removed but not without replacing them with "something else" (Australian Capital Territory Hansard 21 August 2002, 2508). Mr Hargreaves stated:

> I thank God quite frequently that I am not going to be faced with having that final decision. I am quite happy to participate in the decision from a long way, but it's a really confronting position to be in to know that I am not the person who has to turn the lights off. A woman has to do that, and only a woman will ever know what that means. I do not think that society ought to be doing anything but supporting these people. So I am not averse to removing the justifiable termination from the crimes law books at all, but I make this point: you cannot just take it out and not replace it with something else.
>
> (Australian Capital Territory Hansard 21 August 2002, 2508)

The sentiments expressed by Mr Hargreaves articulated the challenge for legislatures to balance the reproductive choices of women and the ethical dimensions of terminating a pregnancy. They also emphasise that whilst an abortion procedure might be a medical issue, the decision as to whether or not the procedure should occur is a moral one. For Mr Hargreaves this warranted the intervention of law in the abortion process, where the intervention would place obligations on the medical profession to undertake abortions in approved facilities, and provide certain types of information (see Australian Capital Territory Hansard 21 August 2002, 2509-2511). What these statements show is that while the procedure of abortion might be the jurisdiction of medicine, the regulation of abortion decisions requires an enhanced regulatory framework when compared to the law for other medical procedures. Here we see that arguments for the legal role of gatekeeping seek to apply regulatory conditions on doctors, just as it does on the abortion choices that women make. This is similar to the legislation that resulted in Western Australia and South Australia, but the nature of the conditions differ. All three stipulate conditions for an abortion procedure, such as the location in which an abortion can be performed, with South Australia focusing more strongly on the rationale for an abortion choice. Legislative debate in these jurisdictions thus differed in how they acknowledged the acceptability of the role of the medical profession.

Mrs Vicki Dunne presented a similar position to that of Mr Hargreaves in her statement to the Legislative Assembly. Mrs Dunne argued that abortion is not like any other procedure and that "medicine is concerned with diagnosis, treatment and prevention of disease…pregnancy…is not a disease - there is no disease for which abortion is the cure" (Australian Capital Territory Hansard 21 August 2002,

2519). Mrs Dunne also claimed that doctors had failed to meet the required level of care for abortion by not providing information of all the various risks involved in undertaking the procedure (Australian Capital Territory Hansard 21 August 2002, 2521). In arguing her position, Mrs Dunne used the following statement made in the Royal Australian College of Gynaecologists and Obstetricians *Bulletin:*

> We have been content to delegate the commonest gynecological operation, one that we dislike, to others less well qualified…we have not ensured that the highest standards of practice have been available or reviewed, nor have we seen to it that adequate counseling and contraceptive advice has been made available.
>
> (McGlashan 1998 in Australian Capital Territory Hansard 21 August 2002, 2521)

What Mrs Dunne's argument suggests is that medical governance of abortion had not been sufficiently managed, and that it had been delegated from being a procedure performed by medical specialists to a procedure performed by medical general practitioners. The claim reiterates the importance of the medical profession in shaping the appropriateness of abortion procedures. It also highlights how Members of the Assembly could use sentiments from within the medical profession during the course of parliamentary debate to give weight to certain claims. It is a reflection of the influence of the medical profession in being able to shape the legitimacy of abortion practice, which subsequently lead to changes in abortion law.

The legislative debate that occurred in the Australian Capital Territory discussed the role of the medical profession in providing abortion services and debated the nature of the role to be performed by medical practitioners. Similar to the jurisdictions discussed so far, the role of the medical profession was broadly accepted as being the authority for defining abortion practice, despite the various competing discourses with regarding to the morality of abortion; reproductive autonomy, patient safety, and freedom of conscience for example. However unlike the debate that occurred in South Australia and Western Australia, the Australian Capital Territory discussed how the medical profession could undertake the legal role of gatekeeping and debated various provisions pertaining to how doctors would practice abortion, including providing certain information to women. What this debate revealed about the gatekeeping role was that the law could apply to a doctor's actions, not just how they navigate women's choices. The legitimacy of the gatekeeping role was thus connected to the acceptability of a doctor's conduct in

assisting women to exercise their reproductive rights, rather than the role being accepted as a way of regulating women's reproductive choices. It is not only women's abortion choices that are being regulated, but also doctors' practices.

Northern Territory

Abortion law reform began in the Northern Territory in 1974, with subsequent changes made in 2006. Changes were also debated in 2017, but these will be dealt with in the context of future research to be discussed in Chapter 8. The change in 1974 was modeled on the legislative amendments of South Australia, but it differed in terms of gestational limits and age restrictions, as well as the requirement that only specialist medical practitioners, gynaecologists or obstetricians, could perform lawful abortions (Rankin 2011, 18-19). This change saw the inclusion of an additional section in the *Criminal Code Act* (NT) for the medical termination of pregnancy which stated that it was lawful for a medical practitioner who was a gynaecologist or obstetrician to provide an abortion for a woman who is not more than 14 weeks pregnant, and after consultation with a another medical practitioner (see *Criminal Code Act* (NT) s 174, as at 11 January 1996). As mentioned previously, the legislative debate pertaining to the 1974 changes was not obtainable, and so this section deals predominantly with the debates of 2006.

The legislative debate that took place in 2006 primarily focused on the move of the section in the *Criminal Code Act* (NT) dealing with medical termination of pregnancy from criminal law to health law. Dr Toyne who was the Justice and Attorney-General at the time in the Northern Territory described the purpose of the bill as being threefold:

> first, to remove the historical anomaly of a non-criminal matter being located in the Criminal Code; second, to restructure and simplify what is currently a very convoluted provision; and third, to remove the absolute requirement for a specialist to perform a medical termination where it is determined that that termination must be performed within the first 14 weeks of a woman's pregnancy. Currently, medical treatment to procure a termination in this early stage of pregnancy can only be performed by a gynaecologist or obstetrician in accordance with the requirements set down in the existing provision. The amendment will allow, within the same

> requirements, a properly credentialed and qualified medical practitioner to give that medical treatment in a hospital.
>
> (Legislative Assembly of the Northern Territory Hansard, 31 August 2006, 19)

The debate in the Northern Territory thus focused on recognising the medical nature of abortion practice and sought to shift regulation of abortion to health law rather than criminal law, similar to the Australian Capital Territory. The changes were proposed as part of a suite of changes to the *Criminal Code Act* (NT). The debate regarding abortion focused on the appropriateness of considering legislative change for abortion amidst other legislative changes, with some members querying if a 'yes' vote to the amendments would suggest that members were supporting abortion (see Mr Wood Legislative Assembly of the Northern Territory Hansard 11 October 2006). Other elements of the debate considered the reality of clinical practice and also the requirement that abortion be subject to additional forms of regulation because it was considered to be unlike other medical procedures. The role of the medical profession in shaping the proposed legislation was significant in this context, with Dr Toyne stating: "These amendments are sensible, safe and bring the matter into line with current medical technology and knowledge" (Legislative Assembly of the Northern Territory Hansard, 31 August 2006, 20).

Dr Toyne noted in particular that the requirement for a medical specialty placed undue pressure on a single specialty in the Northern Territory, a specialty that was facing significant workload pressures, which in turn could create workforce issues for public hospitals into the future (Legislative Assembly of the Northern Territory Hansard, 31 August 2006, see also Mr Stirling Legislative Assembly of the Northern Territory Hansard 11 October 2006). In this situation it could also mean that an abortion procedure could become illegal if the woman had to wait too long after the decision is made to gain access to medical treatment. Elements of the debate thus considered the reality of abortion access for women in rural and remote areas, suggesting that the role of the medical profession in the abortion context was acceptable and that the law needed to better reflect the capacity of the medical profession to actually perform terminations of pregnancy. In other words, the role of the medical profession as gatekeepers to women's abortions was generally accepted because it was a part of medical practice. What the law needed to acknowledge was that the medical profession should not be limited in their

execution of the role, permitting the performance of abortions by doctors rather than a medical specialist.

However, despite legal recognition in the Northern Territory since 1974 that abortion was a medical procedure and could be lawfully performed by members of the medical profession, the legislature continued to debate whether abortion was more than a medical procedure, and this warranted further scrutiny of abortion by some members of Parliament. This was similar to the debate in South Australia, Western Australia, and the Australian Capital Territory, and it shows that the legal legitimacy of the gatekeeping role includes acknowledgement that doctors hold authority over a complex moral issue. As Dr Lim, Member for Greatorex, argued:

> The location of abortion in the *Criminal Code* significantly reminds us - including the medical profession and politicians - that abortion is, at best, a necessary evil and ought only to be performed after fully informed consent, and only after a woman has been properly and expertly counselled on all of the alternatives. For those doctors who are performing abortions lawfully, it is also important to have in their minds that the operation is not just another surgical procedure, but a procedure that will terminate a potential life if done before 20 weeks of pregnancy, and a survivable life if done after 20 weeks of pregnancy. Therefore, let us not trivialise abortion; it is not a medical procedure like any other. Other medical procedures do not involve terminating a potential human life.
>
> (Legislative Assembly of the Northern Territory Hansard, 11 October 2006, 57)

In this statement, Dr Lim was highlighting the moral dimensions of abortion and showed the precarious position of individual medical practitioners who perform abortions. He highlighted that while abortion is a medical procedure, there are moral dimensions to the procedure that warrant increased legal sanctions as would be the case if abortion was retained under criminal law (see Legislative Assembly of the Northern Territory Hansard, 11 October 2006, 57). In this context the authority of the medical profession would be retained but the legitimacy of the gatekeeping role for individual medical practitioners would require careful negotiation by members of the medical profession to acknowledge that "all involved need to have their minds engaged in the thought that they are embarking on a course of action that affects, with lethal consequences, the potential life of another, even if they consider that a potential life had no life" (see Dr Lim, Legislative Assembly of the Northern Territory Hansard, 11 October 2006, 63-64).

With the passing of the Bill, the law was moved from criminal to health law. The requirement for a specialist to perform the procedure was removed, but not the requirement for a medical specialist to sign off on the required reasons for the abortion (see Legislative Assembly of the Northern Territory Hansard, 11 October 2006 and Rankin 2011, 19-21). The debate in this context was not so much about the requirement for an increased level of scrutiny for women accessing abortions, but rather scrutiny of the judgements made by individual medical practitioners. This showed a similar approach to that of the Australian Capital Territory in that it is not only women's abortion choices being regulated, but also the practices of doctors.

An overwhelming majority passed the proposed amendments of 2006 in the Legislative Assembly. The legislative debate that preceded the enactment affirmed the authority of the medical profession as the legitimate providers of abortion services, while also acknowledging that the authority of individual medical practitioners required scrutiny. It showed that whilst the gatekeeping role would legitimately regulate the choices of women, it would also ensure the regulation of a medical practitioner's judgement. Thus from the Northern Territory we can see that the debate accepted the role of doctors as gatekeepers, but sought to limit the exercise of this role. This was similar to the debate in South Australia where the use of a second practitioner in exercising judgement over abortion was argued to be necessary for ensuring that doctors do not overstep their medical authority. The use of two medical practitioners was thus presented as a way of ensuring that a doctor's authority would be executed appropriately, limiting the impact of a doctor's beliefs on the choices that women make.

Victoria

Abortion law reform began in Victoria in August of 2007. The Victorian Parliament decided that the Menhennitt ruling of 1969, the first judicial ruling in Australia to deal with the meaning of the word "unlawful" in the abortion statute similar to the United Kingdom's ruling in *R v Bourne* (1938), "did not give guidance as to the matters that should be taken into account by the doctor when determining risk of harm to the woman, or the means for determining whether an abortion was the

proportionate response to the woman's particular circumstances" (Allan in Victoria Hansard 19 August 2008, 2951; the Menhennitt ruling, *R v Davidson* (1969), will be discussed further in Chapter 5). Thus there was concern that the gatekeeping role of doctors was not clear enough, leaving them open to criminal prosecution. The Victorian Parliament referred the question of abortion law reform to the Victorian Law Reform Commission for advice and requested that the Commission present options to clarify and reform the law. The Commission published its report in 2008, *Law of Abortion: Final Report 15*, and the contents of the report were the focus of the subsequent debate that transpired in the Legislative Assembly and Legislative Council.

According to the Commission's final report, several professional bodies including legal and medical entities supported changes to abortion law in order to protect a woman's autonomy to exercise reproductive choice. It was recommended that abortion should be an issue for a woman and her doctor:

> Professional bodies, including the Law Institute of Victoria, Victorian Women Lawyers, the Public Health Association of Australia, and the Australian Medical Association (AMA) Victoria supported decriminalisation. They characterised abortion as a matter between a woman and her doctor, with autonomy [for women] as the fundamental principle that the law should respect. The Paediatric State Committee, Royal Australasian College of Physicians, stated '[a]ny departure from this principle risks compromise to the health and rights of the woman concerned'.
>
> (Victorian Law Reform Commission 2008, 72)

The Commission's statement noted that various professional bodies from the legal and health domains saw the position of the doctor in the abortion process as both necessary and appropriate. It also recommended that the encounter between a woman and her doctor was the best means by which a woman's autonomy would be respected, with the claim being made that the law should respect this relationship and minimise interference in determining what should or should not occur during the clinical encounter. The AMA of Victoria supported such a position: "the profession is adequately regulated and legal proscription potentially interferes with the patient–doctor relationship" (Victorian Law Reform Commission 2008, 74). There was thus involvement from the medical profession in shaping how abortion was contextualised by the Commission.

An opposing view emerged from the Westgate Catholic Deanery Social Justice Group and National Civic Council during the course of the Commission's inquiries as to the appropriateness of a doctor's role for ensuring that women are protected, with protection in this opposing view equating to the denial of abortion procedures. The argument here was that "the principle of 'do no harm' [was] an ethical basis for why doctors should not perform abortions", and that "decriminalisation is more about protecting doctors and what they describe as an 'abortion industry' than protecting women" (taken from submissions from Westgate Catholic Deanery Social Justice Group and National Civic Council, Victorian Law Reform Commission 2008, 74). The role of the doctor here would be for the regulation of abortion, rather than the regulation of women choosing abortion. The argument made by this group was that the ethical premise of medicine, the principle of 'do no harm', requires that doctors act in a specific way. In this instance it would apply to the harm experienced by women as a consequence of undergoing an abortion procedure and the harm that would be inflicted on a fetus. The law in this case is being conceptualised as a mechanism for controlling the actions of doctors in limiting the harm that can be inflicted by abortion, rather than it being a mechanism for establishing a role for doctors to act as regulators for women's reproductive choices. The gatekeeping role of doctors under abortion law was thus interpreted by opponents of abortion law reform as a means for protecting women from harm, just as it is interpreted as a means of assisting women to exercise reproductive autonomy. This aspect of the Commission's report presents another dimension for our understanding of the gatekeeping role, specifically that the moral complexity of abortion warrants that no person should be permitted to perform an abortion and that the ethical tenet of medicine supports such. The role of gatekeeping in this context would be to ensure that no abortions occur.

The Commission's findings resulted in the emergence of the Abortion Law Reform Bill, which was introduced into the Victorian Parliament in 2008. The legislature in Victoria debated the proposed Bill, with the debate focusing on the moral dimensions of abortion and the appropriateness of the role of the medical profession in regulating women's reproductive choices. The debate concerning Clause 8 of the proposed Bill highlighted the moral dimensions of abortion and the

role of doctors. Clause 8 was the requirement for a medical practitioner who holds a conscientious objection to abortion to refer a patient to another medical practitioner. One Member of the Legislative Assembly, Ms Morand, argued: "The commission recognised that some health practitioners may have a conscientious objection to abortion, and that such practitioners should not be compelled to provide abortions contrary to their beliefs," but that "if requested by a woman to advise on, perform, direct or supervise an abortion, the practitioner inform the woman of their conscientious objection, and refer the woman to another practitioner, in the same regulated profession, who the first practitioner knows does not have a conscientious objection to abortion" (Ms Morand, Victorian Hansard 19 August 2008, 2953). What Ms Morand's statement suggested was that the role of the doctor for abortion should be accepted in so far as it pertains to the medical performance of an abortion. Where a doctor holds a moral objection to abortion, then performance of the role should be referred to another practitioner. The implication here is that the performance of gatekeeping is acceptable provided that it is within the bounds of medicine and not transitioning into the realm of morality.

The rationale for the inclusion of Clause 8 was that it struck an "appropriate balance between the rights of registered health practitioners to conduct themselves in accordance with their religion or beliefs, and to freedom of expression, and the right of women to receive the medical care of their choice" (Ms Morand, Victorian Hansard 19 August 2008, 2954). This was supported by Ms Wooldridge who considered the capacity of women to access abortions in places where there was only one doctor. For Ms Wooldridge, the inclusion of Clause 8 would be "particularly beneficial for younger women and women in regional and rural Victoria, especially areas where there is only one doctor, ensuring that they have access to timely and safe abortion services should they be needed" (Victorian Hansard, 9 September 2008, 3306). Thus the inclusion of Clause 8 was thought to be a necessary legal requirement to balance the rights of doctors and the rights of women to exercise reproductive choice and have access to terminations of pregnancy at a point in the pregnancy when it is safe, and legal, to do so. The notion of timeliness was also a characteristic of the discussion in the Northern Territory where it was argued that the requirement for abortions to be performed

by a medical specialty could result in women not being able to access abortions when they are legal based on the gestation of their pregnancy. What this recognised was that doctors hold moral views and that these views can impact on the capacity of women to not only exercise their reproductive rights, but also access lawful abortions. It recognised that doctors can overstep their medical authority and enter into the moral domain, and hence the legal role of gatekeeping was argued to be necessary to protect women from this occurring.

Opposition to Clause 8 came from some members of the medical profession. Mr Ryan, a Member of the Legislative Assembly, quoting a submission made to him from medical practitioners, stated:

> The conscientious objection clause is extreme and unprecedented. It is not in keeping with the codes of ethics of every major professional health body in Australia. This clause should be strongly rejected as an affront to the concept of freedom of conscience and as an attack on the moral integrity and autonomy of health professionals.
>
> (Victorian Hansard, 9 September 2008, 3311)

He argued that the proposed inclusion of Clause 8 challenged the autonomy of the medical profession and its capacity to ensure appropriate medical practice, because it implied that doctors, and the medical profession more broadly, was incapable of self regulation to ensure that doctors do not overstep their medical authority. Mr Ryan was arguing that the medical profession was capable of ensuring that the moral dimensions of abortion were managed appropriately via the profession's codes of ethics. What this suggested was that an acceptable performance of the gatekeeping role was an issue for the medical profession to manage. It also acknowledged that the gatekeeping role is invariably tied to both issues of medical authority and morality.

The passing of the Abortion Law Reform Bill, with Clause 8 included, reflected the sentiment of the majority of the Victorian Parliament that abortion is both a medical procedure and a moral issue, and that the two cannot be disentangled from one another. A Parliamentary majority felt that the performance of an abortion procedure was an issue for medical practice, but that the decision as to whether or not an abortion should occur at least in the first 24 weeks of a pregnancy is a “private decision for a woman in consultation with her medical

practitioner" (Ms Morand, Victorian Hansard 19 August 2008, 2952). The legitimacy of the medical profession's gatekeeping role in this context extends to their role in ensuring that the medical procedure of abortion is safe, and that women are provided with sufficient information to make an informed decision. It does not include the exercise of moral judgements over the reproductive choices of women. So unlike the previous four jurisdictions, while Victoria gave legal legitimacy to the medical profession to occupy a gatekeeping role, it was only in relation to the exercise of clinical decision-making, explicitly stating that an individual doctor's morality should not impact on a woman seeking an abortion.

However, it should be noted that the Abortion Law Reform Bill applied gestational limits to the exercise of reproductive choice, which is similar in Western Australia but not any other jurisdiction, distinguishing between the role of the doctor in early terminations and late term terminations. In early terminations, the role of the doctor was limited to the performance of an abortion with a woman's consent, but in abortions post 24 weeks the role of the doctor was to determine the grounds for the appropriateness of an abortion procedure (see Ms Morand, Victorian Hansard 19 August 2008, 2951-2952). The rationale for gestational limits was put forward in the Commission's report as being reflective of current clinical practice. It outlined that the AMA of Victoria "reported that gestational age is a factor that informs a medical practitioner's clinical judgement" (Victorian Law Reform Commission 2008, 78; see also 90). Despite the changing role of the doctor based on gestational limits, where the authority of a medical practitioner changes at different stages in a pregnancy, the authority of the medical profession to shape abortion practice remains (see Ms Morand, Victorian Hansard 19 August 2008, 2951-2952). In this sense, the gatekeeping role holds its legitimacy through the shaping of appropriate abortion practice, even though the authority of medical practitioners changes in accordance with gestation.

The legislative debate regarding abortion law reform in Victoria considered the role of the medical profession for abortion and openly acknowledged that doctors can overstep their medical authority and enter into the realm of morality. The debate highlighted that the gatekeeping role of the medical profession was considered to be legitimate in so far as regulating the physical procedure of

abortion, but that the decision as to whether or not an abortion should occur was a matter for individual women in consultation with their doctor. The legislative debate in Victoria thus resulted in the medical profession retaining authority to determine how and when abortions could be performed, but the question of why an abortion should be performed was primarily a consideration for women. While the debate in Western Australia, the Australian Capital Territory and the Northern Territory also did this to some extent, the inclusion of Clause 8 in Victoria made a legal statement to this effect.

Tasmania

In 2013, the Tasmanian Parliament debated reforms to abortion law. The role of the medical profession was a substantial focus of the legislative debate, affirming that abortion was a medical issue. However like Victoria, the scope of authority to be exercised by medical practitioners was the focus of the debate, exploring issues of professional conduct and moral authority. The perspectives of the Australian Medical Association were an important part of the debate, and formed the basis for certain crucial recommendations.

The proposed changes to abortion law in Tasmania were designed to provide women with greater autonomy in exercising reproductive choice. Under the proposed legislation, the exercise of choice could occur in the first 16 weeks of a pregnancy with no interference in the decision-making process, with the period following 16 weeks requiring greater intervention by the medical profession. Mr O'Byrne, the then Minister for Infrastructure, argued for greater legal recognition of women's choices on the basis that

> We need to respect women as capable decision-makers who should not be prevented from choosing terminations or pregnancies themselves and being forced to depend on opinions of medical practitioners to make that choice for them. This is a matter of equity. Women need nothing more or less than full support to be able to make a decision.
>
> (Tasmania Hansard Part 3, 16 April 2013, 99)

Abortion law prior to 2013 gave significant legal power to individual doctors to exercise judgement over women's abortion decisions, a position that Mr O'Byrne suggested was no longer appropriate. The legal power they held prior to 2013 was similar to that held by doctors in South Australia, Western Australia, and the

Northern Territory. However, the proposed legislation applied gestational limits to the exercise of autonomy by women in exercising an abortion decision, maintaining the power of individual doctors after 16 weeks gestation, suggesting that the doctor's role of gatekeeping was still required in the later stages of a pregnancy, similar to the situation in Victoria.

Ms O'Byrne, the then Health Minister, outlined the role of a medical practitioner under the proposed Bill in exercising decision-making power over the appropriateness of an abortion procedure after 16 weeks gestation:

> The doctor is to have regard to the woman's current and future physical, psychological, economic, and social circumstances when assessing the impact of a pregnancy and a termination on a woman's physical or mental health.
>
> (O'Byrne in Tasmanian Hansard Part 2, 16 April 2013, 39)

The legislature recognised a need for greater clarity in defining what a doctor could or could not consider in the context of an abortion decision, such as her current and future physical or economic circumstances. However, this statement still maintained that it is the doctor who must consider all the facets of a woman's life before proceeding with a termination. A woman's decision in this context may not be sufficient grounds for an abortion to proceed as it is the doctor who is required to exercise judgement as to the impact of certain factors on her physical and/or mental health (factors including her psychology, employment, and physical well-being), not the woman alone. The gatekeeping role of the medical profession was thus justified and considered necessary under the new legislation for terminations of pregnancy after 16 weeks.

Similar to Victoria, support for the proposed legislative changes seemed to diminish the authority of the medical profession in shaping the lawfulness of an abortion procedure by reducing the scope of the role for individual doctors in the earlier stages of a pregnancy. This differed from the other jurisdictions discussed so far in this chapter, except for Victoria, because it legally stipulated a different role for doctors at different stages of the pregnancy, whereas other jurisdictions seemed to articulate a single role for a doctor. However, while the decision-making authority for individual doctors was diminished, at least in the earlier stages of a pregnancy, the authority of the medical profession to shape and define abortion practice remained.

The use of gestational time limits to determine what involvement a medical practitioner should have in an abortion decision maintained the authority of the medical profession to shape the legitimacy of a doctor's abortion practice. In making her case for the inclusion of gestational limits, Ms O'Byrne suggested that gestational limits were appropriate because the Australian Institute of Health and Welfare had estimated that only a very small proportion of terminations occur after 20 weeks and that where they do occur, the practice is heavily scrutinised by the internal processes of providers of this service and guided by medical ethics and professional medical bodies (Tasmanian Hansard Part 2, 16 April 2013, 40-41). The existing practices of the medical profession were thus influential in shaping how abortion was understood, and submissions from the health sector were contributory in this regard with many members of the Tasmanian parliament drawing on such submissions to support their argument (see Tasmanian Hansard Part 2, 16 April 2013, and Tasmanian Hansard Part 3, 16 April 2013). So while there was no longer a legal requirement for doctors to establish the requisite grounds for an abortion procedure prior to 16 weeks, the authority of the medical profession to shape and define abortion practice remained.

The legislative debate in Tasmania also focused on the impact of a doctor's conscience on the capacity of women to exercise reproductive choice. The debate, similar to that put forward in Victoria but unlike other jurisdictions, highlighted another challenge to the scope of authority previously held by medical practitioners. Previously, doctors could exercise conscience without any corresponding obligation. The proposed clauses were said to

> continue to recognise a health practitioner's right, except in an emergency, to refuse to treat on the basis of a conscientious objection. The bill will also introduce a corresponding responsibility…a doctor who holds a conscientious objection to terminations is to refer a woman seeking a termination or pregnancy options advice to another doctor who does not hold such an objection.
>
> (Ms O'Byrne, Tasmanian Hansard Part 2, Tuesday 16 April 2013, 41)

During the course of legislative debate, there was substantial opposition to the requirement of a practitioner to refer a woman seeking a termination to another doctor. One Hobart doctor made the following statement in relation to the proposed obligation to refer for conscientious objectors: "This is clearly expecting

conscientious objectors to actively participate in actions which contravene their personal convictions or beliefs" (Hobart Doctor in Mr Hodgman Tasmanian Hansard Part 3, 16 April 2013, 91). Another example came from Mr Hodgman, Leader of the Opposition:

> One of the reasons I am opposed to this bill is that I do not believe it is the province of parliamentarians to seek to dictate the consciences of medical practitioners. I do not believe it is the responsibility of us, as elected members of this parliament, to dictate to medical practitioners who are in various ways subject to a most rigorous regime of regulation of professional ethics and codes. Their profession is held in the highest of regard in our community. It is not for us in this place at any time to be dictating to them how they exercise their consciences in the discharge of their functions and responsibilities. It is an unnecessary and unacceptable incursion into the professional ethics of our medical practitioners.
>
> (Mr Hodgman Tasmanian Hansard Part 3, 16 April 2013, 91)

As this passage shows, opposition to the proposed obligation to refer clauses highlighted the significance of the status of the medical profession. Mr Hodgman statement also revealed his belief that the medical profession is sufficiently regulated through professional codes of ethics and standards of practice. He even suggested that the legislature did not have a role in regulating aspects of medical practice where the conscience of doctors is involved. His position closes the profession to external scrutiny, and he expressed a view that the actions of medical practitioners should be a matter for medical judgement, rather than legislative enquiry.

The AMA of Tasmania reinforced Hodgson's position when they voiced 'grave concerns' in their submission to the Tasmanian Parliament prior to the introduction of the Bill. They argued that the draft legislation "has the potential to criminalise members of the profession with conscientious objection to termination of pregnancy" (Steven 2013, 1). The AMA also noted "mandating a conscientious objector to make a referral to another doctor could be viewed as denying that doctor the ability to live according to their beliefs (if the person considers providing a referral to be participating in an activity to which they object)" (Steven 2013, 3). If we consider that a woman seeking a termination is doing so on the basis of a desire to live according to her wishes and beliefs, then the refusal by a doctor to provide her with any assistance could negatively impact her capacity to

do so. Thus, the legislative debate directly confronted one of the principal dilemmas we encountered in Chapter 2 concerning the weight to be attached to the rights of women and doctors (see Sheldon 1997, Rhoden 1986, MacKinnon 1991, Palmer 2009, and Douglas & Kerr 2016).

However, the AMA recognised this tension between the rights of women and the rights of doctors when they also claimed to support "the right of every woman to make her own decisions about reproduction including abortion", and that "the access of all people to reproductive medicine including abortion services should be free from undue political, commercial, cultural, or religious interference" (Steven 2013, 4). Yet the AMA Code of Ethics, the version in place during 2013, did not explicitly oblige a doctor to provide a referral in the case of a conscientious objection, instead stating in relation to referral that a professional must "recognise your professional limitations and be prepared to refer as appropriate" (AMA 2006, 2). The statements made by the AMA merely reflected this potential tension between the rights of women and the rights of doctors. The obligation to refer in the conscientious objection clauses struck a legal balance between the two sets of rights.

The debate regarding abortion law reform in Tasmania acknowledged that abortion is a medical procedure as well as a choice made by individual women. Yet, the debate reinforced the authority of the medical profession to define abortion practice and legitimated the role of a medical practitioner in the abortion process, similar to the jurisdictions discussed in this chapter. In this way, the role of gatekeeping became one of regulating the conduct of a medical practitioner, rather than the abortion choices of women, ensuring that women could access abortion services in the earliest part of their pregnancy without undue interference should they so choose. What this suggests about the role of gatekeeping in Tasmania, like the other jurisdictions examined above, is that the medical profession was accepted as being a necessary part of abortion practice, but that the exercise of the role needed to be in accordance with the desires of women in the earlier parts of a pregnancy. In other words, the exercise of the gatekeeping role was conditional.

Conclusion

Overall, the purpose of this chapter was to explore how the medical profession became the legal authority for abortion in Australia by firstly exploring if the medical profession had any involvement in defining abortion as a crime, and then subsequently exploring how contemporary legislatures debated the role of the medical profession, and whether this debate legitimated the role of 'gatekeeping'. The medical profession became the legal authority for abortion first through engagement in campaigns for the criminalisation of abortion in the eighteenth century, and then subsequent recognition within the legislatures of the United Kingdom and Australia in the nineteenth and twentieth centuries of the need for abortion law to reflect current medical practice.

The history of abortion law in the United Kingdom demonstrated engagement from the medical profession in shaping abortion as a crime, defining the legitimacy of the practice of abortion as a means of achieving professional status and privileging medical ways of understanding the body. The authoritative position of the medical profession in shaping the lawfulness of abortion procedures resulted in a medical understanding of abortion coming to hold greater significance than that of any other social group, such as women and midwives. This scientific-medical understanding of abortion came to define how abortion would be legally managed at common law and when legislative changes were made. The gatekeeping role of the medical profession is thus a consequence of the authority of the profession to define the legitimacy of abortion practice (see Keown 1988, Thomson 2013, and Sheldon 1997).

However, elements of legislative debate that occurred in the Australian jurisdictions of South Australia, Western Australia, the Australian Capital Territory, the Northern Territory, Victoria and Tasmania prior to the enactment of changes to abortion law between 1968 and 2015, revealed that while the medical profession defines abortion practice and the law recognises the significance of medically scientific knowledge, the individual actions of doctors may not be solely a legitimate exercise of medical authority. The legislative debate that occurred in these jurisdictions acknowledged that abortion is both a medical procedure and a complex moral issue, where doctors can overstep their medical authority and

enter into morality when exercising decision-making regarding abortion. In South Australia, Western Australia and the Northern Territory this was to be managed through the use of two decision makers from within the medical profession. In the Australian Capital Territory doctors are required to adhere to a more detailed regulatory framework, and in Tasmania and Victoria doctors have a legislative obligation to refer a woman to another doctor if their beliefs preclude them from engaging in an abortion. What this means is that the role of gatekeeping is considered to be legitimate in so far as it pertains to the exercise of medical authority, but beyond this the role of the doctor is to be constrained.

In relation to the literature examined in Chapter 2, what this shows is that the moral dimensions of abortion in legislative debates have been as apparent in the medical domain as they are in broader social spheres (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000). In arguing for changes to abortion law, Australian legislatures have sought to manage the impact of the diverse views regarding abortion on the capacity of women to exercise their reproductive rights. So while there may be a gatekeeping role for doctors, the performance of this role should emphasise women being able to access abortion procedures on medical grounds, not policed in their attempts to do so according to the moral conscience of the doctor. However, given that every state and territory has a slightly different legal framework, and approaches to managing the question of morality in the abortion context differ, it is necessary to examine the scope given to the medical profession at law. In other words, what this chapter has given us is a sense of the *intent* of legislative change, but it has not discussed the legislation that *resulted from* the debate. The next chapter will examine the legal frameworks for abortion in Australia from 1968 to 2015, examining whether the intent of the legislative changes found in this chapter translate into the legal role/practice of gatekeeping. What I will examine in the next chapter is the scope of authority given to the medical profession, in particular how it describes the role of the doctor and how they are expected to approach abortion decision-making.

Chapter 5

The legal framework of ‘gatekeeping’ in Australia

Introduction

In the previous chapter I showed how the medical profession became an authority under abortion law by defining abortion practice and privileging medical knowledge. Initially this occurred through the campaigns of the medical profession to criminalise abortion as a way of marginalising illegitimate medical practice. Then, throughout the twentieth century and earlier part of the twenty first century, the practice of medical abortions came to be considered as the norm for a lawful abortion. Australian legislatures argued, to varying degrees, for legal changes in order to reflect clinical practice. Medical authority thus came to define abortion practice, and hence substantiated the legitimacy of a gatekeeping role for medical practitioners at law. However, as the last chapter emphasised, this same authority did not clearly or consistently define the scope of the gatekeeping role, and indeed the scope was contested in each jurisdiction where abortion law reform took place. From this I hypothesised that the legal role of gatekeeping focused on the conduct of doctors and maintained medical authority to define abortion practice, rather than it being reflective of an attempt by the legislature to regulate women's abortion choices, as claimed by MacKinnon (1991) (see also Sheldon 1997, Luker 1984, Baird 1990, Rankin 2001 & 2011, and Palmer 2009). The present chapter seeks to test this hypothesis by exploring in further detail the scope of the gatekeeping role as defined at law. In other words, while the previous chapter explored the debates that lead to changes to the law, this chapter examines the enacted legislation.

This examination of the legal frameworks for abortion in Australia from 1968 until 2015 will explore the scope of the role of gatekeeping at law. The chapter explores three sub questions of this thesis: *What is the legal framework for abortion*? *What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory?* The rationale for these questions concerns the need to substantively understand the legal gatekeeping role, particularly in the context of an acknowledgment that abortion is a medical procedure as well as a moral issue, and an issue for women's reproductive rights (see Dworkin 1994, Wertheimer 1971, Hadley 1996, MacKinnon 1991, and Sheldon 1997 discussed in Chapter 2). Indeed, Sifris (2014, 189 in Douglas & Kerr 2016, 134) argues that medico-legal regulation of abortion does not remove barriers to abortion access, rather it

"entrenches external decision-making for abortion access and excludes women from truly exercising their autonomy or self-determination". Consequently, without exploring the legal frameworks for abortion there is a risk that the authority of the medical profession and the description of them as gatekeepers is simply assumed to be a legislative function and, further, that the nature of this function is clear and unambiguous. Yet, so far in this thesis I have pointed to legal, moral and rights-based grounds that illustrate the contentiousness of abortion legislation.

In this chapter, abortion law in each state and territory is examined through the lens of the following questions: *Is abortion governed by criminal law or health law? (sub question 1) Are there specified legal criteria for lawfulness and what role do doctors have for establishing if the criteria have been met? (sub question 2) and How does the law describe the role of the doctor? (sub question 3).* These questions help to understand if/how the gatekeeping role at law reflects the legislative intention in each jurisdiction as discussed in Chapter 4, and were the basis for examining the material to answer the questions posed above, specifically what the legal framework for abortion is and whether or not the legal framework stipulates a regulatory role for doctors over women's abortion choices. They also provide a basis for establishing the commonality across the jurisdictions and the various points of difference. This is particularly important to explore given the context of the broad characterisation of gatekeeping for the medical profession across jurisdictions, despite the fact that "no two jurisdictions have adopted the same approach to abortion law reform, with the result that we now have a complex patchwork of different legal requirements and criminal defences across Australia" (de Crespigny & Savulescu 2004 in de Costa et al 2015, 105).

The findings in this chapter are presented in three groups based on how each jurisdiction responded to the three sub-questions above. The first group concerns those jurisdictions where abortion has been repealed from the Criminal Code or the Crimes Act where a medical professional is involved (Australian Capital Territory, Victoria, and Tasmania); the second are those jurisdictions where abortion remains solely in criminal law (New South Wales and Queensland); and the third group are those where abortion is regulated across both criminal and

health law (South Australia, Western Australia, and the Northern Territory). An overview of the law in each State and Territory is provided, followed by a discussion of the gatekeeping role as it pertains to each group. These legislative groupings related to the period of fieldwork between March 2013 and April 2015, and are current with the exception of the Northern Territory. In 2017, the Northern Territory passed legislation that represents elements of both the decriminalised and hybrid jurisdictions. The implication of the 2017 changes in that jurisdiction will be assessed in my summary in Chapter 8.

5.1 Decriminalised jurisdictions: Australian Capital Territory, Victoria and Tasmania

The decriminalisation of abortion occurred in the Australian Capital Territory in 2002, Victoria in 2008, and Tasmania in 2013. Each of these jurisdictions has removed the performance of an abortion by a qualified person from criminal law, and there is no criminal offence for the woman concerned. The medical profession is positioned in each of these jurisdictions as the legitimate providers of abortion services, and from the legislative debate explored in Chapter 4 we know that this was a consequence of their influence in defining abortion practice, and hence an argument within the legislature that the law ought to reflect clinical practice. However, noting that each legislature also considered the moral significance of abortion, these jurisdictions also debated the scope of a medical practitioner's role in the abortion context, and thus debated the scope of authority for medical gatekeepers. The following section examines the legal scope of authority provided to medical professionals in the decriminalised jurisdictions. It will address sub questions 1, 2 and 3 for this chapter.

Australian Capital Territory

In the Australian Capital Territory there is no reference to abortion in the *Crimes ACT 1900* (ACT), and it is now contained within the *Health Act 1993* (ACT). The legal framework is a consequence of aspects of the legislative debate described in Chapter 4, which focused on the actions of doctors in providing abortion services. The debate that occurred accepted that the law had a role in protecting both women and doctors during the abortion exchange. However, until the late 1990s,

abortion was contained in the *Crimes Act 1900* (ACT), meaning that the performance of abortions was governed by criminal law. The text for the legislation was almost identical to that of the United Kingdom's *Offences Against the Person Act 1861* mentioned in Chapter 4. On this basis, the judicial initiatives of the twentieth century in New South Wales, specifically the Levine Ruling in *R v Wald* (1971), were thought to have applied for the lawful performance of an abortion in the Australian Capital Territory (see Cica 1998, 3 and Rankin 2001, 249). The Levine ruling determined that there were circumstances in which an abortion might be considered lawful (*R v Wald* (1971) 3 DCR (NSW) 25, see also Cica 1998, 2-3 and Rankin 2001, 234-235). For an abortion to be lawful "the accused must have had an honest belief on reasonable grounds that what they did was necessary to preserve the women involved from serious danger to their life, or physical or mental health", where reasonable grounds could include economic, social or medical reasons (*R v Wald* (1971) 3 DCR (NSW) 25, 29). Common law thus provided scope for a medical professional to shape a defence for an abortion procedure for the later part of the twentieth century.

In 1998, the Australian Capital Territory enacted legislative amendments because the scope of the role for a medical practitioner at common law was seen as insufficient for the governance of abortion. The *Health Regulation (Maternal Health Information) Act 1998* (ACT) was enacted in 1998 and it stipulated conditions for medical practitioners to perform and conduct an abortion procedure. The preamble to the Act stated: "The Legislative Assembly wishes to ensure that proper information is provided to a woman who is considering an abortion…that neither complying nor failing to comply with these requirements to provide information will affect whether or not an abortion or other act is lawful for the purposes of sections 40 to 45 (inclusive) of the *Crimes Act 1900*, which deal with abortion and related matters" (*Health Regulation (Maternal Health Information) Act 1998* (ACT)). The Act sought to ensure that the conduct of doctors was addressed by the legislature, in particular that women accessing abortions were provided with the necessary information to exercise an informed decision. So whilst common law gave doctors broad scope to shape their clinical practice pertaining to abortion, the introduction of the Act was designed to dictate elements of this practice.

However, whilst the Act provided some requirements to be met by medical practitioners, it retained the fundamental premise that a defence for abortion was an issue for the medical domain to determine, adjudicated by the judicial system if/when a person was charged. The Act covered the following: "The objects of this Act are to— (a) ensure that adequate and balanced medical advice and information are given to a woman who is considering an abortion; (b) ensure that a decision by a woman to proceed or not to proceed with an abortion is carefully considered; (c) ensure that abortions are only performed by appropriately qualified persons and in suitable premises; (d) provide statistical reports to government on the occurrences of abortions in the Territory; (e) protect the privacy of women having abortions; and (f) provide for the right of persons and bodies to refuse to participate in abortions" (*Health Regulation (Maternal Health Information) Act 1998* (ACT) s 3). While the legislation provided for greater clarity concerning the performance of an abortion by a medical practitioner, Rankin (2001, 249) has argued that this placed a greater emphasis on the role of the medical profession in the abortion decision, noting that the purpose of the Act "suggests that women do not otherwise carefully consider their decision as to whether or not to terminate their pregnancy". This interpretation suggests that the legislation was framed to privilege the authority of the medical profession, specifically that the conduct of the medical profession in providing information and performing abortions has greater legitimacy *for shaping lawfulness* than the choice of a woman alone.

In 2002, the Act was repealed by the *Health Regulation (Maternal Health Information) Repeal Act 2002* (ACT), shifting the conditions to the *Medical Practitioners Act 1930* (ACT). At the same time, abortion was removed from the *Crimes Act 1900* (ACT) with the enactment of the *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT). In 2005, all abortion provisions were moved to the *Health Act 1993* (ACT). These changes were made as part of broader changes to simplify the various legislative instruments that governed the provision of health care in the Australian Capital Territory (see Corbell, Legislation Assembly for the ACT: 2005 Week 5 Hansard 7 April, 1512). Abortion is now contained in part 6 of the *Health Act 1993* (ACT), sections 80 through 84. These sections are less prescriptive than previous legislation concerning the provision of information by a

doctor, and there is no restriction on the time during a pregnancy when an abortion can be performed. There is also no requirement for a doctor to establish reasons for performing the abortion, and hence no legal criteria to be applied in assessing a woman's abortion request. The sections do state that only a doctor can carry out an abortion, the abortion must be carried out in an approved facility, and that no person is obligated to carry out, or assist in carrying out, an abortion (*Health Act 1993* (ACT) s 80 – s 84). The definition of an abortion is also taken to include the use of an instrument and the administering of a drug (*Health Act 1993* (ACT) s 80). The legal role of the doctor in the Australian Capital Territory is thus to provide abortions safely if their conscience allows, rather than determining the legal sufficiency of grounds for an abortion.

The inclusion of a conscientious objection clause in the legislation allows that a medical professional can opt out of being involved in abortion procedures. Doctors have a legal right not to participate in an abortion and are under no obligation to refer a woman to another practitioner. O'Rourke et al (2012, 87-88) have referred to this as an 'unregulated use of conscientious objection', arguing that it "impedes women's rights to access safe lawful medical procedures…the unregulated use of conscientious objection denies women their fundamental right to lawful medical care". Rankin (2011, 37-39) has also argued, with reference to the Australian Capital Territory, that unregulated conscientious objection negates women having the right to an abortion because a doctor can refuse to provide the service and refuse to provide any further information regarding the service. The law in the Australian Capital Territory thus enables the performance of abortions but can undermine a woman's right to access an abortion by protecting the conscience of individual doctors.

Current legislation in the Australian Capital Territory provides for the lawful performance of abortions under health law, placing a strong emphasis on the medical nature of the practice. The law does not specify any criteria for establishing the lawfulness of an abortion, and hence there is no legal requirement for a doctor to assess an abortion request. Therefore the role of the doctor in the Australian Capital Territory is not to assess women's abortion choices and hence make a legal determination of the sufficiency of their choice, a necessity that is

suggested by the use of the term 'gatekeeping' to describe the legal role of the doctor (see Cannold 2000, 24-25, Hadley 1996, 187, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004), rather the law stipulates regulatory conditions for doctors to adhere to in the performance of abortions. The position of abortion under health law and the decriminalisation of abortion also support this interpretation of the law, because the broader legislative framework pertains to the conduct of the health profession and establishes different governance channels to regulate the conduct of health institutions and health professionals. The law in the Australian Capital Territory thus does not require that doctors perform a gatekeeping role to regulate women's abortion choices.

Victoria

The legal situation in Victoria suggests a similar regulatory environment to that of the Australian Capital Territory in terms of the broad framework that governs the performance of abortions. The legislative debate that occurred in Victoria also, like the Australian Capital Territory, reinforced the significance of the medical profession in providing abortion services and defining abortion practice, but also challenged the scope of the role that doctors were to occupy (see Chapter 4). However, Victoria's legislation originated from a more specific legal challenge, well before either jurisdiction decriminalised abortion (2002 in the Australian Capital Territory and 2008 in Victoria). This involved the first judicial ruling in Australia as to the lawfulness of an abortion procedure, the Menhennitt ruling in the case of *R v Davidson* (1969) (VicSC 106). Victoria is thus discussed here after the Australian Capital Territory because of the year in which abortion law reform took place, but the common law ruling of *R v Davidson* shaped abortion practice in Victoria and the Australian Capital Territory during the latter part of the 20th century.

The judge in *R v Davidson*, Justice Menhennitt, presided over a case where the accused, medical practitioner Charles Kenneth Davidson, was charged on four counts of using an instrument to procure a miscarriage under section 65 of the *Crimes Act 1958* (Vic), and one count of conspiring unlawfully to procure the miscarriage of a woman (*R v Davidson* 1969, (Ruling) VicSC 106). At this time the law governing abortion in Victoria was modelled on the United Kingdom's statutes

of 1861. The case focused entirely on the meaning of the word 'unlawful', with Justice Menhennitt stating: "The particular matter as to which I have heard submissions and on which I make this ruling is as to the element of unlawfulness in the charges" (*R v Davidson* (1969), (Ruling) VicSC 106). In his ruling, Justice Menhennitt noted that the use of the term 'unlawful' in the statute must indicate that there are certain circumstances in which the use of an instrument or other means to procure a miscarriage may be lawful, but that nowhere was the word 'unlawful' statutorily defined (*R v Davidson* (1969), (Ruling) VicSC 106).

Justice Menhennitt used the common law defence of necessity, indicating that in his view this was the most appropriate principle to apply for determining the circumstances in which an abortion may be lawful (*R v Davidson* (1969), (Ruling) VicSC 106, 504-508A). He relied on the definition of necessity as provided by Sir James Fitzjames Stephen in "Digest of Criminal Law": "An act which would otherwise be a crime may in some cases be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and which, if they had followed, would have inflicted upon him or upon others whom he was bound to protect, inevitable and irreparable evil, that no more was done than was reasonably necessary for that purpose, and that the evil inflicted by it was not disproportionate to the evil avoided" (Stephen, "Digest of Criminal Law", 1st Ed. Chap 111 Article 43; 9th Ed. Chap. II Article 11, *R v Davidson* (1969), (Ruling) VicSC 106, 505). The defence of necessity meant that where a doctor had acted to protect the life of a patient and the consequence of the act was not disproportionate to the affect of the act itself, then the act could be considered lawful. In his final direction to the jury Justice Menhennitt stated:

> I accordingly decide that the relevant law in relation to unlawfulness is as follows: For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him was (a) necessary to preserve the life of the woman from serious danger to her life or her physical and mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.
>
> (*R v Davidson* (1969), VicSC 106, 508)

On 3 June 1969, the jury found the accused, Dr Davidson, not guilty on all counts. The Menhennitt ruling provided the legal basis for the provision of abortion

services in Victoria until 2008 when the *Abortion Law Reform Act 2008* (Vic) was enacted, decriminalising abortion and providing measures for the governance of abortion under health law (see Chapter 4 for an overview of the parliamentary debate).

The *Abortion Law Reform Act 2008* (Vic) provides that a registered medical practitioner can perform an abortion on a woman who is not more than 24 weeks pregnant, but that the provision of an abortion after 24 weeks can only occur if the practitioner "(a) reasonably believes that the abortion is appropriate in all the circumstances; and (b) has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances" (*Abortion Law Reform Act 2008* (Vic) s 5(1)). This differs to the law in the Australian Capital Territory; the law there does not restrict the time during a pregnancy when an abortion can take place. The legal role of the doctor in Victoria is thus regulatory in the later stages of a pregnancy, but the scope of authority for a medical professional is limited prior to 24 weeks gestation.

The *Abortion Law Reform Act 2008* also includes an 'obligation' clause for health practitioners who hold a conscientious objection to abortion:

> If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must—(a) inform the woman that the practitioner has a conscientious objection to abortion; and (b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.
>
> (*Abortion Law Reform Act 2008* (Vic) s 8(1))

The 'obligation to refer' clause recognises that the individual rights of a doctor in conscientiously objecting to abortion should not impact on the rights of women to access abortion services. The Act seeks to balance the rights of women with the rights of doctors, a point that is absent from the Australian Capital Territory's legal framework because of the absolute right of doctors to conscientiously object. What this means is that the role of the doctor in providing abortion services is appropriate only in so far as the performance of an abortion procedure, the individual beliefs of a doctor concerning the moral dimensions of abortion are

secondary to a woman's abortion request because the right to conscientiously object is conditional. This positions abortion as a medical procedure and affirms that a person's individual beliefs should not unduly impact on a woman seeking to access such a medical procedure, and hence should not be part of the legal gatekeeping role.

The legal framework for abortion in Victoria reinforces the role of the health profession in providing abortion services, but also provides women with the capacity to seek abortions before 24 weeks in a pregnancy based on individual choice alone. Post 24 weeks, an abortion can be performed provided that two medical practitioners agree that it is appropriate in all the circumstances. A doctor is entitled to conscientiously object to abortion, but this objection cannot impede a woman's access to timely healthcare. There is no legal basis for a woman's abortion decision to be assessed against a defined set of criteria, as in there are no criteria that a woman needs to meet regarding her economic, social, and psychological circumstances.

Abortion law in Victoria thus ensures that the legal function for the medical profession is regulated so that women's reproductive choices can be respected, and women are able to access abortions on grounds as they see fit. What this suggests is that the gatekeeping role regulates a doctor's behavior more so than it regulates women's abortion choices. It also shows how the law can establish a regulatory role for doctors but seek to limit how doctors exercise that same role. The scope of legal authority given to doctors in Victoria is thus limited in the earlier stages of a pregnancy, and constrained at all times due to the conditional nature of conscientious objection.

Tasmania

Unlike Victoria and the Australian Capital Territory, Tasmania made legislative changes to criminal law to allow for the medical termination of pregnancy at least a decade before repealing abortion from the criminal code in 2013. Prior to a legislative change to criminal law in 2001, abortion was solely contained in sections 134 and 135 of the *Criminal Code Act 1924* (Tas). Like Victoria and the Australian Capital Territory, the Act contained clauses that were modeled on the

United Kingdom's statutes of 1861. Section 134 of the old Act dealt with procuring an abortion and section 135 dealt with a person aiding in an intended abortion (*Criminal Code Act 1924* (Tas) s 134 & s 135, as at 1 February 1997). Two additional clauses provided a statutory defence in cases of medical emergency, section 165 'Causing the death of child before birth', and section 51 'Surgical operations' (see Rankin 2001, 230). Rankin (2001, 230) has argued that the Tasmanian legislation in place prior to 2001 was "somewhat of a mystery as there have been no decided cases on the relevant legislation". What this means is that unlike Victoria, there had not been an abortion case tested in the criminal courts and so the application of section 165 and section 51 for a defence to a charge of abortion was uncertain.

An amendment was passed to the *Criminal Code Act 1924* (Tas) in December 2001 that made abortion law in Tasmania somewhat clearer. The 2001 amendment inserted a clause in the *Criminal Code Act 1924* (Tas) at section 164, providing for the medical termination of pregnancy (*Criminal Code Act 1924* (Tas) s 164, amended by no123 of 2001). The section provided that no person would be guilty of a crime if the procedure were legally justified and performed by a registered medical practitioner (*Criminal Code Act 1924* (Tas) s 164(1)(6), 2001-2014). The guidelines for determining a legally justified termination required that "two registered medical practitioners have certified, in writing, that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and…the woman has given informed consent unless it is impracticable for her to do so" (*Criminal Code Act 1924* (Tas) s 164(2a)(2b), 2001-2014). Informed consent was considered to be given by a woman where a medical practitioner has provided counselling as to the medical risk of terminating a pregnancy or carrying it to term, and referred the woman to counselling about other matters relating to the termination of pregnancy and carrying a pregnancy to term (*Criminal Code Act 1924* (Tas) s 164(9), 2001-2014).

The Act also required that at least one practitioner had to be a specialist in obstetrics or gynaecology and that "In assessing the risk referred to in subsection (2), the registered medical practitioners may take account of any matter which

they consider to be relevant" (*Criminal Code Act 1924* (Tas) s 164(5)(3), 2001-2014). The amended law meant that medical practitioners could legally consider any issue or factor within a woman's life to be relevant for determining a risk to her physical or mental health in order to establish sufficient grounds for an abortion. Therefore, there were no legally defined criteria that a doctor had to apply in order to establish the sufficiency of a woman's rationale for seeking an abortion; the assessment as to the appropriateness of the abortion was a balance of risk. The consequence of such a framework was that women were unable to make their own decisions whether or not to terminate a pregnancy (White in Tasmanian Hansard Part 2, 16 April 2013, 51), and that the responsibility for deciding rested with two medical practitioners. So whilst the framework provided scope for a broad range of factors to be considered as grounds for an abortion, the assessment of these factors was the responsibility of individual medical practitioners, ensuring that doctors retained their gatekeeping role in the legislation.

In an attempt to recognise the rights of women to exercise decisions regarding abortion and their reproductive health, the Tasmanian Parliament passed legislative changes in 2013 which removed abortion from the *Criminal Code Act 1924* (Tas) and added offences for anyone other than a medical practitioner or a pregnant woman herself to perform an abortion (see *Criminal Code Act 1924* (Tas) s 178D). The *Reproductive Health (Access to Terminations) Act 2013* (Tas) now governs abortion in Tasmania. The Act provides that a medical practitioner can terminate a pregnancy for a woman who is not more than 16 weeks pregnant with the woman's consent (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4). After 16 weeks, a medical practitioner can terminate the pregnancy provided the medical practitioner:

> (a) reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and
>
> (b) has consulted with another medical practitioner who reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.
>
> (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5)

The medical practitioner is required to comply with two caveats: "In assessing the risk… the medical practitioners must have regard to the woman's physical, psychological, economic and social circumstances" and "at least one of the medical practitioners… is to be a medical practitioner who specialises in obstetrics or gynaecology" (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(2)(3)). This legislation provides women with the capacity to access abortions free from scrutiny in the first part of their pregnancy, and retains the authority of the medical profession to shape the legitimacy of abortion procedures in the later stages of a pregnancy. Therefore there is no requirement in Tasmania for a doctor to establish if certain criteria have been met to justify a termination of pregnancy, suggesting that the role of the doctor is not to regulate women's abortion choices, but to facilitate safe access to the procedure.

Similar to Victoria, the legislation also includes a conscientious objection clause and an 'obligation to refer' clause where an individual holds a conscientious objection. Section 6 of the *Reproductive Health (Access to Terminations) Act 2013* (Tas) provides that no person has a duty to participate in an abortion if they have a conscientious objection to the termination of a pregnancy (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6). Section 7 requires: "If a woman seeks a termination or advice regarding the full range of pregnancy options from a medical practitioner and the practitioner has a conscientious objection to terminations, the practitioner must, on becoming aware that the woman is seeking a termination or advice regarding the full range of pregnancy options, provide the woman with a list of prescribed health services from which the woman may seek advice, information or counselling on the full range of pregnancy options" (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7). The legal inclusion of a right to object and the obligation on medical professionals should they object, attempts to strike a balance between the rights of women and the rights of individual medical practitioners, like the law in Victoria. The importance of this for understanding the gatekeeping role for doctors is that it demonstrates how the law can both provide power to doctors and seek to limit the use of that power. It shows that the performance of a doctor's role is limited to the medical domain and that a doctor's morality should not unduly impact a woman seeking an abortion.

Abortion law in Tasmania legalises the role of medical practitioners in providing abortion services, but like Victoria it seeks to limit the impact of an individual medical practitioner's values and beliefs on women seeking terminations of pregnancy. There is no legal requirement for a woman to provide reasons for an abortion prior to 16 weeks gestation, and no specific criteria stipulated in law for assessing an abortion after 16 weeks gestation. The law thus protects the role of the medical profession as the legitimate providers of abortion services and protects the rights of individual doctors to practice medicine in accordance with their values and beliefs, but limits the impact of this on women seeking abortions, giving women a legislated right to access abortion services based on their own reasons alone. In this context the role for doctors pertains to the authoritative role of the medical profession as the legitimate providers of abortion services, but the law limits the impact of an individual practitioner's morality on women seeking abortions. To understand the role of gatekeeping, the law in Tasmania shows us that the role of the doctor is not 'regulatory' in so far as regulating women's abortion choices, but rather that it governs how and when an abortion can be performed. This means that the law applies regulation to the role of the doctor, suggesting that the legal position of doctors described as gatekeeping is actually applying a form of regulation to doctors and not women.

Discussion on decriminalised legislatures

In the decriminalised jurisdictions discussed here abortion is: predominantly governed by health law; there is no legal requirement for reasons to be established for an abortion at any time in the pregnancy for the Australian Capital Territory, until 24 weeks in a pregnancy in Victoria, and 16 weeks in Tasmania; and the role of the doctor extends to the performance of the medical procedure of abortion unless they hold a conscientious objection. In the Australian Capital Territory, the right to conscientiously object is absolute, but in Tasmania and Victoria it is conditional (see Rankin 2011, 43). The role of the doctor in each of these jurisdictions thus pertains to the performance of the medical procedure that terminates a pregnancy, recognising the role of women in choosing abortion which was a role that women did not have under the initial criminal statutes adapted from the United Kingdom. This suggests that the law operates to provide for

medically safe abortion procedures and respects that doctors will have personal views concerning abortion, but it seeks to limit the impact of these views on women.

It is possible to now consider how a characterisation of gatekeeping applies to medical practitioners and their counterparts in the decriminalised jurisdictions. In the earlier stages of a pregnancy there is no legal requirement for a gatekeeping role, specifically no legal requirement for any reasons to be established by a medical professional to justify the abortion procedure. In the Australian Capital Territory there is no legal requirement for a gatekeeping role at any stage of gestation. As gestation progresses in Victoria and Tasmania, the legal requirement for doctors to establish reasons for an abortion places them in the position of having to legally regulate abortion procedures, and hence positions them in a obvious gatekeeping role. The gatekeeping role of the medical profession in this context limits the regulatory function required of a medical practitioner in the earlier stages of a pregnancy, and increases it in significance as a fetus ages. The law in the decriminalised jurisdictions thus establishes conditions for the performance of abortions, but these conditions apply to doctors rather than specifying legal regulation of women's abortion choices.

However, while the law in the decriminalised jurisdictions does not overtly require that women's abortion decisions be assessed by a doctor according to a defined set of criteria, its position in health law means that it is treated as a medical procedure like any other, "over which the medical profession has a state sanctioned monopoly" (Rankin 2011, 37). Indeed considering Foucault's argument outlined in Chapter 2 regarding the evolution of bio-power (see Foucault 2008, 141-147 discussed), the position of abortion in medicine means that the act of terminating a pregnancy warrants scrutiny by the medical profession because of the role of medicine as a *technique* of power (see Foucault 2008, 141). In other words while the law does not mandate any form of regulation of women's abortion decisions, the mere fact that abortion is considered a medical issue means that it is regulated through the apparatus of medical practice.

However, what the decriminalised jurisdictions also show is that while the operation of bio-power brings women under some type of regulatory scrutiny, it equally brings the conduct of medical professionals under scrutiny. This is because many of the conditions, such as providing advice and undertaking the procedure in an approved facility, pertain to the conduct of the medical profession, as well as there being an obligation on doctors should they conscientiously object to an abortion procedure in Tasmania and Victoria. The legal role for medical professionals in the decriminalised jurisdictions thus operates to regulate the conduct of medical practitioners in the performance of abortions. What this shows is that the gatekeepers are actually being regulated; they are not necessarily as powerful as the gatekeeping thesis suggests.

What this offers us is a way of depending our appreciation of Foucault's observations concerning the translation of law into the apparatus of medicine. Foucault (2008, 144) argued: "I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory". This suggests that the social actors who occupy regulatory positions within these apparatuses are thus performing a regulatory function that is normalised in everyday social discourse. However, what the legal frameworks in the decriminalised jurisdictions show is that the translation of the law into action applies regulatory conditions to both doctors and women, and hence it is the translation of law into the medical apparatus that sees power in action to shape the conduct of doctors as well as define the role of doctors in their engagements with women. In other words the operation of the law as a norm establishes a regulatory function for medicine, which both applies regulation to doctors just as it does do individuals accessing medical services.

5.2 Criminal jurisdictions: New South Wales and Queensland

Unlike the decriminalised jurisdictions, abortion is a criminal act in New South Wales and Queensland. In the criminal jurisdictions there is a common law defence that provides for the lawful terminations of pregnancy by medical practitioners,

but any woman who undergoes an abortion procedure unlawfully is guilty of a criminal offence (see de Costa et al 2015). What this means is that the legality of each abortion is questionable, as the lawfulness of an abortion would need to be ascertained by a court (see *R v Wald* (1971) 3 DCR (NSW) 25, 29, de Costa et al 2015, 107-108, Rankin 2011, 15, and also Douglas 2009). In this section I will show that the stark contrast between the law in the decriminalised and criminal jurisdictions signals a different application for a characterisation of gatekeeping, but it nonetheless reveals a similarity in how medicine is relied upon to ensure that regulatory interventions take place.

New South Wales

In New South Wales, abortion is governed by criminal law. It is contained in the New South Wales *Crimes Act 1900,* which is similar to the United Kingdom's statutes of 1861 (see *Offences Against the Person Act 1861* (UK), 24 & 25 Vict, c 100, ss 58 - 59 as enacted, and *Crimes Act 1900* (NSW) s 82-84; see also Rankin 2011, 12 and Cannold 2011, Online). The *Crimes Act 1900* (NSW) has three relevant sections pertaining to abortion, section 82 'Administering drugs etc to herself by woman with child', section 83 'Administering drugs etc to woman with intent', and section 84 'Procuring drugs etc' (*Crimes Act 1900* (NSW) s 82-84). The term of imprisonment for the offences is ten years, ten years and five years respectively (*Crimes Act 1900* (NSW) s 82-84).

The legislation includes the phrase 'unlawfully', and provides a common law defence for a medical practitioner based on a particular interpretation of the word, similar to the common law ruling established in *R v Davidson* (1969). The New South Wales District Court case of *R v Wald* (1971) presided over by Judge Levine, held that abortion can be lawfully performed by a medical practitioner provided certain reasons are established (see *R v Wald* (1971) 3 DCR (NSW) 25, Cica 1998, de Costa et al 2015, 107, Douglas, 2009, 77, and Rankin 2001, 234). The accused in this case operated an abortion clinic and were charged under section 83 of the *Crimes Act 1900* (NSW). Similar to the judgement made by Justice Menhennitt in Victoria in 1969 (*R v Davidson*), Judge Levine considered that the word 'unlawfully' contained in section 83 suggested that not every abortion would constitute an offence (*R v Wald* (1971) 3 DCR (NSW) 25, 28). Judge Levine applied the same test

of lawfulness used in the Victorian case of *R v Davidson* (1969), adding that the principle established in *R v Davidson* provides sufficient criteria where the operation was performed by qualified medical practitioners (*R v Wald* (1971) 3 DCR (NSW) 25, 29). This determination was logically consistent because the description of necessity requires that the act be on a person to whom the accused had a duty to protect, which in the case of the medical profession would be the patient. However, whilst the Levine ruling established grounds for lawful terminations, it positioned the medical profession as being the lawful providers of abortion. Women were thus permitted to seek abortions, but abortion choices had to be scrutinised by the medical establishment.

Judge Levine also added his own interpretation of what might constitute a 'serious danger' to a woman's physical and mental health:

> In my view it would be for the jury to decide whether there existed in the case of each woman any economic, social or medical ground or reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health. It may be that an honest belief be held that the woman's mental health was in serious danger as at the very time when she was interviewed by a doctor, or that her mental health, although not then in serious danger, could reasonably be expected to be seriously endangered at some time during her pregnancy, if uninterrupted.
>
> (*R v Wald* (1971) 3 DCR (NSW) 25, 29)

Judge Levine's decision expanded the interpretation of 'lawful' to include economic and social grounds as being relevant to an understanding of that which may present a danger to a woman's health. The ruling therefore expanded what a doctor could reasonably consider in establishing reasons for a defence for abortion. On the one hand, this provided women with greater latitude to seek an abortion from a medical practitioner on lawful grounds; but on the other hand, it exposed a woman requesting an abortion to scrutiny by a medical practitioner across a range of factors that may not have direct clinical significance. The doctor is thus legally permitted to assess a woman according to a broad range of criteria that they perceive to be pertinent, rather than the law stipulating what criteria is to be applied. This implied that individual medical practitioners occupy a gatekeeping role, as the authority for establishing what might constitute a lawful abortion procedure is the responsibility of a doctor; the choices of women are

insufficient. However, what this judgement also reveals is that the gatekeeping role exposes doctors to legal regulation, because their decisions can be scrutinised by a court. The gatekeeping role is thus regulating doctors and positioning doctors in a regulatory role over women.

Rankin (2001, 235; see also 2011, 16) has argued that the Levine judgement gave doctors greater authority than it provided rights for individual women because whilst Levine's ruling liberalised the interpretation of NSW abortion statutes, it did not confer any new rights upon women with regard to abortion. This is largely because whilst Judge Levine's ruling expanded the range of issues that could be considered in establishing a defence for abortion, he ruled against the request made by the defendant's counsel that it be deemed lawful "for a qualified medical practitioner to terminate a pregnancy upon the request of the pregnant woman without cause" (*R v Wald* (1971) 3 DCR (NSW) 28-29; see also Rankin 2001, 235). The determination of what might constitute a lawful abortion thus remained with a medical practitioner. Individual women were not able to lawfully define their rationale for choosing an abortion; the reasons had to be within the boundaries of what was acceptable to a doctor.

If we consider the arguments put forward in Chapter 2 concerning the moral and political dimensions of abortion (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000), then the role of the medical practitioner in this context is problematic. An assessment of an abortion request across a broad range of factors provides scope for a medical practitioner to consider anything that they determine to be relevant. This could include consideration of the moral and political dimensions of abortion because, as we know from Chapter 2, for many women the choice to undergo an abortion procedure is a complex evaluation of their capacity to sustain a new life, which can also be based on their views as to the future success of their role as a mother (see McNeil 1991, 156 in Sheldon 1997, 113, Cannold 2000, Luker 1984, and Baird 1990; see also O'Byrne in Tasmanian Hansard Part 2, 16 April 2013, 39). In this context a woman's choice regarding their capacity to become a mother now and into the future comes under the scrutiny of medical practitioners. Doctors are thus given the authority to regulate a complex moral issue within the domain of medicine, and this means that

regulatory interventions could include actions being taken by a doctor based on their own individual values and beliefs regarding abortion, not necessarily their clinical views. For instance, they might have particular views regarding a woman's relationship status and living situation, specifically whether she was married, single or in a long term relationship prior to conceiving a child, which might impact how they perceive an abortion request. Further, noting that there is no legislation in New South Wales regarding conscientious objection, then there is no legal framework for managing how values and beliefs can enter into the clinical encounter, and thus no concerted effort by the legislature to seek to minimise the impact of a doctor's conscience on the abortion choices that women make.

A further case which affected abortion law in NSW was the case of *CES v Superclinics (Australia) Pty Ltd* (1995) (38 NSWLR 47). This case underscored the vagueness of the legal basis for determining the lawfulness of an abortion procedure and the subjective nature of abortion decisions. *CES v Superclinics* involved a civil claim by the plaintiff that "After repeated failure by a number of medical practitioners properly to diagnose a woman's pregnancy, she claimed damages from them for loss of the opportunity to terminate that pregnancy" (*CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47; see also Drabsch 2005, 21). The case thus dealt with a hypothetical abortion, and considered the woman's health at the point in time of a pregnancy when an abortion may have been considered. The presiding Judge, Justice Newman, ruled against the plaintiff, concluding that the plaintiff's pregnancy did not involve a serious danger to her physical or mental health; hence any proposed termination would have been unlawful (*CES v Superclinics (Aust) PTY Ltd* (1995) 38 NSWLR 47, 54). The case was appealed and heard in the NSW Court of Appeal. The NSW Court of Appeal upheld the appeal and used *R v Wald* (1971) to suggest that "had the plaintiff been informed earlier than she was that she was pregnant, and then had that pregnancy aborted by a medical practitioner, that abortion would not *necessarily* have been unlawful" (*CES v Superclinics (Aust) PTY Ltd* (1995) 38 NSWLR 47, 80).

In the Appeals court, Acting Chief Justice Kirby argued that neither *R v Wald* nor *R v Davidson* provided a "list of criteria to which a decision-maker may refer in assessing the level of risk which a medical practitioner may reasonably take into

account in considering the danger to the mother's health", stating that the application of the test for lawfulness "is itself open to subjective interpretation" (*CES v Superclinics (Aust)* PTY Ltd (1995) 38 NSWLR 47, 63). *CES v Superclinics (Australia) Pty Ltd* (1995) reinforced that the determination of lawfulness for an abortion is a complex legal issue, but it did not challenge the role of medical practitioners in shaping the reasons for a defence of lawfulness. While the case did specifically acknowledge the subjective nature of a doctor's decision-making process, it did not seek to challenge the determining role of the doctor. The findings recognised that whilst a gatekeeping role for doctors is vague and problematic, it remains appropriate for regulating access to abortion procedures.

Abortion law in New South Wales positions medical practitioners as the authority for establishing sufficient grounds for the performance of an abortion, but it also highlights how the decisions that doctors make can be scrutinised by a court of law. Doctors are able to utilise a broad range of criteria to assess a woman's request, but this needs to be on the basis that those factors constitute a 'serious danger' to a woman's health. An assessment of an abortion request is thus subject to the decision-making process of a doctor, and how the court might perceive the validity of this assessment to determine whether or not the procedure was lawful. What this means is that the position of medical practitioners is more clearly a gatekeeping role than in the decriminalised jurisdictions. In NSW, the law requires individual doctors to perform a regulatory function over abortion, but does not seek to clearly specify how that function is performed. This contrasts to the Australian Capital Territory, Victoria, and Tasmania, where the law provides greater guidance as to the limits of a gatekeeping role, recognising the role of the woman in choosing an abortion procedure.

Queensland

The law in Queensland provides a similar position for doctors to that of New South Wales, with the contemporary legal environment in Queensland reinforcing how the lawfulness of abortion is contested between the Courts and the medical establishment. Current legislation governing abortion in Queensland is contained in Schedule 1 of the *Criminal Code Act 1899* (Qld). Douglas (2009,74) has noted that Queensland's abortion laws are the oldest in the country. Queensland also

charged a person with procuring a miscarriage in 2009, with the accused, Tegan Leach and Sergie Brennan, standing trial in 2010 (*R v Leach and Brennan* (2010) Everson J (Qld District Court)).

Abortion law in Queensland is largely similar to that of the United Kingdom *Offences Against the Person Act 1861*. The relevant provisions are section 224 'Attempts to procure abortion', section 225 'The like by women with child', and section 226 'Supplying drugs or instruments to procure abortion' (*Criminal Code Act 1899* (Qld), ss 224-226). The penalties are imprisonment for fourteen, seven and three years respectively (*Criminal Code Act 1899* (Qld), ss 224-226). Queensland legislation uses the term 'unlawfully', which gives rise to the possibility of lawful abortions similar to the determinations made in the United Kingdom in *R v Bourne* (1938), in Victoria in *R v Davidson* (1969), and in New South Wales in *R v Wald* (1971). What might constitute a lawful abortion relates to the role of the medical profession in establishing sufficient reasons for the termination of a pregnancy, which is largely covered by a common law ruling and the application of section 282 of the *Criminal Code Act 1899* (Qld) (see Douglas 2009, 76-77, and Rankin 2001, 236). The law is thus similar to that of New South Wales, but contrasts significantly to the Australian Capital Territory, Victoria and Tasmania, all of which recognise a role for women in choosing abortions.

In Queensland, the case of *R v Bayliss and Cullen* (1986) established a common law ruling for the lawfulness of abortions (Cica 1998 and Rankin 2001, 236). The accused were medical practitioners who were operating the Greenslopes Fertility Control Clinic, and their defence relied on section 282 of the *Criminal Code Act 1899* (Qld) 'Surgical operations and medical treatment' (*R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8, 9). Section 282 states:

> (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of
>
> > (a) a person or an unborn child for the patient's benefit; or
> >
> > (b) a person or an unborn child to preserve the mother's life; if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

> (2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.
>
> (*Criminal Code Act 1899* (Qld), s 282)

This section of the *Criminal Code Act 1899* (Qld) provides that a professional is able to surgically operate or provide certain substances for an abortion in situations where there is a risk of harm to a pregnant woman. Dixon (2003, 13) has argued that whilst this section was intended "to protect doctors in situations where a patient is unconscious or otherwise unable to give consent to an operation", the inclusion of the phrase 'upon an unborn child for the preservation of the mother's life' provides a defence for abortion charges under section 224. This is because it recognises that medical treatment can be provided for women where a pregnancy is presenting a risk to their health.

The inclusion of section 282 accords power to the medical profession to make determinations of appropriate care for women according to their assessment of a patient's state. Phrases such as 'in good faith', 'for the patient's benefit', and 'the medical treatment is reasonable', all position the medical practitioner as the authority for exercising decision-making rights over abortion procedures. Also, there is nothing in the legislation to suggest that certain actions or characteristics of women should justify the lawfulness of an abortion. The negation of criminal responsibility would be a consequence of the court's assessment of a doctor's medical judgement.

The inclusion of section 282 positioned the medical profession as a gatekeeper under criminal law, and ensured that abortion became a medical issue. In this context, the performance of an abortion by a medical professional could be defensible, but a woman accessing or performing the procedure would not. This was shown in *R v Bayliss and Cullen* (1986), where Judge McGuire determined that the application of section 282 for abortions would effectively repeat the same test for lawfulness as that provided in *R v Davidson* (McGuire J (1986) 9 Qld Lawyer Reps 8, 45), but he also made it clear that there existed no right for women to access abortions:

> The law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on a whim or caprice does not insidiously filter into our society. There is no legal justification for abortion on demand.
>
> (McGuire J (1986) 9 Qld Lawyer Reps 8, 45; also in Rankin 2001, 236)

A defence for abortion is thus considered to be one that a medical professional must establish, and a woman cannot lawfully choose an abortion or determine that her circumstances warrant a lawful procedure. The language used by Judge McGuire, 'on a whim' and caprice', suggests that doctors must control women's judgements in seeking to terminate their pregnancies. The consequence of this is that the law ensures that a party (i.e. a medical practitioner) adjudicates the abortion decision independent of the woman, recognising an obligation of the State to protect the unborn, as suggested by Judge McGuire. The law in Queensland thus posits that the judgement of the doctor is the proper mechanism for managing abortion decisions, while a woman's choice of abortion is not justified at law.

In 2009, the legality of a woman choosing abortion in Queensland was tested, and the case resulted in the addition of subsection 2 of section 282, specifically that pharmaceutical products could be used in an abortion provided they were prescribed by a doctor. In 2009 a Cairns couple, 19-year old Tegan Leach and 21-year old Sergie Brennan, were charged for abortion-related crimes (see Betts 2009, 25, Cannold 2011, Online, and *R v Leach and Brennan* (2010) Everson J (QLD District Court)). During a police search of the couple's home in Mt Sheridan, Cairns, police found empty packets of RU486, Misoprostol (a drug commonly used with RU486 (mifepristone) to induce a miscarriage) and painkillers (Betts 2009, 25). The search was part of a series of routine police calls to more than 200 dwellings to interview possible witnesses and informants in a murder investigation (Betts 2009, 25). Ms Leach told the police that she had used the drugs to bring about the miscarriage of a sixty-day-old fetus in December of 2008 (Betts 2009, 25). Ms Leach was subsequently charged with procuring her own miscarriage and her partner Mr Brennan was charged with supplying drugs to procure an abortion (Betts 2009, 25). Betts (2009, 25) noted that Leach was believed to be the first woman to be charged with procuring her own abortion in nearly fifty years. The couple was committed to stand trial on 11 September 2009.

The couple was eventually acquitted of the charges as a consequence of an interpretation of the word 'noxious' in the criminal statutes pertaining to the procurement of an abortion. The verdict was founded on a conclusion that neither of the legal and widely used drugs used in the commission of the alleged crime were 'noxious' to the woman, and consequently the abortion was not unlawful (Cannold 2011, Online). Leach was acquitted of the charge because of a medical judgement as to the appropriate use of the drugs (see de Costa 2005 for a discussion of the use of the drugs for abortion), not because she had established that she wanted to terminate a pregnancy on her own terms. The case reinforced the legal interpretation that a woman could not lawfully procure an abortion in Queensland for reasons of her own choosing. Establishing justifiable reasons for a defence for abortion remained the responsibility of a medical practitioner. What this case revealed was that the law establishes a regulatory function for doctors to provide abortion services, it does not accord rights to women to access abortion services of their own volition.

The use of drugs to procure a miscarriage in this case also brought the issue of medical abortion to the forefront of Queensland political debate, provoking a sense of urgency for reform of the law (Betts 2009, 27). The case exposed the potential illegality of medical abortion (that being the use of drugs to terminate a pregnancy as oppose to a surgical procedure), resulting in many private practitioners ceasing to offer medical abortions, referring their patients to hospitals across the border in New South Wales (Betts 2009, 27). To remedy the apparent neglect of section 282 to recognise the role of pharmaceuticals, an amendment to section 282 was passed in 2009 giving doctors the same protection for medical abortions as for surgical ones (Betts 2009, 27). However, this change made no difference to the role of doctors in establishing justifiable reasons for an abortion. It merely ensured that where reasons were lawful, the performance of abortion could be either surgical or medical.

Abortion law in Queensland positions abortion as a matter for medical practitioners to consider, but the legitimacy of their considerations is subject to the scrutiny of the criminal courts. Douglas (2009, 78) has argued that this "position means that doctors in Queensland operate as gatekeepers to lawful

abortion and could in certain circumstances deny a woman's request". The absence of conscientious objection legislation in Queensland strengthens this observation because there is no limitation on the impact of a doctor on women seeking abortion services as is the case in Victoria and Tasmania. The law in Queensland thus affirms that the gatekeeping role for doctors is shaped according to the decision-making capacity of a doctor, and that they must take into consideration a woman's social, economic, psychological and physical circumstance. Women's abortion choices are thus subject to scrutiny by an individual doctor.

Discussion of criminal jurisdictions

The law in New South Wales and Queensland permits women to seek abortions from medical practitioners, but the decision to proceed belongs with a medical professional. As Family Planning NSW state: "Women are not entitled to abortion on demand" (Family Planning NSW 2012, Online). The common law rulings in the criminal jurisdictions have expanded the definition of lawfulness for abortion to accommodate women in accessing abortions through establishing broad criteria that can be used by a doctor to establish a rationale for an abortion, but the nature of lawfulness more broadly is not legally defined, unlike the Australian Capital Territory, Victoria, and Tasmania. A characterisation of gatekeeping thus applies to doctors in these criminal jurisdictions, but the specific legality of their role as it pertains to individual abortion cases is subject to consideration within a criminal court. As Justice Priestly stated in *CES v Superclinics:*

> it cannot be said of any abortion that has taken place and in respect of which there has been no relevant court ruling, that it was either lawful or unlawful in any general sense. All that can be said is that the person procuring the miscarriage *may* have done so unlawfully.
>
> (*CES v Superclinics (Aust) PTY Ltd* (1995) 38 NSWLR 47, 83; see also Rankin 2011, 15)

The role of gatekeeping for individual doctors thus requires an evaluation of an abortion request on legally uncertain grounds. In other words, it requires that medical practitioners make assessments of women to justify a legal defence for a charge of abortion, protecting the actions that doctors make, not the actions of women. However, the law in the criminal jurisdictions does not necessitate that the role performed by doctors inhibit a woman accessing an abortion, simply that they have to shape the rationale for a defence rather than relying on the woman's reasons alone. There are therefore grounds to argue that the power held by the

medical profession in this context can enable women's access, rather than impede their access to abortion procedures.

An example of the role of doctors as enablers of women's access can be found in the guidelines for medical practitioners on therapeutic termination of pregnancy. In 2013, the Queensland Government Department of Health published a guide for medical professionals on the Therapeutic Termination of Pregnancy (see Queensland Government 2013). The 31-page document is publicly available on the Queensland Health website and seeks to "assist health professionals to provide care to women requesting therapeutic termination of pregnancy" (Queensland Government 2013, Online). The document provides an overview of the legislation in Queensland and the applicability of rulings in New South Wales (*R v Wald* (1971)) and Victoria (*R v Davidson* (1969)) as to the lawfulness of an abortion if performed by a doctor. However, the document does not provide specific criteria that doctors use to determine lawfulness, stating:

> The decision to provide a termination of pregnancy is made in partnership with the woman (and her family where appropriate) and her health care professional. It is led by the woman's health needs and concerns.
>
> (Queensland Government 2013, 10)

The statement made here shows that whilst the decision to terminate a pregnancy is lawfully considered in the context of the exchange between a woman and her doctor, the decision should be 'led' by a woman's health needs and concerns. So while the law gives authority to doctors to establish reasons for an abortion, and hence requires a degree of regulation, in establishing those reasons doctors are encouraged to utilise the needs and concerns of women. This suggests that the abortion exchange between a woman and her doctor should not mandate the enforcement of a regulatory function over women seeking a termination of pregnancy, but rather that this regulatory function be negotiated between a woman and a doctor. In this way, the law acknowledges that women can undergo abortion procedures lawfully and provides an element of protection for the judgements made by doctors in the abortion context. The execution of the gatekeeping role by a doctor should therefore be limited to a woman's health needs and concerns.

Freidson's work on the application of knowledge in the medical domain provides a useful analysis for understanding the reliance of the law on the judgement of medical practitioners to shape regulation under such criminalised conditions. Freidson (1988, 341) argued that "medicine consists of a large and complex body of knowledge about the empirical chemical, physical, and other characteristics of those states chosen to be illnesses, as well as about empirical techniques by which those states may be arrested, cured, repaired, removed, or improved". Medicine has thus acquired occupational autonomy based on its claim over the work of medicine which is "guided by knowledge too esoteric and complex for the layman to even evaluate, let alone share, that the knowledge guiding its work is as systematic and reliable (scientific) as the age permits, and, finally, that the knowledge is schooled, stemming from a long period of training through which every practitioner goes" (Freidson 1988, 341). The reliance of the law on the medical judgement of a doctor to establish reasons for a defence of abortion recognises this professional and authoritative status of medicine, the consequence of which is a legitimate reliance on the capacity of doctors to regulate abortions appropriately. This argument thus supports the need for a scientific, authoritative, gatekeeper.

However, a reliance on the judgement of medical practitioners can be problematic when we consider the moral dimensions of abortion discussed in Chapter 2. Abortion is an issue that is often divisive, being one of moral and metaphysical significance (Dworkin 1994, 30; see also Wertheimer 1971). A person's position regarding abortion is shaped according to how they understand the moral significance of an embryo, as well as how they understand pregnancy and motherhood (see Luker 1984, 2, Cannold 2000, Dworkin 1994 and Hadley 1996). In the decriminalised jurisdictions there is specific acknowledgement of this moral significance of abortion in the form of a conscientious objection clause for doctors. In Tasmania and Victoria there is a corresponding obligation on doctors to refer their patients where they have a conscientious objection. There are no such clauses in the criminal jurisdictions and as such the impact of a person's views could extend beyond a conscientious objection.

So whilst the law in the criminal jurisdictions can enable women to access abortion by giving doctors a role in establishing reasons for a defence of abortion, it offers no protection for women in accessing abortion. A woman's request is subject to the views and beliefs of doctors, and depending on how they perceive an abortion request, a woman may be subjected to more or less scrutiny. This firmly positions doctors as individual gatekeepers for the regulation of abortion. The nature of the law in the criminal jurisdictions thus protects the role of the doctor, more so than a woman seeking an abortion. What the contrast in legal frameworks between the decriminalised jurisdictions and the criminal jurisdictions suggest is that doctors practicing in different jurisdictions need to have different skills to deal with abortion decisions, but what are these skills, and how do doctors learn them? These questions will be explored in Chapter 6.

5.3 Hybrid jurisdictions: South Australia, the Northern Territory and Western Australia

Similar to the criminal jurisdictions, abortion remains a crime in South Australia and Western Australia, but there are statutory provisions that provide for the lawful performance of terminations by medical practitioners, therefore providing a basis for lawful abortions if performed by a doctor (see de Costa et al 2015, 107-108 and also Heath & Mulligan 2016). This was also the case for the Northern Territory until legislative changes were passed in 2017, aligning this jurisdiction with elements of the decriminalised jurisdictions, but also retaining some elements of the gatekeeping role as it is described for the hybrid jurisdictions described in this section. In these states, some of the provisions for an abortion are retained in criminal law, whilst others are stipulated under health law, creating a group of hybrid jurisdictions. In these hybrid jurisdictions there is a close relationship between criminal law and health law, acknowledging the medicalised nature of abortion but retaining a supposed seriousness of the act as a criminal offence (see Heath & Mulligan 2016). As this section shows, by retaining the governance of abortion in criminal law, there is recognition that abortion is not like other medical procedures but that the medical profession is the most appropriate body to determine access to its use. This has implications for the gatekeeping role of doctors, as I will explain in the discussion.

South Australia

South Australia was the first jurisdiction in Australia to introduce legislative change for abortion, with the introduction of section 82A of the *Criminal Law Consolidation Act 1935* (SA) in 1969 and the *Abortion Regulations 1970.* The introduction of the legislative changes occurred prior to the Menhennitt ruling in Victoria of 1969 and, as was described in Chapter 4, the legislative debate that gave rise to these changes reflected a desire by the legislature to have the law reflect clinical practice and protect women's health (see also Heath & Mulligan 2016, 42), therefore accepting that there was a role for the medical profession in the provision of abortion services despite it not being legally legitimate.

Section 82A of the *Criminal Law Consolidation Act 1935* (SA) provided for the medical termination of pregnancy and the wording is similar to the United Kingdom's *Abortion Act 1967* (see Rankin 2001, 243, Pringle 2006, 208, and Chapter 4 for discussion of the United Kingdom legislation). The regulations were made under the *Criminal Law Consolidation Act 1935* (SA) and stipulated a range of conditions to be met by a medical professional in terminating a pregnancy. Legislating the requirements to be met in providing abortions meant that a gatekeeping role for doctors was enshrined in legislation, with the lawfulness of an abortion being applicable to the actions taken by medical professionals rather than individual women. The *Abortion Regulations 1970* (SA) were revoked on 1 September 1996 by the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 1996* (SA). The 1996 regulations have since been revoked by the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA).

The 1970 regulations contained provisions which required two medical practitioners to consent to the abortion, provisions for the notification of a termination to the Director-General of Medical Services within fourteen days of the procedure, as well as a requirement for the manager of a hospital to report within twenty days of a procedure to terminate a pregnancy to the Director-General of Medical Services (*Abortion Regulations 1970* (SA)). The *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) contain similar

provisions for notification of the termination of pregnancies and list the prescribed hospitals at which an abortion can take place.

Sections 81, 82 and 82A of the *Criminal Law Consolidation Act 1935* (SA) provide the current legal basis for lawful abortions in South Australia, with the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) providing guidance for abortion procedures. Section 81 subsection 1 retains the criminality of a woman procuring her own abortion, making her liable for life imprisonment (*Criminal Law Consolidation Act 1935* (SA) s 81(1)). Section 82A provides for the medical termination of pregnancy, noting that no person is guilty of an offence under sections 81 and 82 if:

> the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman—
>
> (i) that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or
>
> (ii) that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.
>
> (*Criminal Law Consolidation Act 1935* (SA) s 82A(1))

In making a determination, a medical practitioner can take into account a pregnant woman's actual or reasonably foreseeable environment (*Criminal Law Consolidation Act 1935* (SA) s 82A(3)). Section 82A also includes a section that negates the lawfulness of an abortion procedure for a "woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy", and the abortion is only permissible up to 28 weeks gestation (*Criminal Law Consolidation Act 1935* (SA) s 82A(2)(7)(8)). The law in South Australia also includes a conscientious objection clause allowing any person, this would include doctors and other healthcare providers, to object to participation in any treatment relating to abortion provided that this does not directly endanger the life of the woman (*Criminal Law Consolidation Act 1935* (SA) s 82A (5)(8)).

The legal situation in South Australia thus requires that medical practitioners perform a gatekeeping role, and in doing so they have the capacity to consider

anything within a woman's life as being significant for the lawfulness of an abortion. The law requires that medical practitioners make an assessment of a woman's circumstance, assessing the legitimacy of her request for an abortion based on the impact that a pregnancy will have on her life. This requires that pregnancy be viewed as a health impact for women rather than relying on a woman's own decisions regarding pregnancy, as the reasons for performing an abortion need to be established on grounds that demonstrate that the continuation of a pregnancy would be a greater danger to a woman's health than would terminating the pregnancy.

Abortion law in South Australia thus provides for two spheres of regulation: the regulation of women's abortion choices through the apparatus of medicine and the regulation of medical practitioners by the law. The regulatory conditions stipulated at law pertain to the actions of medical professionals in the abortion context, as any action taken by a woman alone remains a criminal offence. Unlike the decriminalised jurisdictions, South Australia does not recognise the role of women in choosing abortion to the same extent, and the potential criminality of the act for women is similar to that of the criminal jurisdictions. The law also provides protection for doctors with a conscientious objection, placing no obligation on a doctor should they object to abortion on the grounds of conscience. The law thus provides authority to the medical profession to regulate abortion choices, but it also seeks to regulate the actions of the medical profession by requiring that certain measures be followed, such as stipulating where an abortion can occur. The gatekeeping role in this hybrid context operates for both the scrutiny and protection of doctors and the decisions they make, rather than being for the specific regulation of women's abortion decisions *per se*.

Northern Territory

In March 2017 the Northern Territory parliament passed the *Termination of Pregnancy Law Reform Bill 2017* (NT) which removed elements of abortion from the criminal code if performed by a qualified person, and modified the legal conditions for a termination of pregnancy. These changes came into affect in July of 2017, and so the following discussion refers to the legal status of abortion until

2016. The most recent legislative changes for the Northern Territory will be discussed in Chapter 8.

The Northern Territory's legal framework was similar to that of South Australia in that abortion was retained in the criminal code. However unlike South Australia, the Northern Territory enacted subsequent legislation in health law that allowed for lawful terminations of pregnancy. In 1974, section 174 was added to the criminal code allowing for the medical termination of pregnancy. Section 174 remained in the *Criminal Code Act* (NT) until 2006 when it was moved to the *Medical Services Act* (NT) (see explanatory statement for the *Medical Service Amendment Bill 2006* (NT)). At the time of my research, the *Criminal Code Act* (NT) and the *Medical Services Act* (NT) governed abortion in the Northern Territory and hence demonstrated a hybrid approach to abortion law. The legislative debate that gave rise to this legal framework focused on a need to ensure that the decisions of doctors were scrutinised and the rights of women to access abortion services were acknowledged.

Until the legislative change in 2006, section 174 of the *Criminal Code Act* (NT) provided the legal basis for the medical termination of pregnancy. Like South Australia, this type of law enshrined the role of the medical profession as an authority for regulating abortion requests. Section 174 provided lawfulness for a medical practitioner who was a gynaecologist or obstetrician to provide an abortion for a woman who is not more than 14 weeks pregnant, after consultation with another medical practitioner. Both practitioners had to be of the opinion "formed in good faith after medical examination of the woman or girl by them that (i) the continuance of the pregnancy would involve greater risk to her life or greater risk of injury to her physical or mental health than if the pregnancy were terminated; or (ii) there is a substantial risk that, if the pregnancy were not terminated and the child were to be born, the child would have or suffer from such physical or mental abnormalities as to be seriously handi-capped" (*Criminal Code Act (NT)* s 174, as at 11 January 1996). A medical practitioner could also perform an abortion on a woman who was not more than 23 weeks pregnant if the termination was deemed to be immediately necessary to prevent grave harm to a

woman's physical or mental health (*Criminal Code Act* (NT) s 174, as at 11 January 1996).

The requirement for an abortion to be decided by a medical specialist emphasised the legal authority of the medical profession to regulate abortion choices, as it determined a need for a medical speciality to undertake this task. This reinforced the medicalised nature of the procedure and established a need for specialised medical intervention to guarantee the appropriateness of the abortion request. No other jurisdiction in Australia stipulated the role of a medical speciality in assessing abortion requests.

In 2006, the requirement for an abortion to be performed by an obstetrician or gynaecologist was removed from the *Criminal Code Act* (NT), as was much of the content of section 174. The legislative debate examined in Chapter 4 revealed that this was a result of the desire by the then Attorney-General to simplify the legal provisions pertaining to abortion and amend the law to reflect current clinical practice. With the passing of the *Medical Services Amendment Bill 2006* (NT), the content of section 174 was moved to the *Medical Services Act* (NT), but abortion remained in the criminal code with a maximum penalty of 7 years imprisonment. Lawfulness was provided for in the *Criminal Code Act* (NT)*:* "Under section 11 of the *Medical Services Act*, in certain circumstances it is lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy" (*Criminal Code Act* (NT) s 208B-208C, as in force 14 October 2015). These broad circumstances are outlined below.

The *Medical Services Act* (NT) (as in force 1 July 2014) mirrored much of the content contained in section 174 of the *Criminal Code Act* (NT) before 2006. The timeframes of 14 weeks and 23 weeks remain, 14 weeks referring to a greater risk to her life and health than would the continuation of the pregnancy, and 23 weeks referring to an immediate need to prevent serious harm. The need for two medical practitioners remained, retaining an emphasis on medical specialty by requiring that at least one of the practitioners be an obstetrician or gynaecologist "unless it is not reasonably practicable in the circumstances to get a gynaecologist or obstetrician to examine the woman" (*Medical Services Act* (NT) s 11(2), as in force

1 July 2014). The Act also had a conscientious objection clause, but there was no obligation on a medical professional to refer a patient onto another doctor, as is the case in Tasmania and Victoria.

The law in the Northern Territory provided for lawful abortions, but it did not outline what constitutes a risk to a woman's physical and mental health. The determination of such was the responsibility of medical professionals. The legal framework for abortion in the Northern Territory thus required that doctors perform a gatekeeping role, but the law provided that the gatekeeping role was an issue for the medical profession to define. The hybrid nature of this legal framework was such that aspects of both the criminal jurisdictions (specifically the role of the doctor defining the rationale for an abortion), and aspects of the decriminalised jurisdictions (the inclusion of a conscientious objection clause and the suite of regulations concerning the actions of medical professionals) were evident. Regardless of the different aspects of the law though, the doctor's role was similar to that of the criminal jurisdictions and the law sought to regulate doctor's decisions by requiring a justification be made on specified grounds, rather than stipulating regulation for the abortion choices that women make.

Western Australia

Abortion law in Western Australia is similar to that of South Australia and the Northern Territory's law prior to 2017, retaining the criminal offence of abortion and establishing regulatory conditions for the medical termination of pregnancy in health law. Like the other hybrid jurisdictions, the lawfulness of an abortion pertains to the performance of the procedure by medical practitioners only, meaning that the law stipulates conditions for medical practitioners and provides grounds to protect the abortion decisions that doctors make.

Western Australia enacted legislative amendments in 1998 to allow for lawful abortions, reforming the criminal code and stipulating conditions for an abortion under health legislation. Prior to this, abortion was contained in the *Criminal Code Act Compilation Act 1913* (WA) in similar form to that of the United Kingdom *Offences Against the Person Act 1861*. Section 199 of the *Criminal Code Act Compilation Act 1913* (WA) now states: "It is unlawful to perform an abortion

unless —(a) the abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and (b) the performance of the abortion is justified under section 334 of the *Health (Miscellaneous Provisions) Act 1911*". The penalty in Western Australia is pecuniary to the value of $50,000, removing any liability of imprisonment for an unlawful abortion (*Criminal Code Act Compilation Act 1913* (WA), s 199).

The *Health (Miscellaneous Provisions) Act 1911* (WA) also contains a number of provisions that pertain to the lawful performance of abortions, placing the authority to perform an abortion with medical practitioners and governing their conduct in doing so. Section 334 of the *Health (Miscellaneous Provisions) Act 1911* (WA) states that the performance of an abortion is justified for the purposes of section 199 of the criminal code if "and only if - (a) the woman concerned has given informed consent; or (b) the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or (c) serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or (d) the pregnancy of the woman concerned is causing serious danger to her physical or mental health" (*Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3)). The law provides that these conditions apply only to those procedures performed prior to 20 weeks gestation. After 20 weeks gestation an abortion is only justified if "(a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgement of those 2 medical practitioners, justifies the procedure; and (b) the abortion is performed in a facility approved by the Minister for the purposes of this section" (*Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)).

This legal framework provides some clarity for constituting the lawfulness of an abortion, as the abortion can be performed before 20 weeks where informed consent has been given. No other reason needs to be established to justify an abortion prior to 20 weeks, but the legal definition of informed consent mandates counselling by a medical practitioner (Rankin 2011, 27-30). Informed consent, as

defined by the law in Western Australia, requires that a medical professional, other than the person providing the abortion:

> properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term; and ….offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and …informed her that appropriate and adequate counselling will be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.
>
> (*Health (Miscellaneous Provisions) Act 1911* (WA) s 334(5))

What is significant about this clause is that the requirement for counselling is an obligation on medical practitioners to provide information about the medical risk of termination or carrying a pregnancy to term, with all other counselling to occur on referral to another party. A similar condition existed in the Australian Capital Territory until decriminalisation occurred in 2002, but there is no other such requirement in the criminal jurisdictions or the other hybrid jurisdictions. Whilst this may increase the scrutiny of a woman's abortion choice through exposure to another party, it does not mandate that this occur, instead requiring that counselling by a third party be offered before and after the decision is made as to whether the pregnancy will be terminated. The obligation on medical practitioners pertains to the *medical* risks associated with pregnancy and abortion, which arguably constrains their involvement to issues of a clinical nature. The law in this context regulates the actions required of medical practitioners in order to perform an abortion; it does not require that a medical practitioner regulate the choices made by women. The legal role of gatekeeping for doctors thus gives them authority over the clinical procedure of abortion, which is not necessarily authority to regulate the decisions that women make regarding terminations of pregnancy.

The law in Western Australia also contains a conscientious objection clause to protect medical practitioners from being involved in abortions if they hold an objection to performing an abortion. Unlike other Australian states and territories though, subsection 2 of section 334 in the *Health (Miscellaneous Provisions) Act 1911* (WA) allows any person, hospital, health institution or other institution to legally object to perform an abortion, or be involved in the performance of an

abortion, under any circumstance (*Health (Miscellaneous Provisions) Act 1911* (WA) s 334(2)). The inclusion of a conscientious objection clause for both individuals and *institutions* suggests that the regulation of abortion by doctors is optional for both medical practitioners and places where an abortion could be performed. This means that the regulatory function for doctors and institutions in the abortion context are conditional. Therefore, the legal scope of authority given to the medical profession is regulatory but only in so far as it pertains to the medical procedure of terminating a pregnancy.

It is difficult then to envisage how the law in Western Australia requires that women's abortion choices be regulated through the establishment of a gatekeeping role, because the various clauses that provide opportunities for doctors to perform abortions where informed consent is given, or entirely opt out of abortion as a matter of conscience, do not demonstrate this. It is more appropriate to consider the law in this context as being for the protection of doctors and their involvement in the provision of abortion services, rather than seeing the legal role of gatekeeping as being for the regulation of women's abortion choices. This is not to suggest that women's abortion decisions would not be scrutinised as a consequence of their engagement with a doctor, but the law does not define what scrutiny is necessary, providing scope for medical practitioners to determine the extent to which they perform a regulatory function. Like all jurisdictions discussed thus far, the legal framework in Western Australia provides conditions for the performance of an abortion procedure, with any regulation of the abortion choice being a matter for medical practitioners to define. This means that while the gatekeeping role is not established to regulate women's abortion choices *per se,* the position of the medical profession provides scope for this to occur through their role in providing legitimate abortion services. The role of gatekeeping is thus regulatory and applies regulation to doctors performing abortion procedures, but it also provides scope for a doctor to choose how they intend to practice regulation over the abortion choices that women make.

Discussion of hybrid jurisdictions

Abortion law in the hybrid jurisdictions is a mixture of conditions for the performance of abortions present in criminal and decriminalised jurisdictions and

requires varying degrees of regulation for abortion choices. All three jurisdictions have a conscientious objection clause that gives doctors an absolute right because there is no corresponding obligation on a doctor to refer a patient where they hold a conscientious objection, and in Western Australia this extends to institutions. Abortion is lawful in Western Australia up to 20 week's gestation where a woman gives informed consent, up to 14 weeks gestation in the Northern Territory (prior to 2017), and up to 28 weeks gestation in South Australia, provided two medical practitioners agree that continuing the pregnancy would cause greater risk to a woman's health than would terminating it. Establishing lawfulness for abortion after these gestational points varies, but it largely pertains to there being a severe medical condition for the woman or the fetus.

The law in the hybrid jurisdictions thus establishes conditions that are to met by medical practitioners in order for an abortion to be lawful, whilst also establishing the need for regulation of women's abortion choices by requiring mandatory counselling in Western Australia, a key element of informed consent, and multi-practitioner sign off in South Australia and the Northern Territory as to the degree of risk the pregnancy poses to a woman's health status. Multi-practitioner sign off is required in Western Australia after 20 week's gestation while in the Northern Territory and South Australia multi-practitioner sign off is required at all stages. The regulation of abortion is twofold in these jurisdictions: one being the regulation of the medical procedure of abortion and the other the regulation of a decision to seek an abortion. This suggests that doctors occupy a gatekeeping role and as such have an obligation to regulate abortion requests, but the law as written does not specify the regulation of women's abortion decisions that is to occur, instead regulating the actions of doctors in providing abortion services.

The scope of authority provided to the medical profession under the legal frameworks in the hybrid jurisdictions can thus be viewed through the same lens as those of the previous jurisdictional groups, decriminalised and criminal. The Northern Territory and South Australia are similar to the criminal jurisdictions in that the lawfulness of an abortion is to be determined on grounds that see pregnancy and prospective motherhood viewed through the lens of the health impact of a pregnancy on a woman and her life. Western Australia contains

elements of both groups because no reasons need to be given where a woman has provided informed consent, but there are also grounds for justification of an abortion where it is believed that the woman will suffer serious personal, family, or social consequences, or there is a danger to her physical or mental health should a pregnancy continue (*Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3)). Informed consent in Western Australia also mandates counselling for the woman concerned, and so whilst there may be no requirement for reasons to be established for the abortion, a woman's request is scrutinised by a third party in the same way as doctors scrutinise decisions in the criminal jurisdictions and the remaining hybrid jurisdictions.

Foucault's concept of bio-power is again a useful construct for explaining the role of doctors in the hybrid jurisdictions, as it was for the decriminalised jurisdictions. As noted in chapter 2, the operation of bio-power requires that there is a defined need for regulation and a site for regulatory intervention (see Foucault 2008, 146-147). In each of the hybrid jurisdictions the need for regulation is defined by retaining abortion as a criminal offence. This condition is designed to demonstrate that abortion remains a serious moral issue under the law, requiring regulation by the State. To effect sufficient regulation, the State has established a site for regulatory intervention by mandating certain conditions be met in order for an abortion to be lawful. These conditions pertain to the actions of a medical practitioner, not a woman seeking an abortion. The same application of bio-power can be seen in both the criminal jurisdictions and the decriminalised jurisdictions, but in the decriminalised jurisdictions the site for regulatory intervention is focussed on the action of doctors in not facilitating access to abortions rather than focussing on the decisions that doctors make to perform abortions.

In this context the defined need for legal regulation applies to medical practitioners just as it does to women seeking abortions. The law establishes regulatory criteria to be met in order for doctors to provide lawful terminations, and it establishes the regulation of women's choices through the requirement that medical practitioners scrutinise a woman's abortion request. Scrutiny of an abortion request occurs as medical practitioners seek to establish grounds that constitute a risk to a woman's physical and/or mental health. As a result, the role

of doctors in the hybrid jurisdictions positions them as having a regulatory function over women's abortion choices. As a consequence, there is authority given to doctors to assess women's abortion requests, but the assessment is constrained to how a pregnancy might impact on a woman's health. This is similar to the criminal jurisdictions in that it gives authority to the medical profession to determine how they will apply the gatekeeping role.

Therefore the application of bio-power in the hybrid jurisdictions sees the operation of the law seek to constrain both the actions of doctors and the actions of women. The defined need for regulation being retained in criminal law gives a stronger degree of authority over abortion practice than the decriminalised jurisdictions, but the site for regulatory intervention being ascribed using health law firmly posits this authority with doctors by virtue of their authority in medicine. Bio-power is thus in operation in the hybrid jurisdictions by establishing a site for regulatory intervention and defining a need for regulation.

Conclusion

From the outset of this chapter I sought to understand the legal framework for abortion in Australia, to determine what the scope of authority was for medical professionals and whether or not this suggested a regulatory function for abortions. My examination tested the hypothesis generated in Chapter 4 that the intent of the legal role of gatekeeping was more about the actions of doctors and the maintenance of medical authority, rather than it being reflective of a desire by the legislature to impose regulation on women who choose abortions. The exploration of abortion law in this chapter has revealed that there are substantial differences across the legal frameworks governing abortion in Australia. Yet, each jurisdiction revealed the authority of the medical profession as providers of abortion services.

The law in the decriminalised jurisdictions reinforces the medicalised nature of abortion and recognises both the role of the doctor and the need to consider a woman's choice as being sufficient grounds for an abortion to take place. The law thus maintains the authority of the medical profession as the legitimate providers of abortion services, but seeks to limit the impact of individual doctors on the

capacity of women to access terminations of pregnancy with the exception of the Australian Capital Territory. Doctors in this jurisdiction have an absolute right to conscientiously object and are therefore able to impact women by denying any form of assistance for acquiring an abortion. This means that women in these jurisdictions can legally access abortions in the earlier stages of their pregnancy on grounds that they see as being sufficient. There is no legal requirement for scrutiny of the abortion choice, but its place in the domain of medicine could subject the decision to a form of scrutiny.

The legal frameworks of the criminal jurisdictions on the other hand give doctors broad scope to establish reasons to justify an abortion procedure. As a result, women are able to access abortions, but a doctor has to make an assessment of the impact of physical, social, economic and psychological factors on their health. This assessment forms the basis of a defence for an abortion should a criminal charge occur. The hybrid jurisdictions also require that medical practitioners make an assessment of the impact of pregnancy on the physical and mental health of a woman, but the conditions stipulated at law emphasise the regulatory criteria that doctors must adhere to in the performance of abortions. The presence of conscientious objection clauses in these jurisdictions provide doctors with the capacity to opt out of the abortion context, and as such doctors can choose whether or not to be engaged in the regulation of abortion.

Therefore there is a legal gatekeeping role for doctors in New South Wales, Queensland, South Australia, the Northern Territory, and Western Australia. There is also a gatekeeping role in the Australian Capital Territory, Victoria and Tasmania, but this is as a consequence of abortion being managed solely within the domain of medicine rather than it being a legal requirement. In other words, gatekeeping can still occur because of the role of the doctor in regulating access to a medical procedure, not because there is a specified role for a doctor to regulate abortion procedures in a particular way. Many of the legal conditions for abortion presented here protect the role of the doctor in providing abortion services, relying on the judgements of medical practitioners to determine the appropriateness of an abortion procedure.

However, while the present chapter has demonstrated the scope of authority that the medical profession holds in defining access to abortions, it has not considered how the medical profession might determine the appropriateness of an abortion procedure. This is an important point to consider because, as we have seen in this chapter, the law acknowledges the moral dimensions of abortion by legislating for a conscientious objection and yet provides the medical profession with an authoritative role in shaping access. The judgements of medical professionals are thus relied upon to provide women with lawful abortions, and the presence of conscientious objection clauses and the obligation to refer suggests that doctors morally opposed to abortion would remove themselves from the clinical encounter. This suggests a problem frame to examine, specifically how knowledge might be applied at the site of the regulatory intervention, testing how the judgements of medical professionals might impact on the abortion decisions of women. In order to understand the emergence and the practice of the gatekeeping role, we now need to examine the extent to which the application of knowledge concerns medical knowledge and issues within the medical domain, or broader concerns regarding the ethical and moral issues of abortion.

The next chapter considers how the education of doctors might define the application of medical knowledge, specifically to understand whether the teaching of abortion includes considerations of regulatory criteria that would determine a lawful procedure. I am seeking to explore in greater depth the shaping of a medical regulator, exploring what might characterise the process for shaping a regulator and what this might reveal about the nature of the role of gatekeeping.

Chapter 6

Educating for ‘gatekeeping’: teaching abortion decisions

Introduction

The findings of previous chapters supported the claim that the medical profession plays a key role in defining access to abortion procedures, a role that has been characterised as gatekeeping by Cannold (2000, 24-25), Hadley (1996, 187), Douglas (2009, 77-78), and de Crespigny & Savulescu (2004). Chapters 4 and 5 revealed that this legal role of gatekeeping relies on the professional medical judgements of doctors to define abortion practice and to facilitate access for women. In the criminal and hybrid Australian state jurisdictions this equates to a doctor having legal responsibility for establishing sufficient grounds for an abortion to take place, or providing sufficient counselling to satisfy grounds for informed consent. In the decriminalised jurisdictions of Tasmania and Victoria it equates to a doctor facilitating access to abortions in the earlier stages of a pregnancy, by either facilitating the performance of the procedure or referring a woman to another practitioner where they hold a conscientious objection. This is also the case in the Australian Capital Territory, except that the right to conscientiously object is absolute and hence there is no obligation on a doctor to refer. What this means is that the law relies on the professional medical judgements of doctors to apply abortion law and meet the intent of the legislation.

However, Chapter 2 noted that a person's views on abortion hold moral significance and that there are a range of views regarding abortion concerning perceptions of motherhood and the moral status of a fetus (see Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000). Because views regarding abortion vary across social actors, this led me to question whether the variability of views regarding abortion are also found in the medical domain, and are observable in the decisions that doctors make. The next phase in the thesis examines the extent to which moral views are acknowledged in the medical domain and form part of a doctor's professional medical judgement. This concern emerged in the debates and legislative frameworks discussed in Chapters 4 and 5, which acknowledged the types of decisions that doctors make and ultimately the impact that this can have on women's choices. What I am testing here is how the medical domain understands its gatekeeping role, and whether this reflects the intent of abortion law, or forms the basis for ensuring that women's abortion choices are regulated through the medical apparatus.

The present chapter thus seeks to explore the shaping of a doctor's professional medical judgement, examining how doctors are taught about abortion and taught how to apply abortion law. My analysis of the education of doctors examines the fourth empirical question of this thesis, *how does the education of the medical profession address abortion and the legal role of the doctor?* Two operationalising questions were used to focus the research: *what education do medical students receive regarding abortion and abortion law? (sub question 1)* and *are doctors taught certain criteria to determine the appropriateness of an abortion procedure? (sub question 2).*

As noted in Chapter 3, the findings are derived from interviews with persons who teach in medical schools, and from secondary material in the form of course outlines or lecture slides. All participants were asked the same set of questions, but depending on the flow of the interview these may or may not have been answered sequentially. Furthermore, some of the material that emerged concerning students participation in training was a result of participants elaborating on certain points and/or offering greater explanation of the current situation, rather then it being indicative of this occurring in certain places and not in others. Therefore specific observations are treated as being representative of an institution not representative of medical education in its entirety, with greater emphasis placed on the themes that are presented and what this shows about abortion education in Australia.

The findings are derived from 10 of the 18 institutions in Australia that teach medicine, spread across 6 states and territories. The range of institutions represents the legal frameworks discussed in Chapter 5, 4 institutions in the decriminalised states, 5 institutions from the criminal states, and 1 institution from a hybrid state. Of those institutions that did not participate, 5 were based in criminal jurisdictions, 1 in a decriminalised jurisdiction and 2 were in hybrid states. The material provided by the institution which resides in a hybrid jurisdiction was not comprehensive enough to warrant separate examination of the views. However, it was consistent with the teaching of abortion in the criminal jurisdictions, in that it demonstrated a similar approach and revealed similar

themes for abortion education, and as such is discussed as part of the criminal approaches. The table below summarises the sample of participants included in the findings.

Jurisdiction	Source material	Participants
Criminal		
Institution 1	Interviews and course material	Melissa (Clinical ethics) John (Obstetrics and Gynecology)
Institution 2	Interview	Paul (Clinical practitioner & ethics)
Institution 3	Interview	Michelle (Obstetrics and Gynecology)
Institution 4	Interview	Lucy (Public health & General Practice) Jessica (Obstetrics and Gynecology)
Institution 5	Interview	Alicia (Clinical ethics)
Institution 6	Outline of course content	Provided by representative of Obstetrics and Gynecology
Decriminalised		
Institution 1	Interview	Mark (Obstetrics and Gynecology) Rebecca (Ethics)
Institution 2	Interview	Tom (Obstetrics and Gynecology)
Institution 3	Interview	Clare (Obstetrics and Gynecology)
Institution 4	Interview	Emma & Jane (Clinical ethics)

My exploration of the teaching of abortion was framed by the legal frameworks described in Chapter 5 so as to link it with the legal framework in which the teaching operates. The findings were analysed in this way because I hypothesised that the law relies on the professional medical judgements of doctors to understand and apply abortion law, so the education of doctors should reflect the law that operates in each jurisdiction. My expectation was that the teaching of abortion would reflect the legal framework of the jurisdiction. What this chapter will show, however, is that while the teaching of abortion aligns with some aspects of the relevant state law, there are other elements of abortion training that are considered to be the sole domain of medicine, and hence are managed in the

curriculum irrespective of the law, which could also be because doctors are not necessarily expected to practice in the state where they received their education. These elements pertain to ethical decision-making and professional practice. This provides scope for doctors to practice the gatekeeping role, irrespective of the legal framework that establishes it.

6.1 The decriminalised jurisdictions

As shown in Chapter 5, in the decriminalised jurisdictions of the Australian Capital Territory, Victoria, and Tasmania, there is no legal requirement for a doctor to establish reasons for an abortion in the earlier part of a pregnancy, and therefore no need for a doctor to necessarily understand how to assess a request and make a lawful decision to terminate. However, the type of teaching that doctors are exposed to in the decriminalised jurisdictions suggests that there remains a decision-making role for doctors in the abortion context, a role that is greater than the clinical procedure of terminating a pregnancy.

Mark & Rebecca

Mark and Rebecca taught medicine in the same institution, but their teaching was in different parts of the curriculum. Mark was a specialist physician who lectures students and supervises clinical placements for obstetrics and gynaecology. Rebecca was primarily an academic who taught a course focused on health law and ethics. In this institution the teaching of abortion is not a subject in and of itself, being incorporated into different parts of the medical curriculum.

The teaching of the law and ethics subject occurs in the earlier part of the curriculum, in years 1 and 2 of a 4-year medical degree. The course deals with theory, ethics, and law surrounding abortion, "as well as other areas of ethical concern":

> Doctors are given the right to conscientiously object but the role of the ethics course is to understand what this entails…Students are taught to consider abortion in the context of human rights and a woman's right for self determination/reproductive freedom. A woman has a right to determine her own reproductive life and this should not be interfered with by the state or doctors as agents of the state.
>
> (Rebecca, 8 October 2013)

Concerning the teaching of abortion law specifically, Rebecca noted that students were taught how to make decisions regarding abortion based on ethical principles: beneficence, non-malevolence, autonomy, and justice (Rebecca, 8 October 2013). She stated: "If a student applies these principles, there would be no case for a doctor not to assist the woman in being able to procure the procedure" (Rebecca, 8 October 2013). This description of the training that students are exposed to suggests that medical students in this institution are encouraged to consider the rights of women as having precedence over state restrictions regarding abortion. Rebecca acknowledged this when she stated "abortion law is arguably in breach of human rights provisions because it gives authority to doctors not women" (Rebecca, 8 October 2013). The legal role of gatekeeping can thus privilege the role of the doctor above the exercise of rights by women seeking to control their reproductive lives, which in this institution did not seem to be an acceptable position for doctors to occupy.

The type of training that medical students receive in this institution concerning ethical decision-making for abortion highlights that the legal role of gatekeeping is not considered as being a mechanism for exercising authority over women, as was implied by the characterisation of gatekeeping for doctors under abortion law. Indeed, this approach to the law was supported in Chapter 2 by MacKinnon's assessment of abortion law as furthering women's subordination to men (see MacKinnon 1991). It acknowledges that while doctors hold decision-making power in the abortion context, this should be utilised to assist women in procuring terminations rather than hampering them. However, Rebecca's position seems to also suggest that the argument that the gatekeeping role subordinates women's choices to doctors does not always hold, as the education program in this institution does not suggest that the role of the doctor should subordinate women's choices to the decisions they make. This finding is consistent with that from the decriminalised jurisdictions in Chapter 5 where I noted that the law provides a role for doctors to facilitate access to abortions or opt out of the abortion context altogether.

However, as was also indicated in Chapter 5, there is the potential that medical training shapes a regulatory role for doctors in the abortion context by virtue of

the decision being within the medical domain. In other words, the subordination of women's choices can occur because of the privileging of medical knowledge over the decisions that women make regarding their lives. This power of the medical profession was evident in Mark and Rebecca's institution in the clinical components for abortion teaching.

Mark's description of abortion teaching in the clinical components of the medical degree highlighted how medical students are taught to acknowledge women's choices, and apply their own knowledge of abortion and pregnancy when giving advice and/or treatment. Mark stated that "termination of pregnancy is taught predominantly by the sexual health physicians during the fourth year of the medical degree" (Mark, 11 October 2013). He noted that "the team of staff are sensitive to the choices made by women and [termination of pregnancy] is taught in this context…During a student's [obstetrics and gynaecology] rotation, the students are taught about [termination of pregnancy] in the context of fetal abnormality" (Mark, 11 October 2013). In his description of the teaching, Mark highlighted that there is a role for doctors in shaping how pregnant women understand abortion:

> Students are required to consider a range of implications for a woman continuing a pregnancy. They are taught to think critically about the options, and consider the implications from a range of perspectives. Many junior doctors have a menu approach to service; that is they provide a range of options and ask a patient to choose which one is right. I feel that it is our job to make recommendations regarding [termination of pregnancy]. It is a doctor's role to provide options but make a considered judgement and recommendation based on evidence. All of my training gives me the perspective and experience to give informed views. With regard to fetal abnormality cases for [termination of pregnancy], the information provided includes discussion of what the life of the child will be like, what the implications will be for the family, for the mother and the couple, what the health of the child will be like and the burden of care this may bring. Neo-natal doctors are brought in as well to speak to couples so that they can better understand the reality of life for a child with abnormalities. A lot of resources are devoted to providing women and their partners with realistic information about [termination of pregnancy].
>
> (Mark, 11 October 2013)

What this shows is that medical students are taught to exercise judgements based on their medical training and their experience in dealing with similar cases, which in this context extends to knowledge of the future prospects of parenting a child with a disability. They are trained to focus on the future health of the child, and the impact that this will have on the mother and father. In this context, medical students are constructing a knowledge base for parenthood that draws on the experience of various health-care providers to establish a picture of the type of future that a woman either commits to by choosing to proceed with a pregnancy, or chooses to avoid by having a termination.

What the clinical teaching of abortion in this decriminalised jurisdiction reveals is that the position of abortion choices in medicine ensures that abortion is regulated through the lens of a prospective health problem. This supports the hypothesis generated from my examination of Foucault and bio-power in Chapter 2 that the role of gatekeeping is constituted to regulate social norms concerning abortion and reproductive choice through the apparatus of medical practice (see Foucault 2008, 144 and 146-147). However, viewing abortion through such a lens does not remove the moral complexity of abortion decisions. Instead, it requires that doctors consider their professional obligations and make judgements about whether or not an abortion is ethically appropriate, irrespective of what the law requires. This was evident in Mark's description of the education that students receive regarding abortion law:

> [I am] no expert on abortion law but so long as doctors make informed ethical decisions there should not be an issue with providing a [termination of pregnancy]. In situations post 20 weeks, cases are considered by a hospital ethics committee, not because it is legally required but because we believe it to be the right thing to do. It is important that individual cases are considered by more than one pair of eyes to ensure that nothing is missed in the clinical diagnosis and proposed treatment.
>
> (Mark, 11 October 2013)

Mark's description of the teaching here reveals an emphasis on ethical decision-making in the clinical parts of the curriculum because the medical establishment considers it the most appropriate, or 'right thing to do', rather than it being a legal requirement. This acknowledges a difference between the *legal construction* for regulating abortion and the *practice* of abortion regulation in medicine. The law is presented as an element for consideration in exercising decisions, but it is not the

determining factor. This suggests that the law does not govern medical practice, but rather informs it, and hence medical students are taught to shape abortion decisions despite the intent of the law in the decriminalised jurisdictions, discussed in Chapter 5, as being for the facilitation of women and their capacity to exercise reproductive rights.

However, while Mark's observations broadly support the hypothesis of Chapter 2 as described above, namely that gatekeeping is constituted to regulate social norms concerning abortion and reproductive choice, his observations of abortion teaching reveal that some medical students may have no exposure to abortion during their period of education, and thus not all abortion scenarios are managed in the same way. This was particularly the case for teaching that takes place in Catholic hospitals:

> No teaching of [termination of pregnancy] can be undertaken at the Catholic hospital – in fact even women who have given birth at the hospital are not given any contraceptive advice. There is no discussion of issues regarding women and their control of their own reproductive capacity. In some instances as well, the theory of [termination of pregnancy] is not taught.
>
> (Mark, 11 October 2013)

What this suggests is that abortion education can be shaped according to the values and beliefs of the institution where clinical training takes place. In this context, the legal right to conscientiously object to abortion holds greater significance for the facilitation of access than a single doctor refusing to facilitate an abortion on grounds of conscience. The provision of a conscientious objection for doctors stipulated by the law is extended in this particular descriminalised state beyond the individual conscience of a single doctor, equating to a complete disengagement by certain health institutions with the subject of abortion. The law's protection of a doctor in the abortion context can thus result in doctors not being educated about abortion, which Mark argues can have a significant impact on women's health outcomes:

> A [termination of pregnancy] can cause complications and where a woman presents to a doctor for care following complications, there is a risk that treatment will be given without considering the full range of biological factors at play if a doctor is not informed. There is no excuse for not knowing, the risk to a patient's life requires that a doctor be informed.

(Mark, 11 October 2013)

Mark's perspective thus presents a challenge to the law's reliance on the professional judgements of medical practitioners, as it shows that not all doctors may be educated about abortion and hence not competent to exercise judgement in the abortion context. This demonstrates that there is a difference between the legal expectation of abortion regulation and the practice of abortion in medicine.

Rebecca reinforced this perspective that doctors exercise a gatekeeping role in this context:

> Medicine is about power and the exercise of power. The professional status of the profession is so great that there is an expectation by our political leaders that doctors can exercise that power appropriately. It is doctors that drive the development of health law and position the profession as the authority of certain clinical decisions, but often there is obfuscation by the profession of the responsibility to make the decision regarding abortion. It is as if they want the power but do not want to take responsibility for exercising that power.
>
> (Rebecca, 8 October 2013)

Rebecca's perspective on the nature of medical practice highlights that regardless of the law, women may be unable to access abortion services from a particular doctor. So while the law in the decriminalised jurisdictions provides protection for doctors to perform abortions where women give consent, there may be situations where women are exposed to doctors that are unwilling to provide the service, or potentially unable to provide the service due to a lack of education as Mark described.

This institution reveals that there are both clinical and ethical components to the teaching of an abortion decision. In the curricula, the ethical dimensions of an abortion were seen to be critical for how decisions are managed, because doctors can impact on women's choices irrespective of the law not requiring any form of regulation of their choice. Students in this institution are thus taught to assess abortion scenarios on the basis of the likely health impact that a pregnancy will have on a mother in cases of fetal abnormality, while limiting the impact of their personal beliefs on the decisions that they make, or removing themselves from the scenarios where they hold a conscientious objection. What this means is that the law is relying on the professional medical judgements of doctors to facilitate

abortion access for women, but these judgements are based on the degree of exposure that a medical student chooses to have and the capacity of each student to engage with the ethical dimensions of abortion practice, rather than being institutionally defined.

Tom

The teaching of abortion in Tom's institution, also in a decriminalised jurisdiction, was similar to the approach taken in Mark and Rebecca's institution. Abortion was taught in two contexts: "the clinical procedure methodology as to how to terminate a pregnancy during different periods of gestation; and in the context of a reproductive rights framework" (Tom, 25 July 2013). Like Mark, he also highlighted that there may be instances where medical students are not exposed to abortion during the course of their training as a consequence of religious and cultural views.

The teaching of abortion occurred predominantly in the obstetric and gynaecology field, in the fourth year of the medical degree:

> It is a two month rotation in women's health commencing with a one week intensive of seminars, lectures and tutorials. The remainder of the time is filled with clinical rotations where students have clinical interactions with women terminating pregnancies among other issues of [obstetrics and gynaecology] concern.
>
> (Tom, 25 July 2013)

Regarding abortion law specifically, Tom noted that education regarding how to apply the law was not necessarily needed given that abortion is lawful in the decriminalised jurisdictions in the earlier stages of a pregnancy on the woman's request alone, but that "students are taught the rules in relation to abortion law and the need to be aware of the rules in different areas as they differ across states and territories" (Tom, 25 July 2013). The teaching of abortion then focuses more on the clinical procedure of terminating a pregnancy, rather than the role of doctors in facilitating access to abortion. For Tom, this was a consequence of the fact that there is "not enough time in the curriculum to deal with [clinical and ethical aspects of abortion] sufficiently so often we are forced to focus on the methodological elements where insight into how women feel can be less of a focus" (Tom, 25 July 2013). What this shows is that there are both clinical and ethical dimensions to abortion practice, where the ethical dimensions would consider the

sentiments that women hold in making abortion decisions, and that the clinical dimensions often hold greater significance within the curriculum.

However, despite Tom's institution not addressing decision-making regarding abortion choices to a great extent, the education that occurred in the clinical domain still acknowledged the moral dimensions of abortion, through the institution's approach to teaching abortion within a reproductive rights framework. In Tom's institution though, a potential consequence of acknowledging the moral dimensions of abortion is that students can choose not to participate in clinical training regarding abortion, a possibility to which Mark's description of the teaching of abortion alluded to in the previous section:

> [This] institution acknowledges and respects a student's right not to participate in the rotations – do not insist on students attending consultations where women undertake the procedure. The institution takes a liberal view of reproductive rights affirming a woman's right to choose. We try to impart on students a need to acknowledge and respect this choice, but respect their own religious/cultural viewpoints. Where students refuse to participate in the clinical interactions with women terminating pregnancy, we note that if they wish to pursue [Obstetrics and gynaecology] they need to consider abortion and if they cannot then perhaps [Obstetrics and gynaecology] is not the right choice for them.
>
> (Tom, 25 July 2013)

What this suggests is that the moral dimensions of abortion highlighted in Chapter 2 (see Dworkin 1994 and Wertheimer 1971) are acknowledged in the education of medical students in this institution, and are accepted as having an impact on their medical practice. Tom's description of the training that students receive thus shows that the conscience of individual doctors can equate to a medical student not having to participate in any education regarding abortion. It is therefore possible that some will abrogate their gatekeeping role.

However, this abrogation of the role is at odds with the legal status of a conscientious objection and the position statement provided by the AMA, the peak body in Australia representing the professional interest of doctors. The legal right to conscientiously object, and thus not participate in the provision of abortion, applies to each abortion case. In the decriminalised jurisdictions the legal basis for a conscientious objection pertains to individual situations where abortion is

requested, and in Victoria and Tasmania it cannot be held where there is an immediate danger to the life of the pregnant woman (see *Health Act 1993* (ACT) s 84, *Abortion Law Reform Act 2008* (Vic) s 8(3), and *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(3)). The AMA's position statement on conscientious objection acknowledges that a doctor should provide treatment in an emergency situation even if they hold a conscientious objection (Australian Medical Association 2013). It also states that "a doctor who makes a conscientious objection to providing, or participating, in certain treatments or procedures should make every effort in a timely manner to minimise the disruption in the delivery of health care…The doctor needs to take whatever steps are necessary to ensure the patient's access to care is not impeded" (AMA 2013). The management of a conscientious objection should, therefore, occur in the context of each individual medical case, but if the education of medical students permits those with a conscientious objection not to participate in the training, then there is the possibility that women seeking access to abortions, or undergoing terminations in emergency situations, are being treated by doctors that are untrained.

So while the teaching of abortion in Tom's institution was similar to that of Mark and Rebecca, his description of the practices of his institution articulated to a greater extent the moral dimensions of abortion concerning reproductive rights and the rights of doctors to practice medicine according to their own conscience. The medical training provided in this institution suggests that some medical students can choose not to participate in abortion education, and thus potentially limit access to abortion through not participating in treatment on the grounds of conscience. However, Tom argued that this is not the preference of the institution and indeed not the outcome for medical students that the institution is seeking:

> With more time it is hoped that we might be able to convert individuals who think there is no place for abortion ever. There is a slide that we use to illustrate the sensitivities…[it] shows Pol Pot, Hitler and the Pope and asks the students who is responsible for the most deaths. The answer is the Pope because of the restriction on contraception and abortion for Catholics.
>
> (Tom, 25 July 2013)

What this suggests is that the education of abortion in Tom's institution acknowledges the need for abortion in medical practice, and seeks to educate students how to provide abortions and be sensitive to women's choices in the

process, regardless of their ethical views on abortion. Medical students are thus taught about abortion and the need to support women in exercising their reproductive rights, limiting the impact of their own moral views on women's choices. However, because the institution permits students to remove themselves from parts of the education if they hold a belief that is irreconcilable with abortion, the views of a doctor can take precedence in defining how they choose to be educated. This means that whilst doctors are taught to acknowledge women's reproductive rights, they themselves do not have to be involved in women exercising those rights. The legal role of gatekeeping for a doctor remains one that a doctor can choose to undertake or not.

Clare

Clare's description of the teaching provided by her institution in a decriminalised state was similar to that of Mark and Rebecca, as well as Tom. She also described abortion education as combining clinical elements and non-clinical elements. The non-clinical aspects were the legal dimensions associated with abortion decision-making and the need for doctors to facilitate abortion access, and the clinical elements concerned the diagnosis and procedure of terminating a pregnancy. However, unlike the institutions discussed so far, the teaching in Clare's institution tended to emphasise clinical aspects of medical practice to the detriment of an in depth consideration of non-clinical issues.

Clare argued that this emphasis on the clinical elements had not always been the case, and that the current emphasis on clinical teaching to the detriment of non-clinical teaching had emerged when the university transitioned to a new structure for the curriculum in the late 2000s. Clare stated that the old curriculum ensured that students were given a two-hour lecture/tutorial that focused on abortion and the law, including an overview of the law and its application (Clare, 25 November 2013). In the new curriculum there has been a reduction in the number of hours for abortion teaching where "the structure of teaching has changed taking on a less formal approach and is based on students exploring clinical scenarios on a range of issues and working their way through them" (Clare, 25 November 2013). Clare suggested that the new curriculum in her institution had removed the non-clinical aspects of the education that might address abortion, for example maternal

mortality and reproductive medicine (Clare, 25 November 2013). She argued that those elements of the curriculum needed to be returned so as to sufficiently deal with the complexity of abortion practice, but noted that achieving such would be a significant challenge because of the volume of information that a student has to acquire in order to practice:

> There is only one case that deals with abortion and it covers an adolescent who presents requesting an abortion. In the new curriculum, topics like abortion are considered non-core. Basically because there is so much knowledge to be covered that often the legal issues become perceived as 'airy fairy' and the more clinical issues are given focus.
>
> (Clare, 25 November 2013)

Clare expressed a concern regarding the place of abortion in the new curriculum, indicating that she was not comfortable with the current approach being taken: "some people argue that medical students simply need the key ideas and then can find the information themselves, but my view is that students need to be taught instead of encouraged to find because if they don't know there is an issue then you don't know to look for it…medical students need to be aware of the reality that if they do not provide abortions, women die" (Clare, 25 November 2013). What this suggests, as we saw in Tom and Mark's case, is that there is a potential consequence of doctors not facilitating access to abortion which could result in a serious health problems for women. Clare is suggesting that the risk of death for women should warrant greater exploration of abortion in the education of medical students.

Medical students in Clare's institution are thus taught about the clinical nature of abortion, but are not necessarily taught how to exercise decision-making with due recognition of the moral complexity of abortion choices. In this context, the privileging of clinical issues means that abortion decision-making is not a priority within the curriculum, and this presents a challenge for the law's reliance on the judgements of medical practitioners through the establishment of the gatekeeping role. In the decriminalised jurisdictions examined so far, the judgements of doctors are relied upon for providing women with access to abortions within the early stages of a pregnancy, but the education of doctors in Clare's institution does not portray this responsibility as a priority. Doctors are thus given a gatekeeping role

by the law to provide abortion services, but they are not necessarily taught to attach the same level of significance to the issue that the law does.

Emma & Jane

Emma and Jane taught in the same decriminalised medical institution, and both had responsibility for education regarding professionalism in medical practice. Like the other educators discussed so far, they both distinguished between teaching that focused on students acquiring clinical knowledge, and teaching that concerns professional issues such as ethical decision-making. The teaching was similar to the approaches discussed thus far, but like Clare they stressed that in their institution there was an over-emphasis on clinical training to the detriment of non-clinical training. However, Emma and Jane's description of the teaching in their institution provides a more acute appreciation of the significance of ethical vis-à-vis clinical training, highlighting that whilst medical students are exposed to education regarding decision-making, consideration of issues raised within this training may not be a central focus for doctors in their day to day practice.

In Emma and Jane's institution students are taught about abortion law in year 2 and during their women's health rotation in year 3 (Emma, 1 September 2013). The teaching is part of the ethics, law and professional development subject that runs across all years of the medical degree. Students are taught about the legal position of abortion in their jurisdiction and are also given an overview of the law in all other jurisdictions in Australia (Emma, 1 September 2013). In addition to this

> students are taught in year 1 & 2 to consider their personal vs professional ethical responsibilities…Abortion is explicitly referred to here when limitation of service is discussed…Reproductive autonomy is taught in semester 1 of year 2 and abortion is discussed. Here it is discussed as an issue of theology rather than philosophy though issues of personhood are considered and applied in the abortion debate. Students are asked to consider how passionately people hold these views.
>
> (Emma, 1 September 2013)

Emma's description of the teaching of abortion shows that her students are required to consider the difference between their personal views and their professional responsibilities, particularly in the context of how this could impact on the capacity of a patient to access a termination of pregnancy. Students are also taught to consider the different views that people can hold in relation to abortion,

acknowledging that each persons' views regarding abortion can differ. What is of significance here is that the teaching overtly recognises that doctors are moral actors who hold their own particular views regarding abortion and reproductive rights. The teaching acknowledges that doctors can be influenced by their own beliefs in making decisions, but that their professional responsibilities should have greater significance in defining their medical practice than their own personal views.

This was further emphasised by Jane and Emma when describing their attitudes to the current approaches to abortion education. Jane stated: "I am satisfied with the way this issue is covered in the course – as well as being aware of the laws relating to abortion, importantly the students are encouraged to separate their personal views from their ethical obligations" (1 September 2013). Emma supported Jane's sentiments:

> I believe we strike the right balance in relation to abortion and reproduction in general. We are not teaching specialists but rather educating new young doctors who could end up specialising in anything. What is important is that they understand some basic skills in professional decision-making (this includes ethics and law). While we teach the relevant law, what is most important is that the students know how to access this information and how to apply it in their given context. Similarly with ethics, they should know the framework issues such as putting the patient first, navigating their professional responsibilities and personal ethics, tolerating difference in others.
>
> (Emma, 1 September 2013)

In this institution, medical students are taught about abortion and the moral complexity of abortion decisions. The legal role of the doctor is taught as being applicable to each individual case, where doctors are required to exercise decision-making based on a consideration of ethical principles. In this context the education emphasises the role of the doctor in considering ethical issues to reach an appropriate decision, rather than trying to define the types of decisions that students should make. In other words, it is the decision-making *process* of the doctor that is the focus of the teaching, not the decisions specifically.

However, despite the education having a focus on the process of decision-making, it is difficult to determine what factors might impact a doctor's decision-making

process, and what the relative significance of these factors might be. This is important to consider because the clinical elements of medical training in this institution are seen to hold greater significance than ethical training. Hence any consideration of the moral complexity of abortion might be undervalued compared to consideration of clinical issues because, like Clare, both Emma and Jane indicated that the education of medical students seemed to over-emphasise clinical aspects of training to the detriment of ethical training. In particular, Emma believed the institution privileged clinical knowledge:

> There is too much focus on the importance of the science of medicine rather than the art of medicine. Students embrace learning about professional issues such as decisions about ethically difficult issues early on, but are influenced in their clinical years to consider these issues 'soft' and less important later on. I'm not saying the time spent on science and humanities is wrong (though it may be), it is more about the perceived importance of 'professional' vs 'clinical' decision making that is degraded.
>
> (Emma, 1 September 2013)

Emma's perspective, like those of others in this section, shows that the teaching of medicine consists of two distinct elements, clinical training and professional training, where professional training considers ethically challenging issues, but that the clinical element is often accorded greater significance. Jane made a similar observation: "There is an over-emphasis on science and clinical information, at the expense of a focus on the doctor-patient relationship in the context of working within a professional framework" (Jane, 1 September 2013). What this means is that while medical students are taught the importance of limiting the impact of their own views on their medical practice, clinical matters dominate the process of decision-making. The result is that the process of decision-making minimises consideration of ethical matters.

Discussion

The teaching of abortion in each of the decriminalised state institutions discussed here highlights subtle differences in how abortion is taught, but while each institution revealed a slightly different approach, a general theme emerged as being common across all institutions: they teach both abortion in a clinical context and the nature of ethical decision-making. The type of knowledge that doctors are taught to draw on in these institutions in order to practice abortion thus concerns

the clinical skills needed to perform a termination and sufficiently diagnose a fetal or maternal abnormality, as well as knowledge concerning the ethical dimensions of abortion. In this context doctors are not taught criteria to apply in order for an abortion to be performed, rather they are taught to consider the various ethical dimensions of abortion and respond appropriately. The definition of a response is thus one that doctors must generate themselves; it is not the case that a doctor is taught a checklist of symptoms or circumstances that qualify a woman for a termination.

What the teaching here reveals is that there is a decision-making role for doctors at different stages during a pregnancy, despite the law not requiring such in the earlier stages of the pregnancy, and that the performance of this role increases in complexity as a pregnancy progresses. In many ways this reflects the legal frameworks operating in the decriminalised jurisdictions, particularly given that the role of the doctor is to facilitate access for abortions in the earlier parts of a pregnancy (unless they hold a conscientious objection in the Australian Capital Territory where the right is absolute), and facilitate terminations in later stages of a pregnancy where there is a serious danger to the mother's physical or mental health, and/or a fetal abnormality. However, while the teaching of abortion in these jurisdictions faithfully reflects the decriminalised legal framework, the teaching itself does not suggest that this was necessarily the case. There was a general theme across the institutions that the legal role of the doctor and the clinical role of the doctor were not subordinate to one another, and therefore the law does not define medical practice.

What this section has found is that clinical practice holds greater significance in defining medical practice than what the law requires of doctors. This was demonstrated by a number of interviewed teachers who spoke of the privileging of clinical training over ethical training. There was also an assumption in all these institutions that as long as doctors exercised their decision-making ethically, then they were acting within the bounds of the law. The knowledge that doctors acquire in the clinical domain regarding abortion is treated by these teaching institutions as being greater in significance than a doctor's knowledge of the law. In this context the capacity for women to access abortion services is subject to how

abortion is understood within clinical practice, and so regardless of the law in the decriminalised jurisdictions requiring that no reasons be established for a lawful termination, women's choices still remain subjected to medical scrutiny and the application of medical knowledge. This suggests then that irrespective of the legal framework, there is a benign form of intervention, a benign form of gatekeeping.

According to Freidson however, medical knowledge is only one form of knowledge, and he emphasises a distinction between medical knowledge and the knowledge of a layperson (see Chapter 2, and also Freidson 1988, 335 &338). The content of medical knowledge is said by Freidson to be the designation of illness being scientifically systematic and reliable, acquired by a professional expert through their professional training (Freidson 1988, 338-340). However, Freidson also argued that the application of knowledge in the medical domain is evaluative and moral rather than technical, as the application of the technical to public affairs means that a doctor must engage in social activity as well as technical activity (Freidson 1988, 341). He (1988, 340-341) argued the technical activity "itself becomes social in that it has social meaning, is embodied in social relationships, and has social consequences for the members of that relationship".

This section on the teaching that occurs in the decriminalised jurisdictions supports Freidson's observation in the sense that it suggests that the application of clinical knowledge has moral characteristics. Therefore, regardless of the law providing women with access to abortion where they have given consent, the role of the doctor still subjects a woman's choice to some form of scrutiny based on how doctors understand abortion, abortion law, and their role in the performance of abortions. For instance, a doctor could choose to perform, or support, an abortion on the grounds provided by a woman alone, or they could seek to establish additional grounds based on their own perceptions of how justifiable a woman's decision is. There is thus a form of regulation over women's decisions being applied, and hence a gatekeeping role being performed. What this section has revealed about the gatekeeping role is that it is defined by how individual doctors approach the decision-making process and the extent to which they acknowledge and consider their own personal beliefs in the context of their professional obligations.

The education of medical students in the institutions explored in this section acknowledges and supports a differential application of the gatekeeping role. Students come to understand that the moral complexity associated with abortion (see Chapter 2, and Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000) is managed according to the personal judgements that doctors make, rather than being institutionally defined. This was a possibility to which Chapter 2 alluded, given the experience of doctors practicing abortion prior to any form of decriminalisation (see Baird 1990 and Wainer 1972; see also Joffe 1995). What this section has revealed is that students are not taught any specific criteria to determine the appropriateness of an abortion procedure. What they are taught is how to technically perform an abortion, and that their personal views can impact their professional practice, but that there is a need to consider how best to minimise the impact of their personal views. In trying to understand the gatekeeping role, this suggests that it is defined by each doctor and as such, could manifest in different ways for women seeking terminations of pregnancy.

6.2 The criminal jurisdictions

This section will reveal that the teaching of abortion in the criminal jurisdictions adopts an approach to the decision-making process for a doctor that is similar to the decriminalised ones. These states are New South Wales and Queensland. South Australia, a hybrid jurisdiction, will also be part of this discussion as mentioned in the introduction. However as noted in the previous chapter, unlike the decriminalised jurisdictions, the law in the criminal jurisdictions requires that doctors make an assessment of a woman's desire or need to terminate their pregnancy, an assessment that would satisfy a defence for a charge of abortion. Doctors are required to establish that there is a serious danger to a woman's physical and/or mental health in continuing with a pregnancy, thus warranting the lawful performance of an abortion. This places the abortion decision with doctors and not women, reinforcing their gatekeeping role (see Cannold 2000, 24-25, Hadley 1996, 187, Douglas 2009, 77-78, and de Crespigny & Savulescu 2004). As noted at the end of the previous chapter, one could therefore hypothesise that the teaching of abortion in these jurisdictions would concern how a doctor establishes a rationale for a lawful abortion to justify a defence for a criminal charge. However

as the following will show, this is not a straightforward task, as the teaching in these jurisdictions emphasises the decision-making process of the doctor in navigating the legal, moral, and ethical dimensions of abortion, rather than teaching how a doctor should apply a set of criteria.

Melissa & John

The teaching of abortion in John and Melissa's institution was encountered in clinical and ethical subjects, similar to the approaches taken in the decriminalised jurisdictions. John's teaching addressed abortion in the context of fetal abnormality, specifically terminations in cases where a fetus has a high risk of down syndrome, and Melissa addressed abortion in the context of ethics and professionalism. John described the teaching of abortion across the curriculum:

> In year 1 I present a lecture on Down Syndrome where antenatal diagnosis is raised and the decision to have an abortion is discussed as part of the weekly case based learning session. In Year 2 we have an "Interfaith" seminar where a variety of ethical issues (Including abortion) are discussed from differing perspectives, Christian, Islamic and other faiths. Students have another session where they do presentations. In Year 2 we also have a formal law lecture on the Neonate with disability from a lawyer. At the end of year 3 we have an ethics review session and go through a number of differing cases. Students complete an 8 week rotation in Women's Health and abortion and pregnancy are encountered, but probably as a work based experience and quite difficult to quantify exactly what experience each student might have regarding abortion. This topic in the context of our curriculum comes up as an additional issue of a particular topic a number of times during the curriculum rather than as a clearly identifiable seminar on abortion.
>
> (John, 8 July 2013)

The teaching of abortion here recognises that abortion is a complex issue, acknowledging that there are moral, ethical and legal dimensions to abortion practice. Concerning the teaching of the legal dimensions of abortion, Melissa described how the curriculum covers the law in Australia, ethical issues, issues with religion and abortion, autonomy, and consent (Melissa, 9 August 2013). She also noted that "at the end of year 3 we have an ethics review session and go through a number of differing cases that may/may not include abortion depending on the strata of cases chosen" (Melissa, 9 August 2013). However, what this suggests is that abortion does not have a central place within the teaching, as there

is a degree of choice exercised by the teacher as to whether or not it will be dealt with comprehensively.

The teaching of abortion concerning the technical performance of a termination occurs during clinical rotations, much like the institutions discussed in other jurisdictions. However, as John suggests above, it is difficult to quantify the amount of exposure a student has to real abortion cases because clinical rotations concern real patients, and it is hard to predict what patients would present for treatment during a clinical rotation.

Students in this institution are thus taught to consider a wide spectrum of issues associated with abortion, as well as the clinical practice of terminating a pregnancy. Therefore the complexity of abortion highlighted in Chapter 2 by Dworkin (1994), Wertheimer (1971), Hadley (1996), Luker (1984) and Cannold (2000) is dealt with in the education of medical students. This demonstrates that the teaching of abortion in this institution does not reduce the moral and ethical complexity of abortion decisions for doctors; it teaches doctors to navigate both their personal and professional beliefs in the performance of gatekeeping when exercising a decision as to whether or not an abortion can occur.

The description of teaching in Melissa and John's institution also suggests that medical students have varying degrees of exposure to abortion during their tertiary study. However, this is a result of the nature of the medical curriculum rather than students choosing not to participate in the education as was the case in Tom, and Mark and Rebecca's institutions. There are likely to be doctors who have had limited exposure to abortion during their educational years, not as a matter of conscience but because of the nature of clinical practice, that is the degree of probability that certain patients will present for treatment at a particular time. Given this, it is possible that a medical student's abortion education can be constrained by both the impact of conscience (as is the case in Mark and Rebecca's, and Tom's institutions) and the nature of clinical training more broadly (as it is in the case of Melissa and John's institution).

This lack of exposure that a student has to abortion cases during their medical training reinforces the role of the doctor in having to define their own gatekeeping role. It occurs because of the lack of clinical exposure that a student can have to abortion cases rather than being a result of a student's conscience stopping them from participating in the training. Therefore the place of abortion within the medical training domain does not suggest a structured approach to navigating complex issues. Instead, the teaching focuses on individual doctors considering abortion and acting in a way that they believe to be appropriate. The role of gatekeeping can thus be defined by each doctor based on their level of exposure to abortion cases.

Paul

Similar to Melissa and John's institution, the teaching of abortion at Paul's institution in a criminal jurisdiction concerned the clinical performance of abortion and the navigation of ethical and moral issues associated with terminating a pregnancy. There is a course on women and children's health that "encompasses the study and management of all aspects of human reproduction and paediatrics including human sexuality, pregnancy, childbirth, changes in the female reproductive system, assessment of child health, outpatient and community pediatrics, disease recognition and management including study in the areas of: Obstetrics and Gynaecology; Interactional Skills, Clinical Ethics, Integrated basic science, Sexual health, Pediatrics, Perinatal, Infant, Child and Adolescent Mental Health; and Indigenous and multicultural health" (Course materials from Paul's institution, received 31 July 2013). There are two scheduled teaching sessions that specifically deal with abortion: Assessment of fetal abnormality and well-being, counselling for fetal abnormality; and Ethics - termination of pregnancy (Course materials from Paul's institution, received 31 July 2013).

Concerning the ethical components of the teaching:

> Students are required to attend all clinical ethics tutorials. These tutorials will form part of the introductory teaching block and be in the form of group discussions based on prepared hypothetical cases that highlight core ethical and legal issues, and also on role-playing. In addition, students will have the opportunity to raise and discuss any ethical problems that they have encountered in the course of their clinical attachments. Issues that are peculiar to Women and Childrens' Health that

> will be covered include termination of pregnancy; antenatal diagnosis; and the management of mothers with a fetus with known or suspected abnormalities.
>
> (Course materials from Paul's institution, received 31 July 2013)

The teaching in Paul's institution exposes all medical students to the challenges of ethical practice, openly acknowledging that abortion is an ethical issue and one that students must be prepared to engage with. It also provides students with exposure to abortion either through hypothetical scenarios or a discussion of issues they dealt with during their clinical training. There is an emphasis on all students being exposed to abortion education, either through scenarios or real life clinical engagements, unlike those institutions that permit students to remove themselves from the education where they hold a particular view.

Paul also described how this institution teaches the legal situation regarding abortion, in addition to the clinical and ethical elements described above: "as with all medical law, I teach in the context of a medical ethics/moral philosophy/clinical practice framework" (Paul, 10-24 July 2013). He noted that while students are exposed to abortion by the obstetrics and gynaecology teachers, abortion law is not an issue that is specifically addressed, instead stating that medical ethics and health law are integrated into other courses beyond the courses taught by obstetricians (Paul, 10-24 July 2013).

The teaching of abortion law in Paul's institution consists of the following:

> We discuss the fact that abortion is illegal in NSW according to the Crimes Act, but that a common law defence exists, and is interpreted liberally, so that abortion is effectively available 'on demand', at least in early pregnancy. We discuss the fact that the law regarding abortion is no different for later pregnancy, but that the laws about resuscitation of a live born viable infant after induced labour make attempted abortions more complex in later pregnancy, especially in institutions, and we discuss NSW government health policy affecting public hospitals…We discuss the position of doctor as 'gatekeeper' in the context of a doctor who might have a moral opposition to abortion. I suggest to students that the common law defence in NSW makes abortion 'quasi-legal' in our state, and that doctors should be prepared to discuss abortion in a non-judgemental way, and /or to refer appropriately. We also discuss some moral issues and practical issues (eg the differences in first and second trimester abortions, clinically, and the need for foeticide in cases of later abortion in public hospitals).

(Paul, 10-24 July 2013)

Medical students in Paul's institution are thus taught to consider abortion in the context of providing access to terminations rather than restricting it. This is apparent from the use of the phrase 'on demand', suggesting that the law is understood as being grounds for women to access abortions for reasons they determine, rather than a doctor having to assess a woman's request based on a defined set of criteria.

The teaching of abortion here also describes the significance of a 'gatekeeping' role in the context of a doctor's moral position, where students are taught to consider their own moral position and act to reduce the impact of this on women seeking terminations. So while the law requires that doctors perform a gatekeeping role in the criminal jurisdictions by establishing reasons for the performance of an abortion, the teaching of abortion suggests that this should be in relation to the facilitation of access to a termination of pregnancy, rather than inhibiting women from accessing abortions. What this shows is that even though abortion is defined as a criminal act, medical education emphasises the quasi-legal nature of/right to abortion, based on the common law ruling of *R v Wald* (1971) as discussed in Chapter 5, and hence emphasises that women should be permitted to access abortions.

The emphasis on facilitating access for women and reducing the impact of a doctor's moral position on the choices that women make was also suggested in Paul's description of the teaching regarding the application of abortion law:

> I'm not sure that it is appropriate to try to teach too explicitly how a student should apply the term lawful, because, as you know, the field is grey, and changing all the time…My personal feeling is that one shouldn't be trying to make black and white…what we know is not black and white, and so I portray what is grey as...grey. [The point of the presentation given to students in year 1] is to illustrate the way the law works - not to prepare students for practice as gatekeepers of abortion…I revisit the issue in a seminar in Year 4…I do stress however that 'what the law says' does depend, in a *de facto sense*, on what the police and [Director of Public Prosecutions] are prepared to prosecute, and there has been only one prosecution in NSW in 40 years. That prosecution was successful, because the offender made no effort at all (as I understand it) to even create the impression that she was applying the common

> law exception. So, based on the paucity of prosecutions, I suggest to the students that abortion is 'quasi-legal' in NSW; and in that light, that doctors should be prepared to discuss the option with their patients in a non-judgemental way.
>
> (Paul, 10-24 July 2013)

Paul argues that the process of decision-making for a doctor should be negotiated according to a variety of factors, rather than having a doctor execute a decision based on doctrine or specified rules, and/or personal beliefs. The teaching of abortion law in Paul's institution thus acknowledges that whilst doctors hold a gatekeeping role, it is not necessarily a requirement that the role be practiced in a definite way. Paul's specific use of the term 'grey' to describe the application of abortion law signifies that abortion is a situation that is not clear. There are no defined boundaries for the application of abortion law, which is not surprising given that abortion is a complex moral issue, as described in Chapter 2 by Dworkin (1994) and Wertheimer (1971).

In this institution, which is in a criminal jurisdiction, it can be seen that students are taught about the procedure of terminating a pregnancy and the ethical practice of terminating a pregnancy, as well as being exposed to teaching about abortion law. There is an acknowledgement of the distinction between the ethical dimensions of abortion in clinical practice and the legal dimensions, similar to the approaches taken in the decriminalised jurisdictions. What this shows is that there is an acknowledgement within medical training that, irrespective of the legal role of gatekeeping, abortion is a complex ethical problem. The law regarding abortion is thus only one aspect of medical practice concerning abortion, and hence the teaching is focused on the importance of medical professionals being equipped with the principles for decision-making, rather than being taught the authority to apply determinations of lawfulness and assert power over women. This reinforces my observations of the gatekeeping nature of the doctor's role, specifically that is defined by each doctor as they so determine.

Michelle

The teaching of abortion in Michelle's institution occurs primarily in the later stages of the medical degree when students undertake training in perinatal and women's health. It is taught during the course on obstetrics, gynaecology and neonatology. The teaching covers "global abortion issues including legal status;

decisions around unplanned pregnancy; choice of method of abortion; medical abortion and surgical abortion including eligibility, characteristics, side effects; complications; and post abortion care" (Michelle, 13 December 2013). The teaching also covers the law regarding abortion in New South Wales, as well as a short overview of the law in other Australian jurisdictions. Teaching in this context thus concerns both the clinical aspects of abortion and the process for legal decision-making as to whether or not an abortion should be performed.

Michelle felt that the approach to teaching abortion in her institution lacked sufficient exposure to clinical situations, arguing that "practical exposure to clinical situations would be of huge benefit but few abortions are done in hospitals in New South Wales so it is difficult for them to get this exposure" (Michelle, 13 December 2013). So while Michelle's institution does address the process for applying abortion law, the lack of practical exposure to abortion cases means that medical students may not be able to apply their knowledge of the law, nor have sufficient clinical exposure, so as to be able to practice abortion safely.

This is similar to the issues raised in Melissa and John's institution concerning the limitations of medical education as a direct consequence of the nature of clinical practice. Again though, the teaching does not indicate that students are taught any criteria to assess a woman's abortion choice against, instead being taught a range of issues relevant to the clinical treatment of abortion, such as determining the appropriate method for a termination. This suggests that the teaching in Michelle's institution does not intend to restrict women accessing abortions; it aims to educate doctors as to how to perform abortions safely. The gatekeeping role for doctors in this institution is thus taught in the context of it being for the facilitation of access to abortion services, rather than hindering women being able to access an abortion procedure.

Lucy & Jessica

The teaching of abortion in Lucy and Jessica's institution is part of a course on reproduction and neonatal health. The course is part of the curriculum in the fifth year of a medical degree. However, while both Lucy and Jessica taught in the same institution, their perspectives on the adequacy of the teaching for preparing

medical students to practice differed. Lucy's comments focused on the place of abortion within the medical curricula in its entirety, and Jessica described the teaching of abortion in the obstetric and gynaecology domain.

According to Lucy, there was no deliberate teaching of abortion in the curriculum, instead it was an aspect of the teaching of obstetrics and gynaecology:

> Abortion is not included in the curriculum at all until fifth year MBBS (obstetrics-clinical years). I have explored this with the School and it appears that it was in the explicit teaching topics in Med 5 in previous years but now appears to be absent in 2013. Teaching of abortion is now conducted in small groups in unofficial settings.
>
> (Lucy, 24 September 2013)

In this institution, abortion education emerges in the context of the clinical teaching that occurs later in the curriculum, similar to many of the approaches discussed so far across different jurisdictions, such as Michelle, Tom, Mark and Rebecca, and Clare. However, unlike the previous institutions mentioned, Lucy and Jessica's institution does not address abortion outside of the clinical context, and so any education that focuses on decision-making for abortion occurs solely within the clinical domain.

In the clinical elements of the curriculum, students are taught the technical skills necessary to perform an abortion and are also exposed to a range of related issues:

> [Students are taught about] abortion history in Australia and elsewhere; abortion statistics in Australia; the initial consultation with a woman requesting abortion and appropriate counselling; offering of all options for unwanted pregnancy; types of abortion, their merits, disadvantages and risks; informed consent for abortion; followup after abortion; contraceptive advice and provision in conjunction with abortion; importance of safe sex.
>
> (Jessica, 3 September 2013)

The range of issues covered in the curricula suggests that students are exposed to the clinical issues of abortion and elements of the moral dimensions associated in exercising decision-making regarding a termination of pregnancy. Despite this, the teaching does not emphasise the legal role of the doctor as a gatekeeper, instead suggesting that the role of the doctor is to understand abortion and abortion practice as being a necessary part of medical practice. The intent is that the teaching of abortion is not about training doctors as gatekeepers; rather it is to

train doctors as providers of abortion services even though the teaching occurs in a criminal jurisdiction. Therefore, it is not necessary for medical students to be taught how to determine the appropriateness of an abortion procedure because the role of the doctor is to provide access to terminations, rather than stringently regulate access to terminations of pregnancy.

In her description of the teaching of abortion law, Jessica acknowledged that abortion was a legitimate part of medical practice and that the role of the doctor is to facilitate access, rather than limit it: "We also discuss ethical aspects of provision of abortion in particular how doctors with conscientious objections to abortion should manage requests for abortion especially in rural and remote regions where women may find access difficult" (Jessica, 3 September 2013). Jessica then stated that the aim of the teaching is to "get students to understand that all pregnant women regardless of what decision they make about continuing the pregnancy or not deserve expert and sympathetic care" (Jessica, 3 September 2013). This suggests that within her institution, teaching concerning the legal role of the doctor is intended to ensure that doctors can facilitate access to abortion rather than restrict it, which is evident in the emphasis of teaching on the woman's choice regarding her pregnancy. The role of gatekeeping here then is to facilitate access to abortion, not regulate access as implied by the gatekeeping characterisation.

However, despite this degree of exposure that students have to abortion during their clinical training, Lucy argues that a lack of abortion teaching across the medical curriculum from year one means that students are unable to exercise proper decision-making with due recognition of their legal role:

> Students are taught quite a bit about contraception and reproductive care (from first year MBBS - a full semester of teaching on reproductive medicine) but none of this teaching covers the topic of abortion. Students are also taught about ethics (one teaching week in Med 1) and throughout the course in a vertically integrated fashion through problem-based learning. I think that its important to include mention of abortion laws but there is no time in the Med 1 curriculum to do that…Teaching on abortion should be obvious, and a transparent part of the Med 5 curriculum and it is disturbing to learn that this is not currently the case.
>
> (Lucy, 24 September 2013)

Lucy is suggesting that within her institution, the teaching of abortion within the clinical domain during the later parts of the medical degree limits a student's exploration of abortion and the different dimensions that might be applicable to a study of the application of abortion law. It reduces abortion to an obstetric and gynaecological issue. An extensive study of the ethical dimensions of decision-making and the application of abortion law is not available to students. If we consider that the law in the criminal jurisdictions requires that doctors establish reasons for an abortion, then the lack of education potentially places these doctors at risk of legal prosecution. It can also place women at risk because it means that doctors may not be equipped to exercise decision-making in recognition of the law.

Lucy's explanation for why there is such a limited exposure to abortion teaching was that it is demonstrative of a broader trend in the education of medical students whereby the education has, overtime, succumbed to 'political correctness', where the teaching of controversial issues like abortion were sidelined:

> In many respects, medical students are todays' gatekeepers of political correctness. Medical students express no hesitation in reporting an academic who might have offended them. Lectures are recorded, meaning that there is the potential for damaging someone's reputation or the School if offence is caused. Student feedback mechanisms are a powerful force for mainstreaming political views...Any religious view on topics such as 'same sex partners and donor insemination or IVF' and what this means for the 'traditional' family unit are not even considered relevant now in the discourse on reproduction…With regard to abortion, the fact that it is absent from the curricula until 5th year medicine might indicate a fear of causing offence. The offence might be caused to both academics and students.
>
> (Lucy, 24 September 2013)

Lucy's observations here reveal that while abortion is a contentious ethical subject, it is also a controversial subject in the medical curricula of her institution. It can surface as a topic of conflict between those who might advocate for abortion and those who are opposed to it. This is not surprising given that abortion is a moral issue that divides people within the broader society (see Dworkin 1994 and Wertheimer 1971).

Here we also see another use of the term ‘gatekeeper’, applied to the role of students in defining aspects of the scope of education that is presented to them. In some medical institutions (such as Mark and Rebecca’s, or Tom’s), a person’s views on abortion allow them to exclude themselves from aspects of abortion education. Yet, Lucy goes further, claiming that there is a broader cultural trend within medical schools to avoid controversial subjects. She blames this on 'political correctness'. Thus, while the law is relying on the medical domain to shape and define appropriate abortion practice, Lucy claims that there is a trend within some medical schools to marginalise subjects like abortion and thus limit the exposure that students have. The consequence of this is a reliance on the professional judgement of doctors that is not defined by the knowledge they acquire within medical school.

In Lucy and Jessica’s institution, students are taught that the role of the doctor is to facilitate access to abortion, and provide expert care for women whether they choose abortion or not. However, the lack of context for the clinical teaching, specifically ethical training regarding abortion law, indicates that the ethical and legal dimensions of abortion may not be sufficiently dealt with to enable doctors to practice within the confines of the law. Medical students in this institution are thus being taught to draw on their clinical training regarding abortion to exercise decision-making, but this training does not necessarily detail how a doctor might apply the law to ensure that both they and their patients are safe from legal prosecution. Also, the teaching does not specify how a doctor should navigate their own views of abortion and the views of their patients.

What the educational practices in this institution emphasise is that there is an inherent tension between clinical teaching and ethical issues, and that the ethical and moral complexity of abortion is subordinated to the clinical domain. What this means is that the challenge of managing an ethical issue is viewed through the limited prism of the clinical lens. However, as the teaching of abortion in both the criminal and decriminalised institutions has revealed so far, shifting abortion to the clinical domain does not remove the ethical and moral complexity of an abortion decision. It merely creates an environment where the complexity is an issue left to individual doctors to manage in the course of their clinical practice.

Alicia

Unlike Lucy and Jessica's institution, the teaching of abortion in Alicia's institution (also in a criminal jurisdiction) focused primarily on the ethical and legal dimensions of executing a decision in the abortion context. In this institution, there was also some teaching of abortion in the clinical parts of the medical degree, but the teaching of abortion law and the application of the law was primarily in an ethical context rather then being part of the clinical training.

The institution uses a problem-based curriculum for teaching medicine, which focuses teaching on one particular case at a time where "everything a student needs to learn is in a case and each one builds on the next" (Alicia, 2 November 2013). This means that learning is focused on the process of 'navigating' a specific medical case, where students are required to consider all of the clinical, ethical, and legal elements involved to practice as a doctor. In this curriculum, there is always one case that deals specifically with abortion.

In exploring this case of abortion, students are taught to consider their own moral positions and the impact that this might have on decision-making:

> Interestingly, there would be one [case] that was specifically about abortion and abortion law and how it all plays out in practice but there would be another lecture that precedes that, that talks about their own personal values, who is a person, who isn't a person, who is part of my moral community, who is not? When we know these things about ourselves, what do we bring do the decisions we make as doctors and how do these influence things like euthanasia, abortion, ethical contentious issues, things that are about the sacrosanct nature of life if that's what we believe morally. I think that is a pretty important idea to get them thinking about what am I bringing [to the clinical encounter] and why am I reacting the way I do.
>
> (Alicia, 2 November 2013)

Alicia's description suggests that the focus of the teaching in this institution involves students engaging with the morality of decision-making as medical professionals. They are asked to deal with the impact of their own views on the decisions of patients. This type of teaching implicitly deals with the issue of power between a patient and a doctor. It emphasises the need for doctors to consider their own judgements and beliefs, acknowledging that medical professionals bring themselves to the clinical encounter and that they as moral beings, not just as

doctors, can potentially influence the decisions made. The decision-making process for a doctor is thus presented as a careful negotiation of their own values and beliefs regarding certain issues and the choices of patients. This approach is consistent with, or cognisant of, the literature examined in Chapter 2 that argues that the actions of medical professionals can either inhibit or assist women in exercising reproductive choice (see Baird 1990, Joffe 1995, Haigh 2008, Wainer 1972, de Costa 2010, and de Costa et al 2013).

The teaching of abortion in this institution is also based on the premise that the decision-making process for a doctor must involve some consideration of the law. However, Alicia argued that any teaching that considers the legal dimensions of medical practice should enable a doctor to practice safely and protect themselves and their patients, rather than doctors enacting authority over patients. This is an important distinction because from Chapter 2 we encountered arguments that abortion law can subordinate women's choices to the views of the doctor (see Mackinnon 1991). In Alicia's institution, the education of medical students considers that the subordination of a woman's choice to the views of a doctor is not desirable. This ensures that the application of the law is contextualised within the medical domain as a necessary component of a doctor's safe practice. Inclusion of the teaching of abortion law reflects this intention:

> What I am looking for, for them is that when they leave the medical school they can practice as a safe intern, so they need to have a knowledge of what the law is so they can practice safely, and so that they can deliver the level of care required by their patients. They need to know what the law is in Queensland, under what circumstances they might fall on the wrong side of the law, they need to know how they can practice safely within the law. We talk to them about what are the grey areas in the law, what is the law in other states, talk about differences between states. The financial stress of the mother is recognised in some states as being a trigger for [termination of pregnancy] but that is not the case for Queensland. Talk to
>
> them that making a case for abortion in Queensland is about the psychological impact on the mother.
>
> (Alicia, 2 November 2013)

Alicia's description of teaching in this Queensland teaching institution suggests that medical students are not trained to assert power over women, but rather are

taught to focus on exercising decision-making in the context of the law and the health needs of patients. So while the law in the criminal jurisdictions requires that a doctor act as a gatekeeper to women's abortion choices through demanding that reasons are given by doctors to constitute a defence for a charge of abortion, in the educational domain this is deemed to be necessary to protect doctors and their patients from legal prosecution. The emphasis here is for doctors to understand how to establish such lawful grounds.

Alicia elaborated on her rationale for teaching abortion law in the context of safe medical practice, stating that the power held by the medical profession was a consequence of the legal position of the doctor rather than the desire of individual doctors to hold power:

> Doctors have been put in a very uncomfortable position by legislators…to say that a doctor permits or doesn't infers a level of misuse of power that is not actually part of the clinical encounter. And maybe there are some doctors who see it that way but the doctors I know certainly don't. They would say that they are applying the law which is what the legislative assemblies have said is the common morality that the law enacts. It is a very very uncomfortable position for the doctors to be seen as the gatekeeper because that's not how they see themselves, in my experience.
>
> (Alicia, 2 November 2013)

Alicia laments that the power of the medical profession to enact decisions is ascribed by law to the role of doctors, but that doctors do not necessarily wish to be the arbiters of someone else's moral decision. So, while the law requires that women's choices are assessed by a doctor to establish lawful grounds for an abortion, the process of assessment is usually a negotiation between a doctor and a patient to meet the desired outcomes of the patient, while legally protecting the doctor in the process. The power that the law gives doctors is therefore not absolute in the practice of most doctors, according to Alicia. The regulation of women's decisions is then a product of the engagement that occurs between a doctor and their patient, but it does not mean that the doctor is required to regulate women's reproductive choices in a defined way.

What is interesting here is that while the teaching of abortion in this and other criminal jurisdictions might seek to impart on doctors their obligations in performing the role of gatekeeping, some doctors do not see themselves as

gatekeepers. This is also significant given that we saw in Chapter 4 that doctors were influential in framing the law and hence acquiring the role and status of 'gatekeeper'. There is thus a potential disconnect between the legal expectation of gatekeeping and the desire of members of the medical profession to perform, or not perform, a gatekeeping role. This also supports the observations made by Joffe (1995), Wainer (1972), and Haigh (2008) that there is not a homogenous view among the medical profession regarding gatekeeping; the performance will depend on the sentiments that each doctor brings to the clinical encounter.

The teaching of abortion in Alicia's institution reinforces the complexity of abortion and the difficult role that doctors play in balancing the law and the desires of patients. It suggests that the role of gatekeeping is less about the application of specific criteria regarding reproduction and motherhood to a woman's abortion request, but rather about the opportunity for a woman and a doctor to discuss a termination of pregnancy. While the law gives legal authority to a medical professional to arbitrate a woman's abortion choice, this does not *necessarily* equate to a doctor exercising any particular type of moral judgement.

Discussion

The teaching of abortion in the criminal jurisdictions varied from one institution to the next, as did the perscetievs of some of the particpants from within the same institution. However, like the decriminalised jurisdictions there existed a common theme across the curricula. Abortion was taught as a component of clinical training regarding women's and reproductive health, and as an element of training regarding ethical decision-making. Regardless of the training domain however, students' learning emphasised how doctors facilitate access to abortions, defining their own rationale for an abortion in each case. The teaching of abortion in these jurisdictions also contained ethical decision-making taught as an aspect of clinical practice.

What the teaching of abortion in the criminal jurisdictions has revealed is that the application of abortion law is only one element of a doctor's training regarding abortion. The relative significance of its importance within the broader curriculum is also variable. The teaching focuses on equipping medical students with the

principles for executing decisions, rather than being taught the authority to apply determinations of lawfulness and hence assert power over women. What this means for the gatekeeping role is that individual doctors can define how they intend to perform the role.

The teaching of principles to shape decision-making implies that in each abortion scenario, certain factors and characteristics will need to be explored before a decision can be made, and hence the actions of a woman and a doctor will combine to define whether or not an abortion occurs, rather than a doctor executing a decision based on the power they hold through their acquisition of medical knowledge. The decision as to whether or not an abortion should occur is thus determined by the exchange that happens between a woman and her doctor; the doctor holding a legal and professional position does not define it. What this reveals about the role of gatekeeping is that it is a doctor's role to facilitate access to abortions flexibly within the boundaries of the law, rather than to regulate the abortion choices that woman make. The role of gatekeeping then indemnifies the role of the doctor in providing women with access, rather than ensuring that the delegation of the regulatory function to doctors regulates women's choices. So while it was hypothesised in Chapter 5 that the law's reliance on medicine could ensure that the regulation of women's choices occurs despite it not being the law's intent, the education of medical students in the criminal jurisdictions suggests that this is not the case. Instead, in teaching institutions in the criminal jurisdictions, the role of the doctor is defined as respecting the facilitation of women exercising their reproductive rights, and limiting the impact of a doctor's conscience on the choices that women make.

However, given the limitations of clinical training described by Melissa and John, and Michelle, and the context for abortion education described by Lucy, there is always the possibility that medical students may not be sufficiently educated and competent to undertake this particular type of gatekeeping role that the teaching institutes attempt to further. These limitations involve a lack of exposure to clinical cases regarding abortion and thus a lack of context in order to understand how to practice the gatekeeping role. Therefore the intent of the teaching may not translate to the experience that students have with abortion cases, meaning that

the impact of a doctor's conscience can impact on the choices of women depending on how a doctor chooses to practice.

Conclusion

In this chapter I have examined how the education of doctors addressed the legal role of gatekeeping, in particular exploring if medical students were taught abortion law and whether they were taught how to determine the appropriateness of an abortion procedure. This was a necessary avenue for investigation because in Chapter 5 it was revealed that the law protects the role of the doctor in the abortion context, relying on the professional medical judgements of doctors to determine the appropriateness of an abortion procedure. Hence it was hypothesised that the education of medical students would involve how to determine the appropriateness of abortion to facilitate access for women, and thus meet the intent of the law across different state jurisdictions.

The participant sample from which the findings were derived represents senior staff and staff directly involved in teaching medical students from across a range of institutions. This gives substantial weight to the findings presented here as being an accurate reflection of the education that students' receive regarding abortion. However, it should be noted that no student data has been presented and so there is a missing piece in understanding education as a whole, that being that students may not practice what they learn and hence the education may have limited effect on their medical practice. The findings must therefore be taken being representative of the education that students' receive, not as an indication of what students will do when they begin practicing medicine.

What this chapter has shown is that the situation with respect to the education of doctors is highly complex and varied, even beyond jurisdictional issues. The teaching of abortion in the decriminalised jurisdictions demonstrated that, despite the law not requiring that any reasons be established for an abortion to take place, there is still a decision-making role for doctors in defining access to abortion procedures. In the earlier stages of a pregnancy in Victoria and Tasmania, and at all stages in the Australian Capital Territory, a woman's consent justifies a lawful procedure. In the later stages of a pregnancy in Victoria and Tasmania, an

agreement by two doctors that the abortion is necessary given all of the relevant circumstances pertaining to a woman's health justifies a lawful procedure. However, the teaching of abortion in the decriminalised jurisdictions revealed that the moral and ethical complexity of abortion necessitates that medical students be taught about ethical decision-making, and the need to limit the impact of their own personal views on the decisions that women make regarding terminations of pregnancy.

The teaching of abortion in the criminal jurisdictions revealed a similar approach as the decriminalised state jurisdictions to training doctors in the process of ethical decision-making. Here, however, there was a stronger emphasis on doctors understanding how to exercise decisions that facilitate access for women, and at the same time protect doctors from legal prosecution. What is significant here is that while the law requires that a doctor establish reasons to constitute a defence against a charge of abortion, no institution in the criminal jurisdictions taught students how to specifically determine the appropriateness of an abortion. Medical students were taught instead to exercise decision-making that facilitates access to terminations of pregnancy for women based on their health needs, limiting the degree of influence that their own personal views might have on the decisions that women make. Medical students are thus taught about the clinical procedure of terminating a pregnancy, but they are not taught specific criteria or characteristics to determine the appropriateness of an abortion.

What is considered 'appropriate' concerns doctors not allowing their own views to impact on patient choice, but education of this nature was shown to be variable. There were some instances where the moral stance of individual medical students allowed them to exclude themselves from abortion education, and there were other instances where, because of the nature of clinical training, students may not have had the opportunity to partake in abortion education. Thus, despite the emphasis of the training being on the facilitation of access for women, there remains a possibility that access will be impeded because of a lack of training for some doctors.

What this chapter has therefore shown is that it is the individual decision-making capacity of a doctor that defines the role of gatekeeping. The performance of gatekeeping is thus not institutionally defined, but rather it is the responsibility of each individual doctor to negotiate their own moral position and their clinical practice. However, the teaching of abortion in Australian medical schools, regardless of whether the jurisdiction is criminal or decriminalised, emphasises that the decision-making process for a doctor should be driven by the health needs of a woman and not impacted by the personal views of a doctor. This was evident given the emphasis on training doctors in ethical decision-making both within and separate from the clinical domains of teaching. All teaching institutions acknowledged that abortion is a complex ethical problem, irrespective of the established need for legal regulation.

Foucault's description of the law outlined in Chapter 2 as operating "more and more as the norm" (Foucault 2008, 144) is thus challenged by these findings. This is because it is not the law that is being devolved into action by doctors, but rather doctors are given the authority to put power into action as they see fit. What we have observed in the education of medical students regarding abortion is thus only an attempt to put law into action, with greater emphasis being placed on the medical professional being able to make decisions and thus put power into action.

However, there still remains a question as to the extent that individual values impact a doctor's decision-making process, particularly given the ethical complexity of abortion. In the next chapter, this will be tested, exploring the types of decisions that doctors make regarding abortion. The chapter will examine if the purpose of gatekeeping set by the law and the intent of gatekeeping portrayed in the education of medical students also holds in the decisions that doctors make in their medical practice.

Chapter 7

Practicing ‘gatekeeping’: doctors and their approaches to abortion cases

Introduction

My exploration of gatekeeping so far has revealed that the abortion gatekeeping role of the medical profession protects the role of doctors when facilitating access to abortion, allows them to define appropriate abortion practice, and enables them to remove themselves from the clinical encounter where they hold a conscientious objection. In establishing the gatekeeping role, the law is thus relying on the professional medical judgements of doctors to ensure that women can access abortions, and that they deem access to abortion appropriate.

In Chapter 6, I explored how a doctor's professional medical judgement regarding abortion is attained, and I found that a doctor's decision-making capacity relies on an understanding of their professional obligations, to minimise the impact of their personal views regarding abortion on the choices that women make. However, the medical education of doctors also revealed that the capacity of doctors to undertake this task could be problematic, particularly when legal and educational institutions do not determine a doctor's judgement regarding abortion, instead relying on doctors to negotiate their clinical role and their own ethical position. It is also problematic because there are instances in some jurisdictions where doctors may have limited education regarding abortion, and hence the judgements they make are not defined by any knowledge that was acquired during their medical education.

The function of gatekeeping therefore requires that a doctor negotiate their professional obligations with their personal values regarding abortion to limit the impact of their decisions on the capacity of women to exercise their reproductive rights. This means that each doctor should exercise their decision-making according to the situations that they are confronted with, performing the gatekeeping role through acknowledging women's reproductive rights and limiting the impact of personal views on the decisions of others. Thus, a final area for investigation for this thesis to test is *how do doctors actually perform the gatekeeping role* and *do individual values and beliefs influence their abortion decisions?*

In this final empirical chapter, I will explore how doctors perform the gatekeeping role, examining the types of decisions that doctors make and the potential impact that these decisions can have on women seeking to exercise their reproductive rights. The material will be analysed using two operationalising questions: *What reasons do doctors provide for supporting an abortion or not? Are judgements about women's choices made in making a decision to support the request?* These questions form the basis of my analysis in this chapter.

The questions presented above were operationalised using doctor's responses to a series of hypothetical scenarios (except for Scenario 8: Tegan Leach) of women seeking terminations. All women were described as being physically fit to undergo the procedure of terminating a pregnancy, and therefore I was able to explore a doctor's rationale for whether an abortion would be appropriate given the circumstances. The focus here was whether or not the doctor would support the decision to terminate a pregnancy, as opposed to providing a justification for the type of abortion, be it surgical or medical. The circumstances included a woman's age, relationship status, psychological health, religion, culture, and career status, with each case examining different sets of circumstances.

The circumstances were different for each case in order to elicit whether certain characteristics of women would result in different responses, and therefore indicate whether a common set of principles is applied to abortion cases, or whether individual doctors are making a judgement of women based upon specific characteristics of the women. The chapter is structured to consider the responses of each participant around the women presented, with the final case of Tegan Leach (the Queensland woman charged with procuring her own abortion in 2009 - see Chapter 5) drawing together the perspectives of each participant.

It is important to note that the participants discussed in this chapter practiced in both criminal and decriminalised jurisdictions. However, the discussion does not consider how doctors in criminal jurisdictions and/or decriminalised jurisdictions practice their respective gatekeeping roles, because as we know from the previous chapter, approaches to abortion teaching across Australian states and territories emphasise similar themes (that being clinical training and ethical decision-

making), despite the different legal frameworks. This approach was also justified because, as will be shown throughout this chapter, abortion law was a not a factor that was overtly considered in the responses of each doctor to each case. Hence, the observations made in Chapter 6 concerning the relationship between law and medicine as being contextual, rather than directive, in medical training will be shown to apply in medical practice. The table below summarises the participant population.

Participant	**Characteristics**
Anne	Age 40-49, General Practitioner
Deborah	Age 50-59, Gynecology
Beth	Age 50-59, General Practitioner (Women and sexual health)
Samantha	Age 50-59, General Practitioner (Women and sexual health)
Mary	Age 40-49, General Practitioner
Peter	Age 30-39, General Practitioner (Obstetrics and Rural Medicine)

It is also important to understand the limitations of the data presented in this chapter. The scenarios were responded to by a total of six doctors, the majority of which indicated support for abortion and women's reproductive rights. Therefore the sample is not representative and nor was it randomly sampled, meaning that the findings can, at best, be indicative of aspects of gatekeeping but they cannot be taken as being conclusive. In other words, we cannot determine the extent to which individual values and beliefs impact on the clinical encounter at a macro level, only that they could.

7.1 Scenario 1: Rachael

The first hypothetical case was Rachael, a 25-year-old woman who suspected she was pregnant following a night out with friends:

> Rachael is 25 and her period is two months late. She had a pregnancy test three days ago and it confirmed the pregnancy. Rachael has a current boyfriend and has been sexually active with her partner for a number of years. A few months ago, she was out drinking with her girlfriends. It was a big night; so big in fact that Rachael described waking up in the bedroom of a male colleague she had run into the night

> before. Rachael told you that she remembered nothing of the previous night, only that she woke up feeling sore and had bruises on the inside of her legs. Rachael is not sure if she had intercourse with her male colleague, let alone if she consented. She never told her boyfriend and the pregnancy could very well be his. Rachael is considering an abortion.

Four doctors stated they would support the abortion if Rachael felt it was what she wanted. There did not appear to be in any difference in the responses provided by doctors who practiced in criminal or decriminalised jurisdictions, indicating that abortion law was not a substantial factor for the doctors in determining how they would respond to the case. However, the reasons for their decision to support an abortion differed considerably from each other.

Anne stated that she would suggest Rachael have a screen for sexually transmitted infections, as she felt that Rachael was at risk of an infection given what had occurred. She also said that she would counsel Rachael as to the possibility of a paternity test, arguing that the paternity of the baby may be a determinant factor in the pregnancy being wanted or not:

> I would explain to her that it would be possible to determine paternity only if her partner/partners consented to genetic testing and the cost is around $800. Most often women who may have had sex in these circumstances do not wish to discuss this with their long-term partner. I would assist Rachael to access either medical or surgical termination of pregnancy whichever is most acceptable to her.
>
> (Anne, 11 March 2014)

Anne indicated that her previous experience with women in similar situations informed her judgement about Rachael. Also, her response did not overtly address the possibility that Rachael was sexually assaulted.

Mary, on the other hand, did explicitly address the possibility of Rachael being a victim of sexual assault, noting that this would need to be considered in the provision of care:

> I would certainly support her request for an abortion. She does not want a pregnancy and there is a strong possibility that she may have been sexually assaulted, and we would need to discuss this as well, and screen her for sexually transmitted infections. Medical or surgical abortion would be appropriate.
>
> (Mary, 29 May 2013)

Mary indicated that Rachael could seek a termination and that she would support the request. Her response is similar to that of Anne in that she would counsel Rachael as to the risk of a sexually transmitted infection, but she expands on this by showing that the possibility of sexual assault would also need to be considered when providing her with care. The views expressed here indicate a different interpretation of Rachael's case compared with Anne's, in the sense that one overtly addresses the possibility of a sexual assault, but they both, nevertheless, consider the psychological impact of the situation that Rachael had experienced. This reveals that doctors can interpret abortion cases differently, based on how they understand a woman's circumstances. In this instance, the circumstances were not only clinical, using the patient's relationship status and the circumstances of the sexual encounter that lead to her pregnancy as factors for determining treatment. Judgements of women's circumstances leading to an abortion decision are thus part of the clinical encounter, and can impact how a doctor exercises decision-making. What is significant here is that even though two doctors can come up with the same decision about abortion, the rationale for that decision can differ.

While both Anne and Mary considered the sexual encounter in making their decisions, Samantha focused predominantly on clinical elements of the case to determine her approach. However, the clinical factors did not seem to shape whether or not Samantha would support the abortion request. Rather for her, the clinical factors determined the type of abortion that was possible:

> I am assuming from her history that this is an unplanned pregnancy that she does not wish to continue. Hence it is entirely her choice. If her period is 2 months LATE, I would assume she has missed 3 periods and is therefore be at about 12 weeks gestation. The abortion procedure will be surgical if this is the case. However, if ultrasound confirms the pregnancy to be less than 63 days, she could choose a medical option.
>
> (Samantha, 18 June 2013)

Samantha's response to Rachael considered that it is entirely Rachael's choice as to whether or not to terminate a pregnancy, but that the method of termination was a clinical matter defined by the gestation of the fetus. Samantha's performance of the gatekeeping role, in this context, thus supports women's reproductive decisions

regardless of the circumstances or social factors that may have been elements of the rationale for Rachael seeking a termination of pregnancy.

Deborah took a slightly different approach to the case than Anne, Mary, and Samantha, reinforcing the variability in how doctors consider women's reproductive choices. She indicated that it would be necessary to seek additional information from Rachael, and seek greater certainty of the decision to terminate before any agreement as to proceeding with the abortion could be given: "Subject to adequate exploration and certainty re her decision, I would agree to abortion" (Deborah, 2 April 2014). Deborah went on to list the factors that she would encourage Rachael to explore:

> Accurate gestational assessment (ultrasound) may be helpful re timing of conception and therefore likely paternity; would she discuss the situation with her partner and consider paternity testing, which will be a major expense? Would she try to clarify the situation with the colleague? Specialist sexual assault counselling may be helpful with this and other aspects; also consider STI testing and future contraception. Counselling needs to explore Rachael's feelings and wishes in a range of scenarios including how she will feel if she continues the pregnancy unsure of paternity and if she has an abortion.
>
> (Deborah, 2 April 2014)

What Deborah's perspective highlights is that a woman seeking an abortion may need to justify her decision regarding abortion on grounds that the doctor determines to be necessary, rather than grounds that she has defined. Deborah's judgement places Rachael's current and future reproductive health under a stronger medical gaze than the previous doctors, as well as her emotional well-being. In this judgement, the moral and political dimensions of abortion discussed in Chapter 2 (Dworkin 1994, Wertheimer 1971, Hadley 1996, Luker 1984 and Cannold 2000) impact on the experience that a woman has in accessing abortion because of the range of factors that the doctor uses in assessing the woman's circumstances. From this we can ascertain that the role of the doctor in abortion scenarios can challenge a woman's reproductive autonomy. This suggests that the same woman may have a different experience in accessing abortion from one doctor to the next, even though the medical outcome might be the same, that being the termination of the pregnancy.

However, just as it is likely that women can receive abortions despite experiencing different decision-making encounters, it is also possible that they will not receive an abortion based on a doctor's personal ethical views concerning abortion. Peter stated that he would not support Rachael's request for an abortion and that he would be "clear but non-judgemental that referring her for an abortion was against my personal ethics and that I would not do so" (Peter, 14 January 2014). His approach to the case also highlighted the complexity of abortion for women and doctors, in particular the complexity for a doctor in balancing ethical and professional views with the decisions that women make:

> I would be empathetic to her situation since it is a very difficult social circumstance that she is now in. Everyone can get themselves into difficult situations and sometimes people do things that they regret and that can have very far-reaching effects. I would be concerned that she would be coerced into having an abortion and I would wish to emphasise that her choice should be made in true freedom without pressures from boyfriend, family, health/medical workers or society at large. I would have grave concerns for the life of her new baby given the pressures from these sources and the trauma Rachael must be feeling at the moment, which may lead her away from considering the value of the life she has conceived.
>
> (Peter, 14 January 2014)

He concluded that he "would offer ongoing support for all her physical and emotional needs regardless of what her decision was" (Peter, 14 January 2014). Peter's response demonstrates the significance of the morality of abortion for some doctors, morality in this context referring to the status of the fetus, and shows how this can influence their clinical practice. Peter's response is thus indicative of the complexity regarding abortion cases that has been raised throughout earlier chapters in this thesis, because it shows how different moral viewpoints regarding abortion enter the clinical encounter, as well as the personal circumstances of a woman requesting an abortion.

Responses to Rachael revealed a variety of approaches towards an abortion case. Some participants interpreted that Rachael had chosen abortion and thus should be supported, whilst others indicated that Rachael should be given additional support to consider if an abortion was what she wanted. The views given here showed that approaches to abortion can vary between doctors based on their interpretation of the case itself, as well as their views regarding the moral and

ethical aspects of abortion and reproductive autonomy. Each participant exercised decision-making by drawing on their personal and professional knowledge of abortion, combining both in order to make their decision. The responses show that doctors make judgements about women's abortion choices using a complex nexus of information to inform their proposed treatment. Therefore in this context, abortion is an issue that is managed more according to how a doctor views abortion and the value they attach to women's reproductive choices, rather than an interpretation of any legal criteria or regulatory standards. The law is thus relying on the professional medical judgements of doctors, but these judgements can invariably be personally derived rather than medically defined, due to the complex array of factors that doctors need to consider in their decision.

7.2 Scenario 2: Maria

The second hypothetical case was Maria. Unlike the first scenario, Maria was already a mother and part of an existing nuclear family:

> Maria is a senior executive in the public service. She is 45 years old, married and has three children. Her period is three months late, which is not unexpected given she is going through menopause. A pregnancy test confirms she is pregnant. Maria is concerned about having another child late in life. She is aware of potential complications with the pregnancy and the risk of physical and developmental problems with the foetus. Maria is concerned that another child will take away already precious time from her three children. She and her husband are financially stable and could afford another family member, but the emotional toll on her work, family and marriage would be substantial. She does not believe she can have another baby.

In this case the conception of the child occurred in an existing marital relationship, and so the scenario brought variables such as age, current family circumstance, and economic viability into the decision-making process for a doctor.

In their responses, both Mary and Deborah articulated concerns regarding the risk of fetal abnormality and pregnancy for Maria's physical health because of her age. Mary stated

> I would certainly support an abortion. She does not want a pregnancy, and there are significant risks with having a child at her age. I would discuss potential screening tests for chromosomal abnormalities if she wanted to go ahead with the pregnancy,

> but would be happy to refer for termination. She is likely to be too far advanced in this pregnancy for a medical abortion to be appropriate.
>
> (Mary, 29 May 2013)

Mary's view suggests that while a doctor considers clinical issues in making an abortion decision, a woman may also be asked to consider those same clinical elements in making her own determination as to whether or not an abortion is appropriate. Mary's view positioned the abortion decision as being of equal consideration between a woman and her doctor, a decision that would be based on how they both understand certain clinical elements and the value they attach to them, as well as how they understand reproductive autonomy.

Deborah's views also showed how doctors utilise clinical knowledge to exercise abortion decision-making, but in contrast to Mary she introduced the patient's personal circumstance as having an impact on her decision:

> Provide good information about the real risks of continuing the pregnancy and tests available which would inform about fetal problems; offer these if they would make a difference to the decision. Has she discussed/is she willing to discuss with [her] husband? If she is certain that she could not cope with another pregnancy and baby, agree to abortion.
>
> (Deborah, 2 April 2013)

In Deborah's response, it is not clear whether she sees answering the question of the husband's consent as being necessary before proceeding with an abortion, or if this is more about ensuring that Maria feels comfortable with her choice for her family life and her marriage. Regardless, consideration of the husband in Deborah's response reveals a different dimension to the purely clinical approach taken by Mary. Mary and Deborah again reveal how the application of gatekeeping varies between doctors based on how they balance clinical knowledge with the knowledge of a patient's personal life to inform their judgements.

Like Deborah, Beth introduced the patient's personal circumstances in her approach, linking aspects of Maria's life situation to her clinical treatment:

> I would feel quite ok with discussing this situation with [the] patient. I would query whether she had been using any contraception and the reasons why not if that were the case. I would explain the urgency to try to get an idea of how far pregnant she is (scan). This may help her make a decision regarding [termination of pregnancy] or

> not as a lot of women are reluctant to undergo such a procedure after 14-15 weeks as more risk/more developed "baby". Only a surgical procedure would be done if she were around 12 weeks. Does she feel comfortable with having an abortion? Has she had one previously, would she be able to "live with herself" afterwards. I think it is a reasonable option given her age. Has she informed/discussed her husband of result? Would she consider having [termination of pregnancy] without his knowledge if she thought he were against it? If he were anti abortion and she wanted [termination of pregnancy] they would need professional counselling help but time frames may stop this from happening. I would encourage her to speak to a "third party" relative or counsellor as well as husband.
>
> (Beth, 24 July 2013)

Beth's response focused on both Maria's reproductive history and the relationship between Maria and her husband. In this instance, the enactment of legal authority by a doctor, defined as the gatekeeping role, sees a woman answering questions that considers the views of other parties beyond the doctor and the patient. Here again we see the gatekeeping role being defined by a doctor according to their own perception of the patient's life circumstances, rather than the sole basis of a strict application of medical "scientific" knowledge. The general question raised in Chapter 2 following an exploration of Luker (1984) and Cannold's (2000) work (specifically *are doctors influenced by their own views regarding motherhood when exercising abortion decision-making?)* is thus supported by Beth's response, because it shows that a doctor's perception of a patient's family life and their role as a mother can influence the decisions they make.

However unlike Beth, both Samantha and Anne showed that a woman's choice alone in this circumstance can be sufficient to warrant a termination of pregnancy decision by a doctor. According to Anne:

> Maria has clearly thought through the implications on her own life, her family's lives and the potential life the fetus would have. As she is clear about her decision to have a termination of pregnancy, I would assist her by providing surgical termination of pregnancy.
>
> (Anne, 11 March 2014)

Samantha stated "I would support her decision. Her concerns are understandable, and the choice should be hers" (Samantha, 18 June 2013). Samantha and Anne's approaches suggest that in some cases, doctors see their role to be one of

supporting the decisions made by women without needing to assess or scrutinise those decisions.

Peter differed in his approach to that of Samantha and Anne, indicating a similar reliance as Beth on his personal beliefs concerning pregnancy and motherhood. Peter noted that it was against his own ethics to refer for an abortion and that he would not recommend one on that basis, but that he would offer ongoing support for her physical and emotional needs regardless of the decision she made:

> I would be empathetic to her situation and would look for strategies to help her see the positives of the situation. I feel concerned that she may be coerced into having an abortion based on risk factors for developmental and age-related problems and from the medical profession. I am concerned for the life of her new baby given Maria's expressed inability to have another baby and proceed with the pregnancy…I would provide counselling immediately especially regarding positive aspects of pregnancy while also presenting a balanced view of the risks for her.
>
> (Peter, 14 January 2014)

Peter reacted to Maria's situation by seeking to provide information to her on the positive aspects of having another child, describing his role as that of a counsellor. His reaction to the case shows that an individual doctor can potentially exert influence on the decision-making process for women, brought about by their own shaping of the gatekeeping role according to how they choose to balance the desires of their patients and their own views regarding abortion. Peter's response also demonstrates concern for Maria's autonomy, although his treatment of autonomy differs to that of the other participants. Peter believes that Maria's autonomy is likely to have been challenged for her to be seeking an abortion, whereas the other participants have presented a view that the seeking of abortion is the exercising of reproductive autonomy. What this suggests is that doctors can consider multiple ethical dimensions when determining their approach to an abortion case, but that their ethical and moral position will drive how thy interpret and navigate ethical considerations.

Similar to the first scenario, responses to Maria showed variability in how doctors approach abortion cases, variability that can be the result of individual values, different approaches to clinical elements of practice, or the combination of the two, as well as doctors interpreting the case in different ways. Anne and Samantha were

firm that Maria had made a decision and had thought through the implications of the pregnancy, whilst Peter moved to counsel Maria immediately on the positive aspects of a pregnancy that she might not have considered. The other three participants indicated that Maria was yet to make a decision and that more information would be necessary to assist her in making the choice, thereby making their own framework part of the woman's decision-making. Once more, the variability in interpretation of the case shows how doctors engage with women as individuals, and that their own views of what is necessary for informing a woman's decision are likely to influence the clinical encounter, and thus influence their performance of the gatekeeping role.

7.3 Scenario 3: Emma

The third scenario assessed whether the career choices of a woman would have an impact on the decision-making process for a doctor. In this scenario I also sought to test a doctor's possible response to a perception of negligence:

> Emma is as senior associate of a law firm. She is 34 years old and immaculately presented. She wears professional attire and carries expensive accessories. Emma had been to see you several days prior to investigate the source of her late period. She was one month late. During the consultation, Emma stated that she had a phone call from the surgery's nurse advising that her pregnancy test was positive. Before going on to tell you that she was disappointed that the contraceptives you prescribed didn't work, she chastised the surgery for contacting her work and leaving a message. If news of her pregnancy made its way around her law firm she would surely be removed from consideration as a partner. Emma requested an abortion.

Like the two previous cases, responses from participating doctors to Emma varied, highlighting once more that individual interpretations of her case could result in different responses.

Peter, consistent with the two previous scenarios, stated that he would not support Emma's request for abortion due to his own personal ethics. His response focused on the legal aspects of his reasons for not supporting the request, but the legal elements pertained to his own practice rather than being an application of any legal criteria for a lawful abortion:

> This is an intimidating situation with the threat of legal action from a legal professional, regrettable practice action in conveying results, perceived fault of the doctor in providing contraception, and my perceived lack of care for what Emma is requesting. I would attempt to remain calm and caring while addressing each of Emma's issues without coming across as depreciating, inflammatory or judgemental. I have grave concerns for the life of Emma's child which is threatened by her desire to place her career over its life and who appears desiring and able to obtain an abortion… I would be clear to Emma that I would not be referring her for an abortion due to my personal ethics and that I am supported by the AMA and Medical Board of Australia in my conscientious objection. I would offer ongoing support for all her physical and emotional needs regardless of what her decision was. I would offer counselling…but would not refer to services that are known to be pro-abortion… I would offer usual antenatal care and a review appointment, stressing that a decision need not be made immediately.
>
> (Peter, 14 January 2014)

Peter's response reveals how a woman's occupation could influence a doctors' response. In particular, this shows that there are multiple legal and professional frameworks that doctors draw on to exercise decision-making, some of which may bring doctors into conflict with their patients. In this situation the doctor is thus performing a gatekeeping role justified on the basis of their professional codes of conduct, which in this case, supports the right to hold a conscientious objection.

This case again demonstrates the difficult nature of abortion cases for doctors, and in this scenario, the professional status of the woman impacted the extent to which legal considerations would influence the decision made. In this context though, the legal basis for the decision concerns the role of the doctor in exercising decisions that recognise their personal views, rather than the decision being the legal application of principles to enable an abortion to occur. A doctor can thus use abortion law to protect their decision-making capacity, which includes the use of both personal and professional knowledge.

Samantha's response was aligned to that of Peter in that it commented on Emma's professional occupation and her current career situation in relation to her abortion decision. Unlike Peter though, she did acknowledge that should Emma choose an abortion, she would support it:

> Emma may wish to explore her feelings regarding whether she ever wants to have children, and discuss age related decline in fertility that may make it more difficult to conceive naturally in future, and how this might weigh up against the loss or gain of partnership in her firm. If Emma decides that abortion would be the best option, considering circumstances and choices in her life, I would certainly support her decision. If her gestational date is uncertain and ultrasound confirms the pregnancy to be less than 63 days, she could choose a medical or surgical option. If the pregnancy is beyond 63 days, a surgical option will be available.
>
> (Samantha, 18 June 2013)

Samantha's response combined clinical issues regarding fertility and social circumstances, that being the impact of her career on her prospects as a mother. Her response made no mention of the complaint at the doctor's behaviour and incompetence. The clinical aspects of the case pertained to an age-related decline in fertility, but exploration of her feelings regarding future children and her career considered aspects of Emma's current and foreseeable future as a social actor. Samantha's approach indicated that Emma's decision to have an abortion needed to be considered in the context of her not only choosing not to mother at this point in her life, but also whether she would choose not to mother into the future. Both Peter and Samantha's approaches therefore indicate that doctors do consider various facets of a woman's current and future lifestyle and career during the clinical encounter, rather than making a pure assessment of current clinical factors.

Deborah and Beth also considered a variety of factors in Emma's life circumstances in determining how they would approach Emma's case. Deborah introduced a similar focus as Beth on the views of a potential partner asking the question "Does she have a partner and would she consider discussing with him?" (Deborah, 2 April 2014). Beth's views considered the relative place of a partner in the decision-making process, suggesting that the views of a partner may have an impact on the choice Emma has made. Beth's perspective also showed how the prospects of motherhood can impact the decision-making process:

> I would check whether she had a partner and if so whether she had discussed it with him and enquire if she had any future plans for pregnancies. I would discuss what her thoughts had previously been on termination and if this positive result had changed her long held views on abortion. Had she previously had a [termination of

> pregnancy] and if so how had she felt about it afterwards…I have no problem with her having an abortion. When dealing with women such as these it can be very difficult to bring up and discuss alternatives to abortion, as the patient perceives this as you trying to "talk them out of it". But one must raise the issues of continuing with the pregnancy as well as discussing abortion.
>
> (Beth, 24 July 2013)

Beth's final comment indicates that a woman seeking an abortion might not be dissuaded in her choice to abort and may perceive any form of intervention in her decision as attempting to do so, in other words an imposition by a gatekeeper on a woman's rights. Beth's comment that she must raise issues regarding the continuation of the pregnancy, as well as the implications for abortion with Emma, suggests that Beth understands the role of the doctor to present all sides of the abortion argument to ensure that a patient has explored, and considered, all of the possible outcomes. Hence, the protection of a doctor's decision-making capacity under abortion law results in a doctor being able to present a range of possible outcomes. The performance of gatekeeping is therefore defined by the decision-making approaches of doctors, which draws on both their professional and personal experience.

Mary and Anne took a different approach to all views expressed thus far, interpreting the scenario almost entirely on the basis of Emma's right to choose, as opposed to needing to explore her feelings regarding motherhood now and into the future. Both participants also considered the need to discuss Emma's response to the current situation regarding her care. Mary stated

> I would support her request for an abortion, since she does not want a pregnancy. Surgical abortion would probably suit her requirements, as she would no doubt not want a drawn out process, preferring efficient surgical evacuation of the uterus. We would of course need to discuss her complaints regarding the message, and also look into the contraceptive failure, including making sure she understands how to use the pill and what its limitations are.
>
> (Mary, 29 May 2013)

Anne also discussed acknowledging Emma's anger and agreed that her confidentiality should have been protected. Anne's response detailed the need to alleviate some of Emma's anger and ensure Emma felt more in control of her own decision-making process:

> Clearly she is working in a high-pressure situation and is used to being in control of her life and feels her control has been taken away. I would endeavor to make her feel more in control again by focusing on her options in this situation- giving her the choice of medical or surgical termination may help her feel less powerless. I would provide either option for her at this stage.
>
> (Anne, 11 March 2014)

Anne's comments regarding Emma's control over her life suggests that Emma's presentation and her position in a law firm influenced how Anne interpreted the case. The view expressed by Anne suggests that in some circumstances a doctor brings in various judgements of a woman's social, emotional or mental circumstances in order to exercise decision-making regarding abortion.

The views expressed by Beth, Peter, Anne, and Samantha indicated that the professional status of a patient could influence how doctors approach an abortion case. Beth and Deborah indicated that the views of a potential partner might impact the decision-making process, and Mary and Anne situated their approach within the context of Emma's right to choose. Once again, the different views expressed here indicate that the performance of gatekeeping is likely to be a consequence of an individual doctors' interpretation of a patient, as well as the relative significance that they give to patient choice, abortion regulation stipulated by the law, and appropriate abortion practice. This reinforces my earlier claim that the individual values and beliefs of doctors, along with the way they balance these with clinical and other social factors, influence how they undertake the gatekeeping role, resulting in different approaches to treatment for women seeking terminations of pregnancy.

All three scenarios discussed so far have revealed that the age and social status of a woman can have an impact on how doctors perceive their abortion choices. For example, in Scenario 1 there was a suggestion that a paternity test might change Rachael's decision, as well as discussion about the sexual encounter that gave rise to the abortion request. In Scenario 2 there was a different level of significance attached to Maria's choice due to the fact that she was married, hence the questions regarding her husband. In Scenario 2 there was also reference made to her age in the context of a decline in fertility, which was also characteristic of some responses to Scenario 3. What these responses show is that a woman's immediate

and future prospects of motherhood can be part of the clinical encounter, and that doctors negotiate conversations about motherhood drawing on their own clinical experience and their personal values.

7.4 Scenario 4: Sarah

Scenario 4 was designed to explore the impact of age, sexual conduct and career choice as issues encountered in a dialogue between a doctor and a woman requesting an abortion. The occupation chosen for this scenario contrasted with the professional status of the previous case, exploring how views regarding occupational choice entered the clinical encounter:

> Sarah is 19 years old. She works as a street prostitute and has been pregnant at least three times in the last four years. She smells of stale alcohol and sweat. During her initial consultation with you, Sarah revealed that her period was two months late. She believes she must be pregnant because she had unprotected sex with several men over the past couple of months. A pregnancy test four days ago had confirmed the pregnancy. Sarah requested an abortion because she believed a baby would be bad for business.

Samantha's approach to this case concerned Sarah's use of contraception now and into the future:

> It is Sarah's choice, and I would support her decision. I would explore the history and reasons for repeated pregnancies, whether they were planned and what the outcomes were. It may be helpful to empower Sarah with access to Long Acting Reversible Contraception so that she has reliable control over her fertility.
>
> (Samantha, 18 June 2013)

Samantha's response made no reference to Sarah engaging in prostitution, instead exploring how Sarah could reliably control her fertility into the future based on the contraceptive choices Sarah had made in the past. The response revealed how a doctor can engage in the abortion decision-making process to accommodate the current circumstances of the woman, but also prevent future situations where the same woman may need an abortion again. Thus the practice of gatekeeping can be for both the immediate abortion scenario, and future instances where an abortion might be considered.

Unlike Samantha, Mary's response to Sarah revealed a judgement of Sarah's circumstance in relation to her future as a mother: "Clearly it wouldn't just be bad for business, it would be bad for the baby!" (Mary, 29 May 2013). Mary then stated that she would support the request for an abortion, but felt a surgical abortion would be more appropriate because she felt that Sarah was unreliable (Mary, 29 May 2013). Mary did not describe what she meant by 'unreliable', but it is likely that she was referring to a perceived lack of ability on Sarah's part to complete the multiple steps required for a medical abortion, specifically the taking of medication at specified times. The approach suggests that in making her decision as a gatekeeper, Mary made a judgement of Sarah's personal conduct, and the medical treatment she would provide considered her character and circumstances.

Peter and Anne also revealed how a doctor's perception of a patient's lifestyle can influence the approach a doctor takes to a woman requesting an abortion, irrespective of whether or not they support the abortion request. For example, Peter categorically stated that he would not support the request for an abortion, but emphasised his compassion for Sarah because of her difficult lifestyle:

> I feel that in addition to medical management there needs to be social, financial, emotional, psychological and relational support. I have concerns for the baby who has its life threatened due to the work/social position of Sarah, in addition to potential difficulties for the baby being brought into her current life circumstances.
>
> (Peter, 14 January 2014)

Peter's decision involved him providing immediate counselling to Sarah and then referring her for counselling with pregnancy support agencies (Peter, 14 January 2014). His response sought to address her life choices, as well as the immediate abortion request. What this suggests is that the performance of gatekeeping can extend beyond a clinical assessment of the immediate abortion case. The provision of treatment offered sought to address a range of issues for Sarah, including her social circumstances, and the proposed treatment of either an abortion or pregnancy. In this instance, Sarah's capacity to exercise her reproductive rights is constrained by how a doctor has understood her personal circumstances.

Anne's response also showed how beliefs beyond the immediate reproductive health of a woman can enter the clinical encounter:

> Sarah is at significant risk of [sexually transmitted infections] and I would suggest she have a [sexually transmitted infection] screen now and every 3 months…Sarah may well have significant disadvantages in her life and have little social assistance and support. She may well benefit from social assistance and support from our service and other agencies we link in with. It would be worthwhile helping her link in with…peer supports. I would encourage her to have regular health checks. I would talk with her about contraception that may make her life easier such as Mirena. I would provide termination of pregnancy for Sarah and appreciate the challenges she encounters in even being able to get to the centre for her procedure.
>
> (Anne, 11 March 2014)

While Anne did support the abortion, her response also suggested a preventative approach to Sarah's future health predicaments, seeking to engage Sarah in utilising preventative strategies and accessing support agencies. In this case, Sarah would be offered treatment that deals with her sexual conduct, as well as the abortion she is currently seeking.

The participating doctors in this case responded consistently with their responses in the previous three cases, with Deborah stating "As for other cases, explore Sarah's feelings re abortion and continuing pregnancy" (Deborah, 2 April 2013). Anne, Deborah, Peter, and Mary all discussed screening for sexually transmitted infections to varying degrees, but the responses to the actual abortion decision showed different understandings of Sarah's current and future life choices.

In trying to understand the gatekeeping role, we can see from these responses that the regulatory intervention for an abortion can include scrutiny of a patient's whole life, which in this instance included her occupational choice. There is thus the possibility that the gatekeeping role brought about by abortion legislation can include the regulation of not just women's reproductive choices, but their reproductive conduct and personal conduct more broadly. This is not unsurprising given that the law broadly allows doctors to take into account a woman's current and foreseeable future in establishing grounds for an abortion, but it shows the possibility of the extent to which this can occur and the impact that this might have on women seeking abortions.

The gatekeeping role can, therefore, impact on women and their capacity to exercise their reproductive rights, despite the intention of the law to balance the needs of women who seek abortions, the doctors who choose to assist them, and the doctors who choose not to assist them because of their own moral or ethical beliefs. So, while abortion law does not attempt to regulate abortion choices *per se*, the legal role of gatekeeping ensures that this occurs through the requirement that abortions be accessed through the medical profession, and the performance of gatekeeping can equate to some form of scrutiny of the occupational and family choices that women make. What Scenario 4 has thus shown, more so than the previous three scenarios, is that consideration of an abortion request, and the proposed treatment suggested by a doctor, can expand to consider broader issues for a woman's personal circumstance than just those pertaining to the current pregnancy she is facing. The gatekeeping role then can be performed in relation to abortion choices, but it can also address a woman's life situation to improve her future health risks.

7.5 Scenario 5: Jane

The fifth scenario was a woman who presented with significant emotional distress:

> Jane discovered she was pregnant four months ago and she and her partner Bill decided that a baby might be a positive influence on their relationship. Jane and Bill have since separated and their relationship has become emotionally abusive. Jane is overwhelmed at the prospect of becoming a single mother and is becoming depressed at the thought of carrying Bill's child any longer. Jane is seeking an abortion, but is not sure what options are available to her. Jane is 28.

This case explored how a doctor might approach a woman who showed signs of psychological distress later in her pregnancy as a direct result of a relationship breakdown with the father of the child. It sought to explore explicitly how the personal relationships of a patient might impact on a doctor's decision-making process. The gestational time limit of the case was also added so as to understand how gestational limits might alter a doctor's sentiments towards an abortion. This scenario was considered useful because of the role of gestation in establishing certain parameters for terminations of pregnancy under abortion law in Australia in all those jurisdictions where abortion law reform has taken place (Victoria, Tasmania, South Australia, Western Australia, the Northern Territory, and the

Australian Capital Territory), and hence responses to this case help to indicate how doctors understand abortion law.

As with his previous considerations, Peter's response showed significant concern for Jane's emotional well-being. He believed that treating her emotional well-being would see her continue with the pregnancy:

> I would not support referring her for an abortion and would strive to present her all the other options available for women in her situation…I would be empathetic with her situation and would need to ascertain her current mental state and safety. Emotional abuse and depressed mood puts Jane in a vulnerable position in need of emotional/psychological support. I have fears for the baby that its life might be ended due to Jane feeling overwhelmed and unsupported. I have confidence that if these issues were addressed it may well be a good outcome for the baby well into the future.
>
> (Peter, 14 January 2014)

It is not clear from Peter's response what is meant by "all other options" available for women, but he did note in his full response that he would discuss the option of relationship counselling with Jane. The approach drew on alternative methods for managing Jane's request, methods that sought to have Jane continue with the pregnancy. Peter's performance of the gatekeeping role is thus being driven by his personal beliefs in relation to abortion. What is interesting here is that even though Peter holds a conscientious objection to abortion, he chooses to provide medical care to women in situations where abortions are being considered. The legal right to conscientiously object can thus remove a doctor from the performance of abortions, but it does not necessarily mean that doctors who hold conscientious objections will not treat women seeking abortions and hence provide treatment aimed at the continuation of the pregnancy.

Similar to Peter, Anne showed concern for Jane's emotional well-being, but her interpretation of the scenario involved providing Jane with a termination in order to help her gain more control of her life:

> Jane will probably need a fair bit of emotional support as she has little support having now separated from her abusive partner. She may benefit from linking her in with domestic violence supports in the community. It is entirely reasonable that she does not wish to share parenting with abusive Bill and doesn't wish to parent alone.

> I will help Jane to feel more in control of her life again by providing her with a termination of pregnancy and enlisting any other supports available to Jane.
>
> (Anne, 11 March 2014)

Anne's response suggested that she believed an abortion would improve Jane's psychological well-being, whereas Peter believed that emotional and psychological support would see Jane continue with the pregnancy. The difference in interpretation of the case between Peter and Anne was also evident in Anne's use of the word 'abusive', suggesting that Jane be referred to a domestic violence counselling service, whereas Peter indicated that he would discuss the option of relationship counselling with Jane. These two approaches provide contrasting interpretations of Jane's emotional well-being, which lead to different approaches to her treatment. The stark contrast in views shows the different ways that doctors can interpret cases, and the different ways that an abortion can be perceived as being necessary, or unnecessary, for the psychological well-being of the mother. In trying to understand how doctors shape their own gatekeeping role, these responses show how a patient can be impacted differently when seeking treatment from different doctors. Hence while the legal framework for abortion provides authority and protection to doctors, this authority shapes a regulatory intervention defined by each individual doctor that can result in different treatment outcomes for a patient.

Whilst Peter and Anne offered interpretations of Jane's life situation as being factors for consideration in exercising their gatekeeping role, Beth's response revealed how her own views of late term abortions would impact her approach:

> Jane would now be at least 16-18 weeks. I would not feel comfortable with the idea of her having an abortion at this stage unless there were serious fetal malformations. I have rarely been involved in late abortions. There is nothing here locally that would do such a procedure on the grounds described. I would encourage her to talk to a counsellor. This may be someone at the larger termination clinics interstate such as Marie Stopes and may be accessed via telephone initially. I would find out more information from such a clinic and refer her to them for discussion [as to the positives and negatives of the] procedure. She needs to be aware that it is a 2-stage procedure that may involve a "mini labor" and there will be significant financial cost involved and probably emotional cost afterwards.
>
> (Beth, 24 July 2013)

While Beth's response involved qualified support for Jane's request by facilitating access to other care providers, she is clearly uncomfortable about the prospect of being involved in a late-term abortion. Her response also shows that the location in which she practices influences whether or not an abortion can be performed. The suggestion that Jane would need to go interstate is a reflection of the reality of abortion practice where women may be required to travel to different jurisdictions to have abortions either because of legal restrictions in one jurisdiction, or as a consequence of the medical establishment not providing abortions on certain grounds, that being grounds where there is no indication of a significant health risk to the mother or the fetus (see Black, Douglas & de Costa 2015, and de Costa et al 2015 for a discussion regarding access).

Beth's response is the first time where issues concerning access to certain health care providers' abortion services have impacted on a woman's capacity to access an abortion. What this shows is that depending on a woman's location, the capacity of a doctor to perform a lawful abortion will differ. It also shows that the rationale for an abortion may be sufficient in one location but not in another. What this suggests is that even though there may be a legal basis for an abortion, there must also be institutions and doctors willing to perform the termination in order for women to be able to exercise decisions regarding their reproductive future.

The three remaining participants, Mary, Deborah, and Samantha, provided similar decisions in utilising gestation to determine if/where an abortion could be performed, but they assessed the impact of the relevant details differently. Mary stated that Jane needed urgent counselling before making a decision, noting that the abortion could only be surgical, and that she would support the request only after counselling had taken place (Mary, 29 May 2013). Samantha also noted that the abortion would have to be surgical, but her response included a more detailed description of the need for Jane to understand the cost and availability of late term abortions: "If, after discussing the supports that are available to her should she continue the pregnancy and the services available for delayed gestation abortion, she decides that abortion is the best option, I would support her decision" (Samantha, 18 June 2013). Deborah focused on the availability of late term abortions: "Later abortion can be considered if it is within local law and there is a

practitioner willing to perform it, requires specialized service" (Deborah, 2 April 2013). The different approaches taken by Mary, Deborah and Samantha suggest that the gestation of the fetus warrants greater exploration of the abortion request than the previous scenarios, and also consideration of clinical options for abortion later in a pregnancy.

The responses provided here addressed gestational limits and the impact of this on abortion practice to varying degrees, particularly where reference was made to the law and the provision of abortion services during later stages of gestation in certain locations. The doctors' decisions thus show a potential impact of abortion law on abortion practice. However, more importantly, what this scenario adds to our understanding of gatekeeping is an appreciation of the fact that while abortion law can define where abortions can be performed, and the time during a pregnancy when they can performed, the rationale for the procedure might depend on how individual doctors understand abortions in the later stages of pregnancy and the degree of comfort they have in recommending abortions when a woman is in the third trimester. Each doctor, except for Anne, considered gestation in recommending treatment options for Jane, but their individual approaches to her case differed. In particular, the contrast in interpretation of the case between Peter and Anne, regarding how best to improve Jane's psychological well-being, showed the extent of variation that can occur between different doctors, and demonstrated that doctors' understanding of the law and their feelings about abortion choices can influence the decisions they make. This suggests that any form of legal regulation for abortion is subject to how a doctor chooses to apply it.

7.6 Scenario 6: Mica

The scenario of Mica sought to ascertain whether a patient's religion or culture impacts on a doctor's abortion decision:

> Mica is 27 years old. She is currently 3.5 months pregnant. She found out she was pregnant 2 months ago but has been trying to reconcile her religious and cultural views in relation to being a mother. Mica identifies as Muslim. She is not married and lives with her parents. Mica's father is very strict. Whilst Mica does not wish to

> abort the pregnancy, she has come to you seeking an abortion because she feels that as a pregnant unwed woman she will be ostracised from her community.

In this case there was no reference made to the father of the child because the emphasis was on Mica being unmarried in a community where marriage is the accepted norm before a child is conceived. The case portrayed the cultural and religious boundaries that Mica might have to contend with, testing how a doctor might navigate different cultural contexts and the impact that this might have on abortion decisions.

Samantha, while eventually stating that she would support the abortion, said "She does not wish to abort the pregnancy" (Samantha, 18 June 2013). She suggested that Mica is likely to be at risk of negative psychological consequences following an abortion and so felt that dedicated counselling by a culturally sensitive unplanned pregnancy counsellor would be a good resource to engage (Samantha, 18 June 2013). A range of questions were presented by Samantha as being necessary to explore with Mica prior to an abortion taking place, including "is she able to tell her parents? Would they really ostracise her? What supports would she have if she continued the pregnancy? How might she manage the negative attitude of her community?" (Samantha, 18 June 2013). Samantha's approach thus took into consideration the social context of Mica's decision, highlighting how an abortion choice is likely to be impacted by a range of factors for both women and their doctors. Samantha's response is a good example of how doctors need to consider issues beyond their medical training when playing their gatekeeping role.

Peter took a slightly different approach to the case, but nevertheless also considered the religious and cultural elements of the case as being determinant factors for the type of treatment Mica would receive:

> Mica is in a difficult position and I feel both sad and angry that she is under pressure and even coercion to have an abortion. Freedom to choose abortion should be freedom from coercion, otherwise it is not a free choice. I am heartened that Mica appears to want to keep the baby but fearful for her social situation… I would affirm Mica's views on wishing to proceed with the pregnancy and offer her my support if that is what she chooses. I would problem-solve her options including local and non-local support, moving out of home, letting her parents know, how to engage her relationship with the father, etc. This would be more of a brain-storming session and

> we would organise a follow-up appointment once the options have been explored a bit more. I would refer her for culturally-sensitive counselling for both psychosocial and practical purposes. I would not refer to pro-abortion services.
>
> (Peter, 14 January 2014)

Peter's approach emphasised Mica's desire not to abort her pregnancy, particularly given that he would not provide a referral to pro-abortion services. His response also focused on exploring how Mica could be supported to transition away from the community so she could continue with her pregnancy, rather than acknowledge that her desire to terminate could be a consequence of her wishing to remain in the community. This response is another example of how a doctor draws on their own perceptions of motherhood in making decisions as seen in Peter's focus on Mica's role as a prospective parent, as well as his own personal views in executing a decision.

Similar to Peter and Samantha, Deborah outlined her concern for Mica's well-being, suggesting that Mica access expert counselling "to explore her feelings and ambivalence before making a final decision" (Deborah, 2 April 2014). Unlike Peter, but like Samantha, Deborah suggested that abortion could be offered if that was Mica's eventual decision, but she added "Does she have an ongoing relationship with the partner?" (Deborah, 2 April 2014). Whilst there was no further detail provided as to the impact that an ongoing relationship with a partner might have on her abortion decision, the inclusion of the question suggests it might influence it. Even though I designed the scenario in order to test religious and cultural boundaries, the views of the father of the child and the relationship that Mica has with the father were a consideration for Deborah in assisting Mica with her abortion request. It is possible therefore that, regardless of the rationale that a patient presents with, there will be questions from a doctor which seek to understand elements of a patient's life that each doctor perceives to be necessary, including the influence of other parties on a patient's life. This is not surprising given the nature of medical practice, but what the evidence from this thesis reveals is that the perception of what is necessary will differ from one doctor to the next based on their perception of a patient. Hence, it is probable that the experience that a woman has in accessing an abortion will differ from one doctor to the next.

Mary's response problematised the inclusion of other parties in Mica's life in the decision-making process because of her understanding of Mica's reproductive rights:

> I would treat this in the same way as any unwanted pregnancy – it's the woman's choice, although sadly in this case it is more a cultural pressure than her true choice. I would recommend that she have appropriate counselling before deciding.
>
> (Mary, 29 May 2013)

Anne also made no mention of Mica's father or the father of the child in the process for determining access to abortion:

> It would be worth giving Mica the opportunity to discuss her thoughts with a counsellor who is empathetic to her religious perspectives and can assist her to think through her own personal thoughts and religious beliefs versus the fear of how others may interpret her pregnancy. It may be that she has already done this and arrived at the decision to terminate this pregnancy. I would assist and support her and provide an abortion to her.
>
> (Anne, 11 March 2014)

The range of responses provided by the doctors to Mica's scenario revealed different interpretations of the significance of cultural and religious views, but all doctors considered religion as a factor which could present a significant risk to Mica's psychological health. Samantha and Anne made reference to the need for 'culturally sensitive' counselling, whereas Deborah made reference to 'expert' counselling, and Mary suggested Mica have 'appropriate' counselling before deciding. Peter also made reference to 'culturally sensitive' counselling, but he noted that he would not refer to a pro-abortion service.

What Mica's scenario demonstrated was the scope of interventions that women can be subjected to, interventions that involve more than the clinical procedure of terminating a pregnancy. This is consistent with the intention of the law demonstrated from the earlier chapters. In exercising their gatekeeping role, the doctors were carefully negotiating a delicate situation by taking multiple issues into consideration. However, yet again we see from this scenario that this negotiation is subject to how a doctor perceives a woman's circumstance, and so while the proposed treatment may seek to provide holistic care for a woman, the type and quantum of this care is defined by how a doctor personally understands her situation. What this reveals is that irrespective of the law providing women

with the capacity to exercise their reproductive rights, the role of the doctor in exercising decision-making regarding treatment for women seeking an abortion can impact their capacity to do so.

7.7 Scenario 7: Julia

The seventh scenario involved the case of Julia:

> Julia is 42, married and has 4 children. Her husband travels for work and her children are all in primary school. They attend church every Sunday and the children go to the local Catholic school. Julia has never used birth control. Her periods are two months late and she has come to you for assistance. Julia does not believe she is pregnant despite a positive pregnancy test indicating that Julia is two months pregnant. Her last pregnancy was difficult and she suffered post-natal depression. Julia is seeking some kind of medicine to regulate her periods; she believes that she is too old to be pregnant and that stress has caused her periods to stop. She is seeking your advice.

This scenario was designed to explore how a doctor might navigate the decision-making process for a woman whose beliefs exclude her from seeking a termination *per se*. The possibility of this scenario came from a discussion between myself and a mid wife of twenty-odd years who recalled that, occasionally, doctors had provided medical abortions to Catholic women to restore menstruation, not explicitly referring to the treatment as an abortion (see also Baird 1998 for a discussion about the different presentations of how women understand pregnancy and abortion). This approach was taken in order to provide women with abortions without naming the procedure, which in turn helped address the ongoing psychological health of a woman who could not, for religious reasons, partake in contraception or abortion, but could equally not mother additional children. So in effect, Julia is seeking an abortion but is in denial about the pregnancy and what the effect on that pregnancy would be when the menses is restored.

Deborah and Mary noted that Julia needed to undergo specialist counselling regarding the risks of pregnancy, postnatal depression, possible termination, and her religious beliefs. Mary stated

> I'm a little unclear whether she is actually wanting or asking for an abortion. Is she in denial about the pregnancy? Is she actually asking for a medical abortion without

> having to be specific (which would presumably contravene the dictums of the Catholic church). I would clarify all of this and avoid the use of euphemisms with her. She needs counselling regarding all of this. I would support a medical abortion for this lady if this was her desire.
>
> (Mary, 29 May 2013)

Deborah took a similar approach:

> If pregnancy is confirmed, Julia needs expert consultation and advice re risks of pregnancy, further postnatal depression etc and then to consider her options. Abortion could be considered if she wanted this, but there needs to be an alertness to religious beliefs which may affect the long term acceptability of this option to Julia.
>
> (Deborah, 2 April 2014)

Like Mica's case, both Mary and Deborah indicated the likely significance of Julia's religious environment on her capacity to request an abortion and be able to cope with her decision in the future. As Mica's case showed, doctors can consider a patient's values to be important in approaching the abortion decision. This can lead to a doctor recommending against abortion due to the negative *psychological* consequences that could surface, rather than recommending an abortion to address a psychological risk for a woman. Given that, in most Australian state jurisdictions, there needs to be a demonstrable risk to a woman's psychological health for an abortion to be lawful, these responses from Mary and Deborah suggest that the criteria for a 'health risk' applies to women being able to seek abortions, just as it can apply for women not seeking an abortion.

Anne and Beth also acknowledged the likely psychological issues facing Julia as a consequence of her religious beliefs. However, Anne's response indicated that she felt Julia was in denial "due to the drastic implications for her life and her family of an unwanted pregnancy" (Anne, 11 March 2014), whereas Beth suggested that Julia was seeking an abortion but did not wish to call it such (Beth, 24 July 2013). Both participants acknowledged a need to discuss the pregnancy with Julia, with Anne noting that she "may well have depression currently or even a psychosis where [she] is delusional and her mental health needs to be assessed" (Anne, 11 March 2014):

> It may be that Julia needs to tell others that she has irregular periods for fear of how her family and community would react. It may be acceptable to her to take

> Mifepristone and Misoprostol tablets to cause a "miscarriage" and consequently regulate her periods. I would explore her ideas about MA [medical abortion] which in some countries like Pakistan is actually called "menstrual regulation".
>
> (Anne, 11 March 2014)

Beth on the other hand considered surgical abortion to be more appropriate, but felt that an abortion was not in Julia's best interest given her religious beliefs:

> Julia wants to get rid of the pregnancy without calling it an abortion. She has been brainwashed by the church and the society she mixes in that to have an abortion is wrong. It would be very difficult for her to overcome such long held beliefs and I don't think she would be able to go through with a termination of pregnancy. She needs to be convinced that she is definitely pregnant and that there is no such medicine to make her regular again…If she insisted I would refer her for a surgical termination but I don't think it would be in her best interests long term as I don't think that she could cope mentally afterwards in view of her life long indoctrination.
>
> (Beth, 24 July 2013)

While Anne and Beth both acknowledged the importance of Julia's religious beliefs, they differed in the response they offered as gatekeepers to abortion. On the one hand, Anne focused on the social stigma attached to abortion in Julia's religious community, requesting that Julia's feelings regarding medical abortion be explored before proceeding with treatment. On the other hand, Beth focused on the likely psychological impact of a termination for Julia, arguing that it would not be in Julia's best interest for her psychological health, and that referral to surgical treatment would be given only if Julia insisted. What is of interest here for my thesis is the variability of the gatekeeping role, depending on how the significance of religious views is perceived by the gatekeeper.

Julia's scenario also provided insight into how a *doctor's* religious views can influence their perception of an abortion request. For example, Peter articulated a level of comfort with Julia's faith in being able to recognise the importance of human life: "I would be somewhat more reassured that a woman/family with a Christian ethical system may more readily recognise that from the moment of conception a new life has been created and that it should be accorded the same rights as the rest of the human species and not be threatened simply because of chronological age" (Peter, 14 January 2014). Whilst he would not refer Julia for a termination, he would support her afterwards if she chose to seek a termination

and “Given her religious tendency I would explore Julia’s feelings and include this in the context” (Peter, 14 January 2014). Peter’s consideration of a 'Christian ethical system' suggests that the significance that a doctor attaches to a patient's religious beliefs can alter how they perceive a patient, and thus potentially how they approach their gatekeeping role.

Samantha also acknowledged the impact of religious values on the abortion decision-making process, suggesting that Julia might benefit from information on Fertility Awareness Based methods of contraception, a method that “is acceptable to the Catholic Church, and supportive educators and resources are available for couples who wish to use these methods” (Samantha, 18 June 2013). The presence of such services, and the potential for a doctor to refer to these services, indicates that religion is sometimes a factor that impacts on the choices women make regarding abortion, and can affect the decisions that doctors take when confronted with similar scenarios. As was shown in Mica's case, religion is another factor that is part of the decision-making process for abortion.

The inclusion of religion in this case highlights additional issues that can arise for the performance of gatekeeping, namely the application of religious treatment options that are acceptable to the governing bodies of a faith. The law acknowledges that gatekeeping must draw on multiple aspects of a person’s present and future life in order for doctors to perform their regulatory role with respect to access to abortion and reproductive healthcare more broadly. However, what Julia's scenario shows - like the previous scenarios - is that a doctor’s perception of current and future circumstances can vary. Responses to Julia's case showed that some doctors can perform the role of gatekeeping according to their own values and beliefs, and how they respond to the values and beliefs of their patients will sometimes depend on the strength of their own values and beliefs. In other words, how a doctor understands a patient and their life circumstances will include issues pertaining to age, occupation, and social status (as demonstrated in the first six scenarios) but also the relative significance for a doctor of the patient’s religious and cultural beliefs.

7.8 Scenario 8: Tegan Leach

In the final scenario, the participants were asked to provide comment on the case of Tegan Leach, the Queensland woman who was charged in 2009 and tried in 2010 for procuring her own abortion (see chapters 3 and 5; see also Betts 2009 and *R v Leach and Brennan* 2010, QLD District Court 74). Participants were asked specifically to indicate if they would have supported the abortion had Tegan approached them for assistance:

> Tegan was 18 years old. Tegan and her partner discovered she was pregnant. They consulted with their family and friends about the possibility of becoming parents. They decided not to continue the pregnancy. Sergie, Tegan's boyfriend, had his sister send RU486 to them from overseas. Tegan took the pills to induce a miscarriage.
>
> During a routine police search of the couple's home in Mt Sheridan, Cairns (a search which was part of a series of routine police calls to more than 200 dwellings to interview possible witnesses and informants in a murder investigation), police found empty packets of RU486, and painkillers (Betts 2009, 25). Tegan told the police that she had used the drugs to bring about the miscarriage of a sixty-day-old foetus in December 2008 (Betts 2009, 25). Ms Leach was subsequently charged with procuring her own miscarriage; her partner Mr Brennan was charged with supplying drugs to procure an abortion (Betts 2009, 25).

At the time of Tegan's arrest, and during the subsequent trial, the case featured in the media. Tegan was the first woman in Australia thought to have been charged with procuring an abortion in nearly fifty years (Betts 2009, 25). The responses given by participant doctors was consistent with their decisions in earlier scenarios presented in this chapter, and as a result they presented different interpretations of Tegan's case.

Deborah's response to this case was indicative of her previous responses in the sense that it reflected support for abortions, provided that women had considered the request carefully, in particular how they felt about the pregnancy and abortion, and how their personal relationships might be impacted by either a pregnancy or an abortion. She also argued that there was a need to consider the sexual health and behaviour of women in determining a treatment approach. Her responses overall revealed that less intervention was justified in earlier gestation periods because: "As a general principle, abortion by medicine is appropriate in early pregnancy when the options and decision have been considered and there are no

general health matters which affect the choices" (Deborah, 2 April 2014). For Deborah, consideration of the abortion request was thus a private matter for women in consultation with their doctor, with her responses suggesting that the role of the doctor was to ensure that a woman was certain of her choice and that she understood the impact that this might have on her relationships and personal well-being.

While Deborah's approach to gatekeeping involved ensuring the conviction of a woman's decision, Peter's approach drew on his own values and beliefs regarding the morality of abortion and the moral status of a fetus. His responses tended to use more emotive language than the other doctors to describe his reaction to abortion scenarios and abortion law. His views on the Tegan case were thus consistent with all of his responses, specifically that his ethical beliefs would prevent him from supporting an abortion:

> I feel that these were just charges for a law that was written to protect human life…I am angry that our legal system, policy-makers and society have twisted law and opinion around to permit effective genocide. Such a case further forces law and medical involvement towards normalizing abortion and coerces public opinion into considering it a good option…I feel so sorry for people like Tegan and Sergie who felt that killing another human was the right thing to do…I feel intense pain and sorrow for their baby who was killed, and the tens of thousands of other babies in Australia who are also killed each year, mostly for social reasons.
>
> (Peter, 14 January 2014)

Peter's reaction to the case showed that despite legislative changes made in Australia to allow for the lawful termination of a pregnancy, he would not personally support this action. Peter's responses also revealed that he would seek to dissuade women from seeking abortions and refer them to pro-pregnancy counselling services. His performance of the gatekeeping role is thus defined by how he understands the moral significance of abortion and the moral status of the fetus.

Anne's performance of the gatekeeping role in Tegan's case was also a consequence of how she understood abortion and abortion law, but her approach was different to that of Peter. Anne's responses emphasised her role in supporting women to exercise their reproductive rights, and her response to Tegan reflected

the tension between law and medicine concerning what is legally permissible and what is medically possible. Anne argued that medical abortion should be made much simpler with "less obstacles and bureaucratic interference to accessing such safe and effective care" (Anne, 11 March 2014):

> I wouldn't want any young people or women generally to have to go through the experiences of Tegan and Serge. The silver lining to the cloud of their prosecution is that it has legally tested and clarified some of the issues with Medication Abortion.
>
> (Anne, 11 March 2014)

The issues regarding medical abortion to which Anne refers are those issues with Queensland law described in Chapter 5, specifically that the legal protection of a doctor to provide abortions in Queensland had, until 2009, only been for cases where a surgical abortion takes place.

Anne's response to this case thus reflected her broader sentiments towards abortion, specifically that abortion is a necessary part of women's healthcare and that women should be supported to exercise their reproductive rights. In all of the previous cases Anne supported the abortion request, seeking to assist the woman concerned to feel more in control of her reproductive future. Her approaches were in the context of providing support to the woman seeking an abortion, viewing the termination request as a woman's attempt to regain control over her life. Her responses to all scenarios revealed an approach to gatekeeping that seeks to provide access to abortion with minimal interference. Anne thus performs the gatekeeping role by seeking to assist women to exercise their reproductive choices through the provision of an abortion, and offers support strategies in the form of counselling, contraceptive advice, and other educative avenues, all aimed at women regaining and retaining control of their reproductive lives.

Similar to Anne, Samantha's response to Tegan's case was indicative of the inherent tension in the gatekeeping role between law and medical practice. This tension involves the legal expectation of doctors' decision-making and the lived experience of doctors having to negotiate that expectation with the desires of their patients, a tension that we have seen throughout this and the previous two chapters:

> This is a great illustration of the problem with abortion law, with the social stigma that still hangs around the subject of abortion in our community and the difficulty of

> access to safe timely affordable abortion services. The fact that such an anachronistic concept in law can be invoked to cause such trouble to these young people, and that taxpayer money is spent in prosecuting such a case is a sad indictment on our society. It is a trip back in a time warp to the early 20th century and beyond, where the police and illegal abortion were good mates at the nasty game of assuming control over women's bodies. I would certainly support Tegan's decision to have an abortion. I regret that she did not have a simple uncomplicated experience. However, one positive outcome of the trial was the expert evidence that emphasized the good safety profile of RU486.
>
> (Samantha, 18 June 2013)

More than any of the previous scenarios, Samantha's response to Tegan's case clearly articulated her sentiments regarding abortion law and medical practice. Her approaches varied in scope regarding the range of applicable treatment options depending on the situation, but she was broadly supportive of abortion requests, provided that further counselling with the woman had occurred and that the woman was certain of her choice. Samantha's response to Tegan, however, revealed her broader views regarding abortion regulation by the law, and emphasised the complexity of the moral and ethical dimensions of abortion. Samantha saw the prosecution of Tegan's case as illustrative of the problems of the illegal abortion industry, and she suggested that enforcement of current abortion law contradicts current abortion practice. She expressed a strong position in support of legalising abortion, and this view was consistent with the way in which she engaged with the previous scenarios. Importantly, these personal views she held could not but influence the way she performed the role as gatekeeper, being liberal in her advocacy of abortion.

Beth also discussed her general dissatisfaction with current abortion law when considering Tegan's case, stating that at the time the case became public she remembered thinking "that the police should be doing better things with their time than charging this young couple" (Beth, 24 July 2013). She also noted that the case showed how little information there is for women in the public sphere regarding access to terminations and that "people will do desperate things when they don't want to be pregnant" (Beth, 24 July 2013). Her response was similar to that of Samantha, and their views on abortion drove their approach to the gatekeeping role.

In her responses to the previous scenarios, Beth (responses were only provided for Maria, Emma, Jane, and Julia; Sarah, Mica and Rachael were not answered) also consistently referred to the tension between the law and medical practice. In particular, in some cases, a woman would need to be referred to another state for treatment because of the 'realistic' availability of surgical and medical terminations. What Beth's responses showed was that simply because the law provides for abortions, this did not mean that women can necessarily access them. If there are no clinics or doctors willing to provide abortion services, then women will not be able to access terminations of pregnancy. There can thus be a gatekeeping role in abortion law without the doctors being the gatekeepers.

Mary's response to Tegan's case was similar to Beth. She expressed her dissatisfaction with current abortion law and in doing so she also echoed the same sentiments she expressed in her previous responses regarding the role of the doctor to provide access to abortion services so that women can exercise their reproductive rights:

> I was appalled that this case was ever brought to court. I would have thought that the police would have had some discretionary power to avoid that happening. Women have surgical abortions every day in this state, and medical practitioners have been campaigning for some time to allow medical termination, which is available overseas. There is ultimately no difference in outcome between medical and surgical abortions, so to make one method illegal for no good reason is nonsensical. I would have supported this abortion as this was a woman with an unwanted pregnancy.
>
> (Mary, 29 May 2013)

Mary's response showed that despite the nature of abortion law in Queensland, doctors do provide access to the procedure. Her previous approaches all supported a woman's request for an abortion, but in the cases where religion and culture were present (similar to Deborah, Samantha, and Beth), Mary noted the need for counselling before proceeding. Overall, Mary's views show how doctors carefully consider the impact of patient values and belief systems on their abortion choices, just as they can draw on their own belief systems to exercise abortion decision-making.

The reactions of the participants to the case of Tegan aligned with the responses previously provided by each participant. Anne's approach was to support women accessing abortions as a way of helping them to regain control of their lives. Similarly, Mary supported the requests for abortion noting that as it was a woman's choice, then she would assist them. Deborah also supported women accessing abortions, but presented a view that the relationship of the father could be a determining factor in the decision-making process. Samantha and Beth both supported women accessing the procedure, and suggested that more counselling was needed in order to ensure a woman was certain of her choice, while Beth noted that the reality of medical practice would mean that some patients are forced interstate to access the necessary procedure. Peter was not supportive of any abortion request and would not refer to pro-abortion support services, and consistently suggested that pregnancy support counselling was the most appropriate treatment to pursue. He did note that he would support their ongoing treatment regardless of the decision they made.

The summation of each doctor's experiences in being gatekeepers highlights the variability of the gatekeeping role, and how the moral and ethical complexity of abortion shapes how doctors approach abortion cases (see Dworkin, 1994, Wertheimer 1971, Hadley 1996, Luker 1984, and Cannold 2000). This is not surprising given that doctors are social actors who possess a set of moral values. However, what the findings from this chapter show is the extent to which a doctor's views will impact on their medical practice. What we know now about the role of gatekeeping is that doctors are provided broad scope to assist women in facilitating access to abortions, but that the impact of the moral and ethical complexity of abortion means that women can be subjected to a range of treatments as determined by each individual doctor. These interventions will not necessarily impact whether a woman receives an abortion or not; rather they will define if the treatment provided is substantial or not.

Conclusion

The approaches to each of the scenarios by practicing doctors revealed that doctors perform the gatekeeping role in different ways, with variation not only being dependent on their support for abortion but their perception of an

appropriate abortion decision. Variability in decision-making occurred between the doctors as a consequence of doctors interpreting the cases in different ways, attaching different levels of significance to the choices that women make as a consequence of their social status, religion, or culture, and interpreting the impact of the role of others on the decision-making process. The summary of the views discussed in the approaches to Tegan showed that there are similarities in how each doctor approached the different scenarios, but differences between the doctors in their approaches to the same scenario. The variability resulted in some approaches being minimalist in the treatment options presented (ie unobtrusive assent to an abortion), with others requiring substantial counselling and medical testing before the abortion decision could be granted.

These findings demonstrate that doctors perform the gatekeeping role based on how they perceive a patient's personal circumstances, how they perceive the validity of the law and whether the law reflects current medical practice, and how they morally and ethically understand abortion, as well as utilising clinical judgement. The decisions that they make are made on grounds that go beyond purely clinical grounds, and enter into social, economic and ethical realms. The suggestion made in Chapter 2 that the moral complexity of abortion might be apparent within the medical domain as it is apparent across social actors (see Dworkin 1994, Wertheimer 1971, and Hadley 1996) therefore seems to be a valid one, as it is social, economic and ethical grounds that have featured in the doctors' decision-making rationales in this chapter. However, given the relatively small sample size, these findings need to be assessed with caution; what they have shown is the presence of individual values and beliefs in the clinical encounter and the possible implications for women, they cannot be used as the basis for determining the extent to which this occurs or the degree of impact that this has on women trying to access abortion services.

What this final chapter has revealed is that while women might be able to access abortions lawfully, they can be subjected to a range of different treatments that can differ from one doctor to the next. It is thus possible that the same woman could seek an abortion from one doctor with little to no interference in the decision-making process, just as they could experience substantial interference from

another. The legal role of gatekeeping for doctors thus protects the role of the doctor in facilitating access to abortion or removing themselves from the abortion encounter if they hold a conscientious objection, but in doing so it provides capacity for doctors to choose the type of approach, and the scope of that approach, which they consider to be necessary. Based on these findings, the role of gatekeeping is therefore a form of regulation, but it is a weaker form of regulation than that which is legally defined in state and territory legislations because it is necessarily based on the individual approaches taken by doctors.

Chapter 8

Conclusion

This thesis examined the question: *what constitutes the gatekeeping role for abortion in Australia?* The question sought to establish the validity of the use of the word 'gatekeeping' to describe the role of doctors by authors including Cannold (2000, 24-25), Hadley (1996, 187), Douglas (2009, 77-78), and de Crespigny & Savulescu (2004). What was being tested was whether or not there was an actual gatekeeping function being performed, particularly when use of the word 'gatekeeping' implies that doctors perform a regulatory function in relation to women's abortion choices. In this final chapter I summarise my findings and offer some observations about the contemporary gatekeeping role. I also discuss Foucault and gatekeeping, highlighting the significance of this thesis for how we understand the application of Foucault's notion of power. In the concluding section, I examine the proposed changes to the law in New South Wales and Queensland in 2016 and the legislative amendments of the Northern Territory in 2017 to show the utility of my findings. This also highlights future areas of research.

In Chapter 2, the problematic characterisation of gatekeeping for doctors was demonstrated. Using existing literature concerning abortion, and medicine and power to demonstrate the different facets of the abortion problem, the need to empirically examine the role of doctors in this context was highlighted. What the literature claimed was that legal abortion regulation was impacted by a professional struggle of the medical profession to define legitimate medical practice, and either justify restrictive abortion practices or protect doctors who perform abortions (Reagan 1998, Keown 1988, Wainer 1972, Joffe 1995, and Haigh 2008). This regulation of abortion took place against a backdrop of moral and political arguments as to the appropriateness of abortion, including rights to life, women's rights and a woman's capacity to control her reproductive freedom (Dworkin 1994, Wertheimer 1971, Cannold 2000, Luker 1984, Hadley 1996, and MacKinnon 1991).

The literature argued that gatekeeping positions doctors in a role where they can regulate women's reproductive rights, and this thesis set out to examine whether this was the case using literature concerning medicine and power, in particular Foucault (1982), (2010) and (2008), and Freidson (1988), as a lens through which

to further understand the problem. Chapter 2 argued that the involvement of the medical profession in shaping abortion as a medical issue leads to an assumption that a medical intervention is justified, because doctors, as members of a profession, use medical knowledge and apply that legitimised knowledge in their clinical encounters. However, given the social contentiousness of abortion, also identified in Chapter 2 (see Dworkin 1994, Wertheimer 1971, Cannold 2000, Luker 1984, and Hadley 1996), abortion decision-making for doctors was considered to also include moral dimensions, and hence the decisions doctors make may not be on the basis of medical knowledge alone. From this, I hypothesised that the decision-making power of the medical profession as gatekeepers could have an impact on women exercising reproductive rights, not because of the application of medical knowledge *per se*, but rather as a consequence of the decision-making process of doctors being both moral and clinical.

Drawing on Foucault and his approach to studying power, specifically that power only exists when it is put into action (see Foucault 1982, 788), this thesis used three sites of empirical investigation; law, education and medical practice. It sought to explore how the *expectation* of gatekeeping established by the law translated in to the *practice* of gatekeeping by individual doctors when they approached abortion cases. Foucault's understanding of power was thus applied to the notion of gatekeeping, necessitating a research design that spanned multiple sites for investigation. These three sites were set out to reveal the nature of abortion gatekeeping for doctors in Australia, and also indicate what the nature of gatekeeping could mean for women seeking terminations of pregnancy.

Chapters 4 and 5 explored abortion law, examining the history of abortion regulation at law, the legislative debate that gave rise to changes in abortion law, and the current legal frameworks for abortion operating across Australian states and territories. What these chapters sought to understand was how the medical profession became an authoritative entity for abortion law, and the scope of this authority. Chapters 4 and 5 thus established what the legal expectation is for the gatekeeping role. Three primary questions were addressed, *how did the medical profession become the legal authority for abortion? What is the legal framework for*

abortion? *What is the scope of authority for medical professionals over abortion and in what sense is the role regulatory?*

The history of abortion law examined in Chapter 4 demonstrated engagement from the medical profession in shaping abortion as a crime. Through this process the medical profession defined the legitimacy of abortion practice, which was argued by Thomson (2013), Keown (1988) and Reagan (1998) to have given the medical profession grounds for achieving professional status. The result of the medical profession's involvement in defining abortion as a crime meant that a medical understanding of abortion came to hold greater significance than that of any other group's understanding, including women and midwives. The medical profession was thus positioned as the authoritative entity for defining the legitimacy of abortion practice, and hence the authority for shaping what constitutes an appropriate abortion.

However, from my examination of the parliamentary debate that occurred in the Australian states and territories of South Australia, Western Australia, the Australian Capital Territory, the Northern Territory, Victoria and Tasmania prior to the enactment of changes to abortion law between 1968 and 2015, discussed in Chapter 4, we know that the exercise of authority by individual doctors, and hence their capacity to define abortion, pertains to the application of medical knowledge only. This became evident because debates recognised that abortion is a complex moral issue as well as a medical procedure, and that doctors can overstep their medical authority and enter into morality when exercising decisions regarding abortion. In shaping legislation, the gatekeeping role for doctors was thus considered to be legitimate in so far as the exercise of medical authority, which the parliaments considered to be the application of clinical knowledge, and the influence of moral beliefs was to be constrained through the enactment of certain legislative clauses regarding conscientious objection, the need for two doctors as decision-makers, and in some states, an obligation to refer a patient where a conscientious objection is held by a doctor. It was therefore argued in Chapter 4 that abortion law was more about shaping the individual actions of doctors and the maintenance of medical authority than it was about imposing legal regulation on women who choose abortions.

In Chapter 5 this claim was tested further, examining abortion law in each Australian state and territory over the period 1968 to 2015. My exploration of abortion law demonstrated that there is a legal gatekeeping role for doctors in New South Wales, Queensland, South Australia, the Northern Territory, and Western Australia. There is also a gatekeeping role in the Australian Capital Territory, Victoria, and Tasmania, where abortion has been decriminalised, but this is a consequence of abortion being managed solely within the domain of medicine rather than it being a legally defined requirement. In other words, gatekeeping can occur in these decriminalised jurisdictions because of the role of doctors in regulating access to medical procedures, not because there is a role specified by the law for a doctor to regulate abortion in a particular way. What this chapter showed was that abortion law protects the role of the doctor to provide abortion services, relying on the professional judgements of medical practitioners to facilitate appropriate access or alternatively, opt out of the abortion context if they hold a conscientious objection. The law's reliance on the professional medical judgement of doctors to achieve this became the subject for further exploration of medical education and medical practice in Chapters 6 and 7.

The education of medical students was examined in Chapter 6 in order to understand how the medical profession determines the appropriateness of an abortion procedure. What was being examined was whether or not the medical profession defined how the gatekeeping role should be practiced. From this, I wanted to understand how a doctor's medical judgement on abortion was shaped, given that the law relied on such to ensure that abortions are accessible and provided in certain circumstances. The question examined in Chapter 6 was *how does the education of the medical profession address abortion and the legal role of the doctor?*

Chapter 6 found that medical education in Australia is variable. Medical students are taught, to varying degrees in different institutions, about the clinical procedure of terminating a pregnancy and the need to exercise ethical decision-making. They are not taught that there are specific criteria or characteristics of women to determine the appropriateness of an abortion. What is considered to be

'appropriate' in managing abortion cases involves: doctors not allowing their own views to impact on patient choice; being driven by clinical practice; and the health needs of individual women. Chapter 6 also revealed that there are some instances where students can choose not to participate in aspects of abortion education due to their personal beliefs. From this I concluded that it is the individual decision-making capacity of a doctor which defines the role of gatekeeping, rather than it being institutionally defined.

In Chapter 7 I examined the likely consequences for women of this gatekeeping role that is not institutionally well-defined, being shaped by individual doctors. The questions explored were *how do doctors actually perform the gatekeeping role? Do individual values and beliefs influence their abortion decisions?* What Chapter 7 showed was that doctors can perform the gatekeeping role based on how they perceive a patient's personal circumstances (for example religion, culture, marital status, sexual conduct and occupation), how they perceive the validity of the law and whether the law reflects current medical practice, and how they morally and ethically understand abortion, as well as utilising clinical judgement.

The law's reliance on the professional judgement of doctors results in women's choices being scrutinised according to the values and beliefs of doctors. This is not limited to whether or not a doctor supports abortion (whether or not they morally support abortion or are opposed to it), instead it reflects the observations made by Dworkin (1994), Cannold (2000) and Luker (1984) that views on abortion are not binary and are often related to how a person perceives motherhood and women's reproductive rights. So while women might be able to access abortions lawfully, they can be subjected to a range of different queries and then treatments that can differ from one doctor to the next. The legal role of gatekeeping for doctors thus protects the role of the doctor to facilitate access to abortion or remove themselves from the abortion encounter if they hold a conscientious objection, but in doing so it provides capacity for doctors to choose the type of approach, and the scope of that approach, which they consider to be necessary.

From this I can conclude that the gatekeeping role of the medical profession under abortion law is not intended to specify the regulation of women's abortion choices;

rather it operates to protect women in accessing abortion procedures and the doctors that assist them. However, in protecting doctors, the legal gatekeeping role can regulate women's abortion choices because doctors exercise judgment by drawing on their medical training and their own values and beliefs. The law's protection of doctors in the abortion context can thus protect a doctor's decision making moving beyond the medical domain and into the realm of morality. Therefore the hypothesis generated in Chapter 2 (specifically that *the role of gatekeeping is constituted through a range of mechanisms that exist to balance the choices of women with the beliefs and interests of doctors, while indemnifying individual doctors who are involved in the provision of abortion services*), holds on the basis of the findings of my thesis but the indemnification of doctors can impact women in variable ways.

Drawing on these findings we are able to deepen our appreciation of Foucault's concept of *bio-power,* a concept that emerged as being useful for understanding gatekeeping in Chapters 2 and 5. Foucault used the concept of bio-power to describe a transition in societal governance from an overt exercise of power to a more covert form of social regulation (see Foucault 2008, 142-143). In describing this transition Foucault (2008, 142-143) suggested that the form of power in operation was *bio-power*, where power would encompass living beings at the level of life itself; "it was the taking charge of life, more than the threat of death, that gave power its access even to the body". In this context, the overt exercise of power by judicial institutions became subsumed "into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory" (Foucault 2008, 144). The power inherent in law can thus be seen as an overt form of regulation and societal governance, *a defined need for regulation*, and the regulation applied through different social and administrative apparatuses, *a site for regulatory intervention* (see Foucault 2008, 146-147). This site for regulatory intervention is a covert form of power, which when exercised, has the function of regulating social conduct (see Foucault 2008, 146-147).

What the findings of this thesis suggest is that the application of power by doctors at this site of regulatory intervention, that being the exchange between a woman and her doctor, is a matter to which doctors have significant agency. The degree of

agency is not constrained to the application of medical knowledge, and is thus defined as being the application of both medically scientific knowledge and individually professed moralities. Adopting Foucault's concept of bio-power, the translation of abortion law into a continuum of apparatuses, specifically the medical domain, is not the translation of the regulatory function of law into medical practice, rather it defines a regulatory status for a medical professional to exercise decision-making on grounds defined by each individual doctor.

The hypothesis generated in Chapter 2, specifically that *the constitution of gatekeeping in Australia regulates social norms concerning abortion and reproductive choice through the apparatus of medical practice*, is thus not supported by my findings. This is because while the law establishes a role for doctors in regulating women's abortion choices, the intent of the legislature and the teaching of abortion suggests that an abortion case should be driven by the woman's health needs and in many states, her decision alone is sufficient for an abortion to occur in the earlier stages of a pregnancy. The application of knowledge regarding the moral and social dimensions of abortion and reproductive choice therefore is not a direct consequence of the translation of law into medical practice, rather it is an outcome of the negotiation of moral beliefs and medical practice by individual doctors. In other words, gatekeeping can regulate social norms regarding abortion and reproductive choice, but this is not an intended consequence of the legal role of gatekeeping, rather it is a by-product.

These findings were reinforced by the proposed legislative amendments in New South Wales and Queensland in 2016, and the enacted changes in the Northern Territory in 2017, all of which occurred after my period of fieldwork. What they showed was a continued reliance on the medical profession to facilitate access to abortion despite its moral complexity, and that the impact of a doctor's individual values and beliefs on women seeking abortions needed to be constrained.

In New South Wales in August of 2016, Dr Mehreen Faruqi, MLC, introduced a Private's Members Bill to change the law regarding abortion. The Bill, *Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016*, was to establish an Act "to amend certain Acts to repeal offences relating to abortion, to specify a ground of

unsatisfactory professional conduct by a medical practitioner with respect to abortion and to establish exclusion zones in order to prohibit certain behaviour near premises at which abortions are provided" (*Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016)*. The Bill was defeated in the Legislative Council in May of 2017, following a conscience vote of 25 votes to 14. Despite this, the proposed legislation suggested that the gatekeeping role needed to balance the rights of doctors and women, recognising that abortion is both a medical procedure and a complex moral issue.

The parliamentary debate that preceded the conscience vote was characterised by sentiments that were not dissimilar to the observations made in Chapter 4 of this thesis, specifically that, despite abortion being a complex moral issue, it remains an issue that is most appropriately dealt with in the bounds of the medical domain. The Honourable Adam Searle's contribution to the debate reinforced this:

> If we want a civilised society, and I believe most of us do, I believe very strongly that we must ensure access to abortion is appropriately and fairly regulated, and that those services are safe for women. The gateway should be left to women and their doctors only.
>
> (NSW Legislative Council Hansard 11 May 2017)

What this reinforced was that there is a need for a 'gate' to be kept in defining access to abortion and that the role of doctors is pivotal to the function of this gatekeeping. What it also showed though was the status of the woman, in particular the woman's status in defining the gateway in consultation with the doctor. Indeed Mr Searle went so far as to suggest that the regulation of abortion is a necessary element for maintaining a civilised society (see NSW Legislative Council Hansard 11 May 2017), which in this context implies that both doctors and women are constituent entities for ensuring the regulation of abortion and hence ensuring social control of matters that concern reproduction. The proposed changes in New South Wales thus reflected the authority that medicine holds in defining abortion access, but also the significance of women in also being able to shape this access.

The proposed changes also sought to change legislation concerning the conduct of health professionals such that where a doctor who holds a conscientious objection does not refer a patient to another practitioner, then the inaction should be

deemed as constituting unsatisfactory professional conduct (see *Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016*). While this clause drew significant opposition from Members of Parliament (see NSW Legislative Council Hansard 11 May 2017), its inclusion in the proposed suite of reforms suggests that those who initiated the Bill saw the role of the doctor as providing health services, rather than the use of individual morality to determine whether or not a woman can access certain services. The scope of these proposed reforms emphasises the negative consequences for doctors who allow their conscience to impact on a woman's capacity to access an abortion, more so than the legal obligation on doctors to refer a patient in Victoria and Tasmania (see Chapter 5, 'Decriminalised jurisdictions'). The proposed changes in New South Wales thus suggest a desire by some members of parliament to strengthen the focus of abortion law on providing women with access to abortion free from moral scrutiny.

However, these proposed changes fail to recognise that, as my findings have shown, a doctor's views on abortion and the choices women make is defined by a wide range of factors including relationship circumstances, sexual behaviour, career choices, and sexual health. If it is the desire of Australian legislatures to provide women with greater access to abortion services, then the impact of morality on the decisions that doctors make needs to be considered beyond whether or not a doctor holds a conscientious objection. The decision-making process and the impact that this can have on women seeking terminations of pregnancy is central to understanding this process, and given that the law in New South Wales remains unchanged, an examination of these issues, as this thesis has done, could inform the development of a broader policy position on abortion access and the role of doctors in the abortion domain. If this was to occur, there would need to be a consistent approach to the training of medical professionals and a structured decision-making/treatment framework so as to ensure that abortion decisions are driven by the desires of women, and not influenced by the personal views and beliefs of doctors.

A similar passage of abortion law reforms was introduced into the Queensland Parliament in 2016. The Bill, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016*, was withdrawn in February of 2017 after it became evident

that the Bill would be unlikely to succeed (see Caldwell 2017). This was following commentary from a Parliamentary Committee that the bill should not be supported (see Health, Communities, Disability Services and Domestic Family Violence Prevention Committee 2016). The Queensland Attorney-General, Yvette D'Ath, referred the proposed legislative changes to the Queensland Law Reform Commission (QLRC), stating that she would be asking the QLRC "to clarify the existing practices, to look at options the remove the termination of pregnancies by medical practitioners from the [Criminal] Code, and to look at a new framework" (in Caldwell 2017). The Attorney-General went on to state that the Labor Party of Queensland would introduce the new Bill in the next term of government (Caldwell 2017), meaning that law reform is forecasted in Queensland but it is not guaranteed.

The implications of the proposed changes in Queensland are difficult to determine, as the proposed changes were not debated in parliament like those changes proposed in New South Wales. That being said, the comments made by the Health, Communities, Disability Services and Domestic Family Violence Prevention Committee and certain media commentary on the subject of the amendments suggests that the role of medical professionals in determining access to abortions would not differ from the role that doctors have in other Australian states (see Health, Communities, Disability Services and Domestic Family Violence Prevention Committee 2016, and Caldwell 2017). Therefore it is likely that the findings of this thesis with respect to the role of doctors to define a gatekeeping role based on clinical and moral knowledge would be as significant in Queensland as it is in other states and territories., but it will be some time before we are able to appreciate if this might be the case.

Unlike New South Wales and Queensland, proposed legislative changes in the Northern Territory were passed in March of 2017, with the legislation coming into effect on 2 July 2017. The changes were intended to "increase access by women to safe terminations of pregnancy in either of out-of-hospital or within hospital settings, with health practitioners applying evidence-based practice within a framework of professional standards and guidelines relevant to assessment and treatment" (*Termination of Pregnancy Law Reform Bill 2017 Serial No. 15*,

Explanatory Statement). The changes also provided that health practitioners are entitled to hold a conscientious objection, but that there is a corresponding obligation to refer a woman to another practitioner if they hold a conscientious objection (*Termination of Pregnancy Law Reform Act 2017* (NT) s 11).

The law in the Northern Territory is now similar to that of Victoria and Tasmania in the sense that it has removed abortion from criminal law where a medical practitioner is involved and it includes an 'obligation to refer' where a health practitioner holds a conscientious objection. In terms of the gatekeeping role, however, it is similar to the states of Western Australia and South Australia, in retaining the role of the doctor in determining the basis for an abortion, whereas the law in Victoria and Tasmania provides that an abortion can be performed where the woman provides consent up to 24 weeks gestation in Victoria and 16 weeks gestation in Tasmania. The law in the Northern Territory also provides a two-step framework for gestation where a single doctor can determine the appropriateness of the abortion before 14 weeks gestation, and two doctors are needed before 23 weeks gestation (*Termination of Pregnancy Law Reform Act 2017* (NT) s 7, s 8 & s 9). This is different to the other states and territories, where there is no threshold in the Australian Capital Territory, the threshold is 24 weeks in Victoria, 16 weeks in Tasmania, 28 weeks in South Australia, and 20 weeks in Western Australia. There is no threshold in New South Wales and Queensland because the law remains largely unchanged from the wording of the criminal code originating in the United Kingdom in the 1800s. The changes in the Northern Territory are thus representative of the role of gatekeeping for doctors, but in the context of other abortion law reform they show, yet again, how different states and territories define the gatekeeping role and hence indicate the degree of scope for doctors to define their own gatekeeping role.

The legislative changes in the Northern Territory, similar to the other changes made in Australian states and territories from the early 2000s, emphasised changing the law to increase the ability for women to access abortions with minimal effort, brought about by eliminating the previous requirement to have a medical specialist involved in the procedure and for the procedure to be performed in a limited number of locations (see Chapter 5 for a discussion on

access for women in the Northern Territory and also *Termination of Pregnancy Law Reform Bill 2017 Serial No. 15*, Explanatory Statement). The changes were also made to ensure that evidenced-based practice is relied on for exercising decision-making regarding abortions (see *Termination of Pregnancy Law Reform Bill 2017 Serial No. 15*, Explanatory Statement). Therefore, despite the recent legislative changes in the Northern Territory, the law continues to provide a gatekeeping role for doctors to determine the appropriateness of an abortion request. However, as my thesis has consistently pointed out, this role is not institutionally well-defined and is therefore likely to perpetuate the variability in experiences for women seeking abortions that my thesis has identified. A potential area for future research would be to understand the extent to which this occurs, drawing on the experiences of women seeking abortions in the Northern Territory post July 2017 when the law came into effect. This would allow us to understand how different legal approaches yield different outcomes for women, despite the fact that the overall intent of abortion law in most jurisdictions is for increased access to safe abortion services.

Keogh et al's (2017) recent work on the consequences of abortion law reform in Victoria from the perspectives of abortion service providers has paved the way for further research to understand the consequences of abortion law reform. What these authors found was that "law reform, while positive, has failed to address a number of significant issues in abortion service provision, and may have even resulted in a 'lull' in action" (Keogh et al 2017, 18). What this suggests is that despite changes to abortion law, the capacity of women to access abortion services remains a challenge, and when this is coupled with the findings of my research, the capacity of women to access abortions becomes more challenging because of the way in which gatekeeping manifests itself as a representation of both clinical factors and moral decisions. It is therefore necessary to examine both the perspectives of women and the perspectives of doctors in examining the consequences of abortion law reform, ascertaining the extent to which the practice of abortion meets the intent of abortion regulation stipulated at law.

Overall, what this thesis has found is that the gatekeeping role of the medical profession for abortion in Australia is a complex interplay between the law and

medical practice. It has revealed that there is a degree of gatekeeping for women's abortion choices, but this role is neither legally nor institutionally well-defined, instead being shaped by the individual values and beliefs of doctors and their use of clinical knowledge. This thesis has also demonstrated the applicability of a Foucauldian approach to the study of regulation, in particular how, and if, expectations of legal regulation are visible in the encounters that occur between people, in particular, doctors and pregnant women.

Such an approach has broader application beyond the subject of abortion, and indeed presents greater opportunities for research. My approach to studying regulation could be applied to the role of any entity responsible for implementing aspects of the law; the police, social workers, and teachers to name a few. The essential question to drive studies of this nature would be, *to what extent do the decisions of regulatory actors reflect the intent of the legal regulatory framework that establishes their role, and to what extent does this regulate social conduct?* My study of gatekeeping in the abortion context provides preliminary answers that can be tested in other realms of power and decision-making.

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Western Australia

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Participant List

Alias	Research Site	Date	Format
Alicia	Site 2 – Tertiary Institution Educator	2 November 2013	Interview in person
Clare	Site 2 – Tertiary Institution Educator	25 November 2013	Interview via telephone
Lucy	Site 2 – Tertiary Institution Educator	24 September 2013 & 3 October 2013	Asynchronous interview – completed questionnaire
Emma	Site 2 – Tertiary Institution Educator	1 September 2013	Asynchronous interview – completed questionnaire
Jane	Site 2 – Tertiary Institution Educator	1 September 2013	Asynchronous interview – completed questionnaire
Mark	Site 2 – Tertiary Institution Educator	11 October 2013	Interview in person
Rebecca	Site 2 – Tertiary Institution Educator	8 October 2013	Interview via telephone
John	Site 2 – Tertiary Institution	8 July 2013	Material submitted via email
Black	Site 2 – Tertiary Institution	31 July 2013	Material submitted via email
Tom	Site 2 – Tertiary Institution Educator	25 July 2013	Interview via telephone
Michelle	Site 2 – Tertiary Institution Educator	13 December 2012	Interview via phone
Paul	Site 2 – Tertiary Institution	10 – 24 July 2013	Asynchronous interview – email

	Educator		discussion
Melissa	Site 2 – Tertiary Institution Educator	9 August 2013	Asynchronous interview – completed questionnaire
Jessica	Site 2 – Tertiary Institution Educator	3 September 2013	Asynchronous interview – completed questionnaire
Orange	Site 2 – Tertiary Institution	10 September 2013	Material submitted via email
Anne	Site 3 – Practicing Doctors	26 February 2014 & 11 March 2014	Asynchronous interview – completed questionnaire and hypotheticals
Deborah	Site 3 – Practicing Doctors	2 April 2014	Asynchronous interview – completed questionnaire and hypotheticals
Beth	Site 3 – Practicing Doctors	24 July 2013	Asynchronous interview – completed questionnaire and hypotheticals
Samantha	Site 3 – Practicing Doctors	18 June 2013	Asynchronous interview – completed questionnaire and hypotheticals
Mary	Site 3 – Practicing Doctors	29 May 2013	Asynchronous interview – completed questionnaire and hypotheticals
Peter	Site 3 – Practicing Doctors	14 January 2014	Asynchronous interview – completed questionnaire and hypotheticals

Annex A

Call for participants

Ms Jennifer Beattie BA (ANU) MCrimJ (Monash)
PhD Candidate
School of Sociology

0433 654 886
Jennifer.beattie@anu.edu.au

Canberra ACT 0200 Australia
www.anu.edu.au
CRICOS Provider No. 00120C

ABORTION AND THE LAW IN AUSTRALIA – REQUEST FOR RESEARCH PARTICIPANTS

Medical practitioners who have practiced in Australia anytime between 1969 and 2012 are needed to participate in a research project on the topic of abortion law and practice in Australia. Participants will be asked a series of questions on the acquisition of knowledge pertaining to abortion law and practice. Participants will also be asked to respond to a series of hypothetical scenarios in which women have requested an abortion. The research forms part of a PhD in Sociology exploring the relationship between abortion law and abortion practice in Australia.

All information and the identity of participants will be kept in the strictest of confidence. The Human Research Ethics Committee of the Australian National University, Canberra, Australia, has approved the research. The project is supervised by Associate Professor Alastair Greig.

Interviews will be conducted at your convenience, with the possibility of responding to questions via email, or via Skype/telephone if you would prefer.

For more information, please contact the researcher, Ms Jennifer Beattie (Jennifer.beattie@anu.edu.au).

You can contact the research supervisor at:

Associate Professor Alastair Greig, School of Sociology, ANU
Telephone: 02 6125 4913
Email: alastair.greig@anu.edu.au

If there are questions that the supervisor cannot answer, or concerns regarding the conduct of this research, you may also contact:

The Ethics Manager
ANU Human Research Ethics Committee
Australian National University
Telephone: 02 6125 3427
Email: human.ethics.officer@anu.edu.au

Annex B

Participant information form – practicing doctors

RESEARCH INFORMATION SHEET

Title of Project:

"Gatekeepers" of abortion: The medical regulation of abortion in Australia

Period of Investigation:

January 2013 – December 2016

Investigator:

Jennifer Beattie, School of Sociology, Australian National University. This research is being conducted toward a Doctor of Philosophy degree, and is conducted independently by the researcher.

Supervisor:

Associate Professor Alastair Greig, Reader, School of Sociology, Australian National University

Research Topic:

This project seeks to explore the characterisation of the medical profession in Australia as 'gatekeepers' to women's abortions. The project seeks to establish how the construction of the legal gatekeeper was enacted and is maintained, and how this construction shapes the attitudes and perceptions of individual medical practitioners. It is hoped that the information gathered in this project will inform medical professionals of the laws regarding abortion and the various ways that they have changed. It is also hoped that this research will contribute to a broader body of work that explores the nature of governance in relation to the body.

Invitation to participate:

You are invited to respond to a series of questions and scenarios sent to you via an email attachment. You will be provided an opportunity to discuss your responses if you choose via telephone or Skype, at a time convenient to you. You are free to participate or not.

If you agree to participate:

- You will be asked about the length of time you have practiced, where you have practiced and for how long;
- You will be asked about your experience in learning about abortion and the law relating to abortion;
- You will be asked to respond to several hypothetical situations where a woman has requested an abortion;
- You should not refer to any illegal practice in your response;
- Your identity will be kept confidential as far as the law allows and you will not be individually identifiable in the report of the project;
- An alias will be assigned to your responses for storage and publication; and
- You will be given an opportunity to view the thesis following examination.

You are under no obligation to participate in this research. If you decide to participate, even after agreeing you can:

- Opt not to answer any particular question;
- Withdraw from the project at anytime for any reason; and
- Ask questions about the project at any time.

If you decide to withdraw from the project, any/all responses you have provided will be destroyed unless you specify in writing that your responses can be kept.

Use of Data:

The information gained during this project will be analysed by the researcher and presented in summary form in a doctoral thesis. The information may also be used in publications and/or reports concerning abortion law and the medical profession. No participant will be identifiable in any future publication. The data will be kept for a period of five years after publication.

During the course of the investigation, participant contact details will be entered into a database and assigned an alias. This information will be stored in a password-encrypted database. As responses are received, the email attachment will be saved to a password protected computer and assigned an alias. The email will be permanently deleted to ensure confidentiality.

Potential risks:

The nature of the questions asked may cause participants distress as the subject of abortion is sensitive to many. However, you will not be required to provide or justify your personal views on abortion at any stage.

Further, as abortion remains in the criminal codes of all jurisdictions in Australia except Victoria and the ACT, participants are potentially discussing issues of an illegal nature. However, participants will be presented with a series of hypothetical scenarios to respond to, negating the risk of any person providing self-incriminating evidence.

Should participants experience any distress in responding to the questions posed, they are free to cease at any stage and should contact *Lifeline Australia* on 13 11 14.

Contact details:

If you have any questions about the research, I can be contacted on:

Jennifer Beattie, School of Sociology, ANU
Phone: 0433 654 886
Email: Jennifer.beattie@anu.edu.au

If you have questions that I cannot answer, you can contact the research supervisor at:

Associate Professor Alastair Greig, School of Sociology, ANU
Telephone: 02 6125 4913
Email: alastair.greig@anu.edu.au

If there are questions that the supervisor cannot answer, or concerns regarding the conduct of this research, you may also contact:

The Ethics Manager
ANU Human Research Ethics Committee
Australian National University
Telephone: 02 6125 3427
Email: human.ethics.officer@anu.edu.au

Annex C

Letter to heads of medical schools

Australian National University

Sunday 7July 2013

[Address]

Ms Jennifer Beattie BA (ANU) MCrimJ (Monash)
PhD Candidate

School of Sociology

0433 654 886
Jennifer.beattie@anu.edu.au

Canberra ACT 0200 Australia
www.anu.edu.au

CRICOS Provider No. 00120C

Dear [Head of Medical School]

REQUEST TO VIEW COURSE MATERIAL CONCERNING ABORTION AND APPROACH LECTURERS TO DISCUSS THE MATERIAL

I am writing to request access to course outlines, reading lists and teaching staff for subjects taught in your school that relate to abortion.

My name is Jennifer Beattie and I am a PhD Candidate in Sociology at the Australian National University. I am undertaking a PhD project exploring the characterisation of the medical profession in Australia as 'gatekeepers' to women's abortions.

The project seeks to establish how the construction of the legal gatekeeper was enacted and is maintained, and how this construction shapes the attitudes and perceptions of individual medical practitioners. It is hoped that the information gathered in this project will inform medical professionals of the laws regarding abortion and the various ways that they have changed. The research has been the subject of an Ethics Application in accordance with the protocols of the Australian National University, Canberra, Australia.

My project utilises both primary and secondary material. The present request seeks your permission to view course outlines and approach course conveners to discuss the various ways that students are educated about abortion.

I sincerely appreciate your consideration of my request and I look forward to hearing from you.

Yours sincerely

Jennifer Beattie
PhD Candidate

Annex D

Participant information form – tertiary institutions

RESEARCH INFORMATION SHEET

Title of Project:

"Gatekeepers" of abortion: The medical regulation of abortion in Australia

Period of Investigation:

January 2013 – December 2016

Investigator:

Jennifer Beattie, School of Sociology, Australian National University. This research is being conducted toward a Doctor of Philosophy degree, and is conducted independently by the researcher.

Supervisor:

Associate Professor Alastair Greig, Reader, School of Sociology, Australian National University

Research Topic:

This project seeks to explore the characterisation of the medical profession in Australia as 'gatekeepers' to women's abortions. The project seeks to establish how the construction of the legal gatekeeper was enacted and is maintained, and how this construction shapes the attitudes and perceptions of individual medical practitioners. It is hoped that the information gathered in this project will inform medical professionals of the laws regarding abortion and the various ways that they have changed. It is also hoped that this research will contribute to a broader body of work that explores the nature of governance in relation to the body.

Invitation to participate:

You are invited to respond to a series of questions sent to you via an email attachment. You will be provided an opportunity to discuss your responses if you choose via telephone or Skype, at a time convenient to you. You are free to participate or not.

If you agree to participate:

- You will be asked about the length of time you have practiced and the length of time you have been an educator for students of medicine;
- You will be asked about the type of education provided for abortion and the law relating to abortion;
- You should not refer to any illegal practice in your response;
- Your identity will be kept confidential as far as the law allows and you will not be individually identifiable in the report of the project;
- An alias will be assigned to your responses for storage and publication; and
- You will be given an opportunity to view the thesis following examination.

You are under no obligation to participate in this research. If you decide to participate, even after agreeing you can:

- Opt not to answer any particular question;
- Withdraw from the project at anytime for any reason; and

- Ask questions about the project at any time.

If you decide to withdraw from the project, any/all responses you have provided will be destroyed unless you specify in writing that your responses can be kept.

Use of Data:

The information gained during this project will be analysed by the researcher and presented in summary form in a doctoral thesis. The information may also be used in publications and/or reports concerning abortion law and the medical profession. No participant or institution will be identifiable in any future publication. The data will be kept for a period of five years after publication.

During the course of the investigation, participant contact details will be entered into a database and assigned an alias. This information will be stored in a password-encrypted database. As responses are received, the email attachment will be saved to a password protected computer and assigned an alias. The email will be permanently deleted to ensure confidentiality.

Potential risks:

The nature of the questions asked may cause participants distress as the subject of abortion is sensitive to many. However, you will not be required to provide or justify your personal views on abortion at any stage.

Further, as abortion remains in the criminal codes of all jurisdictions in Australia except Victoria and the ACT, participants are potentially discussing issues of an illegal nature. However, participants will be presented with a series of hypothetical scenarios to respond to, negating the risk of any person providing self-incriminating evidence.

Should participants experience any distress in responding to the questions posed, they are free to cease at any stage and should contact *Lifeline Australia* on 13 11 14.

Contact details:

If you have any questions about the research, I can be contacted on:

Jennifer Beattie, School of Sociology, ANU
Phone: 0433 654 886
Email: Jennifer.beattie@anu.edu.au

If you have questions that I cannot answer, you can contact the research supervisor at:

Associate Professor Alastair Greig, School of Sociology, ANU
Telephone: 02 6125 4913
Email: alastair.greig@anu.edu.au

If there are questions that the supervisor cannot answer, or concerns regarding the conduct of this research, you may also contact:

The Ethics Manager
ANU Human Research Ethics Committee
Australian National University
Telephone: 02 6125 3427
Email: human.ethics.officer@anu.edu.au

Annex E

Research consent form

[1]RESEARCH CONSENT

"Gatekeepers of abortion": The medical regulation of abortion in Australia

I have read and understood the Research Information Sheet describing the project mentioned above. I agree to participate as a respondent in the project. I consent to the publication of the findings of the project on the basis that I will not be individually identified in any report of the project, and that confidentiality is preserved. I understand that my responses will be assigned an alias and published under that name.

I understand that my responses may be used in future publications.

I understand that at any time I may withdraw from the project, as well as withdraw any information that I have provided.

I note that this project has been the subject of an Ethics Application in accordance with the protocols of the Australian National University, Canberra, Australia.

Accept ☐ Don't accept ☐

Name:
Date:
Email address:
Telephone number:

[1] Once complete, please return the consent form as an email attachment to Jennifer.beattie@anu.edu.au. Upon receipt, the questionnaire will be forwarded to your nominated email address.

Annex F

Protocol for medical educators in schools of medicine

Part A: Individual Biography

A1. Current age: (20-24) (25-29) (30-34) (35-39) (40-44) (45-49) (50-54) (55-59) (60+)

A2. Sex: Male/Female

A3. Number of years in the profession: _____

A4. Number of years as an educator: _____

A5. Could you tell me about the teaching environment in a medical school?

A6. How would you describe your role?

A7. Do you still practice medicine or would you consider yourself an 'academic' per se?

Part B: Teaching about abortion

B1. At what stage during a medical student's education are they taught about abortion?

B2. Does it form part of a particular course or is it a course of its own merits?

B3. What are the key points students are taught regarding abortion?

B4. Are students taught about the law regarding abortion? Does this include exploring how to apply the law?

B5. How do you feel about the education students are given in relation to abortion and reproductive care? Would you change anything if you could?

Annex G

Protocol for practicing doctors in in Australia – Part 1

Part A: Individual Biography

A1. Current age: (20-29) (30-39) (40-49) (50-59) (60+)

A2. Sex: Male/Female

A3. Length of time as a medical professional in years: _____

A4. In which State/Territory do you currently practice?:_____

A5. Have you practiced in other jurisdictions?__YES/NO_____

A6. What is your area of speciality (i.e general practice, obstetrician, gynaecologist)? _____

Part B: Learning about abortion and your views of abortion law

B1. Do you remember learning about abortion during your tertiary studies? Could you describe that time?

B2. How would you describe your education about abortion? Was it detailed/brief, did it have a central focus?

B3. What do you know about the law regarding abortion? How did you acquire this knowledge?

B4. Do you think that your education regarding abortion was adequate? Do you feel confident in your understanding of abortion law? Why/why not?

B5. In your professional opinion, is abortion law in Australia appropriate? Why/why not?

B6. If you could make any recommendations in relation to abortion law and practice, what would they be?

Thank you for your time so far. Your responses to a series of hypothetical scenarios would be much appreciated. They can be found as the second attachment to my email.

Annex H

Protocol for practicing doctors in Australia – Part 2

Part C: Hypothetical scenarios

INSTRUCTIONS: The following scenarios are descriptions of different women who have either requested an abortion or may be candidates for one. Please read each scenario and provide comments as to whether or not you would support the abortion. Describe how you might react or feel towards the woman. What advice would you give?

Scenarios 1 through 7 are fictional; scenario 8 is based on a litigated case of abortion that occurred in 2009. For the purpose of the scenarios, assume that all women are physically and clinically fit to undergo treatment.

Scenario 1 - Rachael

Rachael's is 25 and her period is two months late. She had a pregnancy test three days ago and it confirmed the pregnancy. Rachael has a current boyfriend and has been sexually active with her partner for a number of years. A few months ago, she was out drinking with her girlfriends. It was a big night; so big in fact that Rachael described waking up in the bedroom of a male colleague she had run into the night before. Rachael told you that she remembered nothing of the previous night, only that she woke up feeling sore and had bruises on the inside of her legs. Rachael is not sure if she had intercourse with her male colleague, let alone if she consented. She never told her boyfriend and the pregnancy could very well be his. Rachael is considering an abortion.

Response:

TYPE HERE

Scenario 2 - Maria

Maria is a senior executive in the public service. She is 45 years old, married and has three children. Her period is three months late, which is not unexpected given she is going through menopause. A pregnancy test confirms she is pregnant. Maria is concerned about having another child late in life. She is aware of potential complications with the pregnancy and the risk of physical and developmental problems with the foetus. Maria is concerned that another child will take away already precious time from her three children. She and her husband are financially stable and could afford another family member, but the emotional toll on her work, family and marriage would be substantial. She does not believe she can have another baby.

Response:

TYPE HERE

Scenario 3 - Emma

Emma is as senior associate of a law firm. She is 34 years old and immaculately presented. She wears professional attire and carries expensive accessories. Emma had been to see you several days prior to investigate the source of her late period. She was one month late. During the consultation, Emma stated that she had a phone call from the surgery's nurse advising that her pregnancy test was positive. Before going on to tell you that she was disappointed that the contraceptives you prescribed didn't work, she chastised the surgery for contacting her work and leaving a message. If news of her pregnancy made its way around her law firm she would surely be removed from consideration as a partner. Emma requested an abortion.

Response:

TYPE HERE

Scenario 4 - Sarah

Sarah is 19 years old. She works as a street prostitute and has been pregnant at least three times in the last four years. She smells of stale alcohol and sweat. During her initial consultation with you, Sarah revealed that her period was two months late. She believes she must be pregnant because she had unprotected sex with several men over the past couple of months. A pregnancy test four days ago had confirmed the pregnancy. Sarah requested an abortion because she believed a baby would be bad for business.

Response:

TYPE HERE

Scenario 5 - Jane

Jane discovered she was pregnant four months ago and she and her partner Bill decided that a baby might be a positive influence on their relationship. Jane and Bill have since separated and their relationship has become emotionally abusive. Jane is overwhelmed at the prospect of becoming a single mother and is becoming depressed at the thought of carrying Bill's child any longer. Jane is seeking an abortion, but is not sure what options are available to her. Jane is 28.

Response:

TYPE HERE

Scenario 6 - Mica

Mica is 27 years old. She is currently 3.5 months pregnant. She found out she was pregnant 2 months ago but has been trying to reconcile her religious and cultural views in relation to being a mother. Mica identifies as muslim. She is not married and lives with her parents. Mica's father is very strict. Whilst Mica does not wish to abort the pregnancy, she has come to you seeking an abortion because she feels that as a pregnant unwed woman she will be ostracised from her community.

Response:

TYPE HERE

Scenario 7 - Julia

Julia is 42, married and has 4 children. Her husband travels for work and her children are all in primary school. They attend church every Sunday and the children go to the local Catholic school. Julia has never used birth control. Her periods are two months late and she has come to you for assistance.

Julia does not believe she is pregnant despite a positive pregnancy test indicating that Julia is two months pregnant. Her last pregnancy was difficult and she suffered post-natal depression. Julia is seeking some kind of medicine to regulate her periods; she believes that she is too old to be pregnant and that stress has caused her periods to stop. She is seeking your advice.

Response:

TYPE HERE

Scenario 8 – Tegan

Tegan was 18 years old. Tegan and her partner discovered she was pregnant. They consulted with their family and friends about the possibility of becoming parents. They decided not to continue the pregnancy. Sergie, Tegan's boyfriend, had his sister send RU486 to them from overseas. Tegan took the pills to induce a miscarriage.

During a routine police search of the couple's home in Mt Sheridan, Cairns (a search which was part of a series of routine police calls to more than 200 dwellings to interview possible witnesses and informants in a murder investigation), police found empty packets of RU486, and painkillers (Betts 2009, 25). Tegan told the police that she had used the drugs to bring about the miscarriage of a sixty-day-old fetus in December 2008 (Betts 2009, 25). Ms Leach was subsequently charged with procuring her own miscarriage; her partner Mr Brennan was charged with supplying drugs to procure an abortion (Betts 2009, 25).

Please describe your reaction to this case, particularly if you would have supported the abortion.

Response:

TYPE HERE