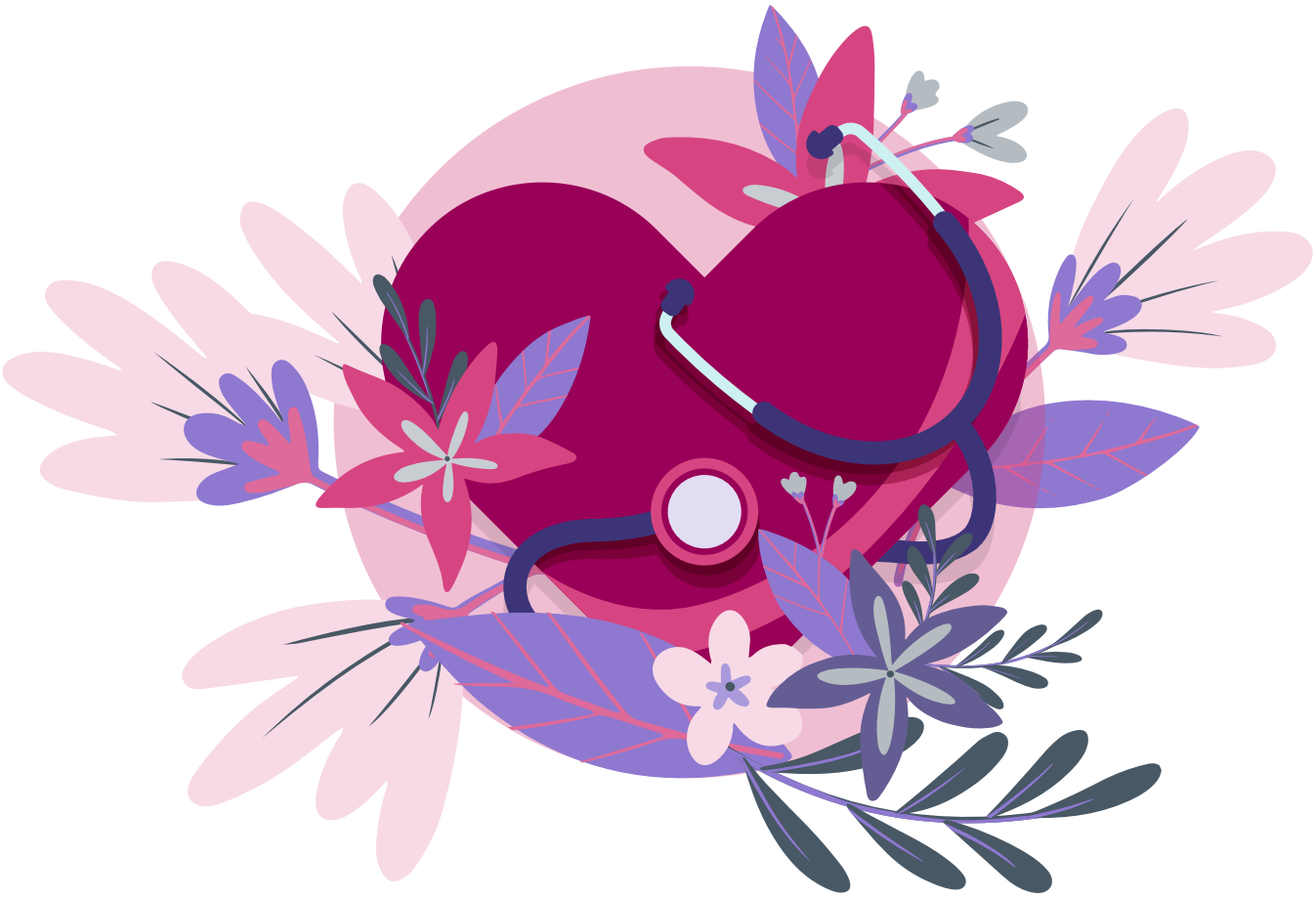
Government of **Western Australia**
North Metropolitan Health Service



Abortion care

Information and legal obligations for medical practitioners

Contents

Introduction

This booklet aims to:

- Increase awareness of the requirements for an abortion in Western Australia;
- Provide an overview of medical risks of both abortion and pregnancy; and
- List options for accessing pregnancy and abortion support services.

Medical practitioners should be aware that:

- Abortion is a safe procedure
- Abortion is legal prior to 20 weeks gestation in Western Australia, providing conditions of informed consent are met
- Abortion is only legal from 20 weeks gestation in Western Australia in specific circumstances; and
- There are two options available for abortion, medical and surgical.

Medical practitioners should also consider:

- Arranging a dating ultrasound scan as soon as possible if there is uncertainty about the date of first day of last normal menstrual period
- Providing an appropriate environment for assessing the pregnant women to ensure as far as possible that no coercion or pressure has been applied; and
- That there is a cost associated with abortion. In situations of financial distress, financial support may be available by referral to the Pregnancy Choices and Abortion Care Co-ordinator at King Edward Memorial Hospital (KEMH)
  KEMH.Referrals@health.wa.gov.au or fax (08) 6458 1031.
  KEMH will contact the patient via telephone and conduct a needs assessment.

Please note that the information in this booklet refers to pregnant women but it is also applicable to other individuals who can become pregnant such as girls and those who are gender diverse.

Abortion and the law in Western Australia

In May 1998, amendments to legislation, including the Criminal Code 1913 and the Health Act 1911, known from 2016 onwards as the *Health (Miscellaneous Provisions)* Act 1911 (WA), enabled the lawful performance of an abortion when:

- The abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and
- The performance of the abortion is justified under section 334 of the *Health (Miscellaneous Provisions)* Act 1911 (WA).

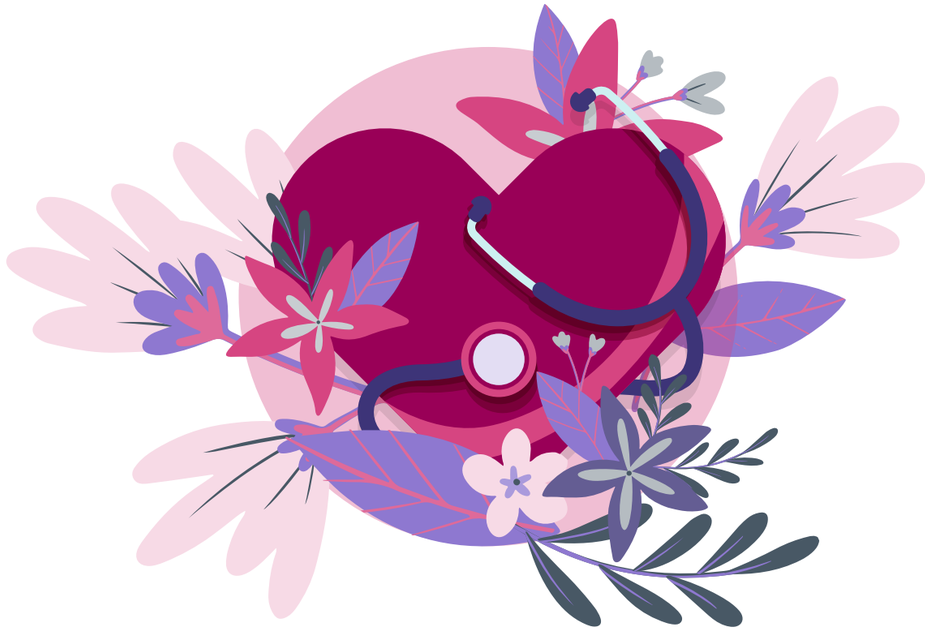
Under section 334 of the *Health (Miscellaneous Provisions)* Act 1911 (WA), the performance of an abortion is justified for the purposes of section 199(1) of the Criminal Code if:

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.



Abortion before 20 weeks

Abortion is available on request before 20 weeks of pregnancy provided that informed consent has been given.

There is always a balance between referral early in pregnancy and allowing sufficient time for decision-making. However, it is important to ensure that women wanting abortion care are referred early, as the risk of complications from the procedure, and costs, rise with increasing gestation.

Abortion from 20 weeks

Section 334(7) *Health (Miscellaneous Provisions)* Act 1911 (WA) states that:

If at least 20 weeks of the woman's pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless:

a) Two medical practitioners who are members of a panel of at least six medical practitioners, by appointment 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 judgment of those two medical practitioners, justifies the procedure; and

b) The abortion is performed in a facility approved by the Minister for the purposes of this section.

If a woman is requesting an abortion which may need to occur from 20 weeks gestation the referring medical practitioner must contact the King Edward Memorial Hospital Pregnancy Choices and Abortion Care Co-ordinator on (08) 6458 2222. The co-ordinator will discuss how to proceed with an application to the panel and facilitate the necessary Maternal-Fetal Medicine assessment or perinatal psychiatry assessment.

Note:

- The referring medical practitioner is still required to obtain the woman's informed consent.
- Abortion from 20 weeks gestation can only be performed at a facility approved by the Minister for Health; these are King Edward Memorial Hospital and Broome Regional Hospital.

Requirements of informed consent

Western Australia's abortion legislation sets out the "informed consent" that a woman must freely give prior to an abortion. A medical practitioner responsible for this "informed consent" cannot also perform or assist with the abortion. This effectively results in two separate requirements, where, after discussion with the first medical practitioner, the woman wishes to proceed with the procedure.

1. The *Health (Miscellaneous Provisions)* Act 1911 (WA) defines informed consent, for this purpose, as consent freely given by the woman where a medical practitioner has:

- properly, appropriately and adequately provided her with counselling about the medical risk of abortion and of carrying a pregnancy to term; and
- offered her the opportunity of referral to appropriate and adequate counselling about matters relating to abortion and carrying a pregnancy to term; and
- informed her that appropriate and adequate counselling will be available to her should she wish it, following an abortion or after carrying the pregnancy to term.

If the woman does not provide informed consent as above, no referral should be made.

Medical practitioners should note that the term 'counselling' in this case is synonymous with providing information; it is not psychological counselling to assist with decision-making about pregnancy choices. Although many doctors would see supportive counselling as part of their role, it is not a legal requirement in relation to informed consent.

- This booklet provides information to assist in properly, appropriately and adequately providing her with counselling on risks related to pregnancy and abortion; see 'Abortion and Pregnancy information' below.
- Information is also provided on organisations funded to provide unintended pregnancy counselling at no cost to the woman, should she decide to take up the offer of referral to counselling. See a list of providers in the Resource section at the back of this booklet under 'Unplanned pregnancy counselling'.
- Many medical practitioners may provide counselling themselves but are also obliged to offer the opportunity of referral. Whether or not such an offer is taken up is a matter for the woman, i.e. she does not have to be counselled elsewhere in order to meet the requirements. A brief guide outlining the principles of counselling can be found on page 28 of this booklet.

2. The second medical practitioner must not perform an abortion unless they are satisfied that the woman has given informed consent (as understood at common law) to the procedure. That is, consent must be voluntary (the decision must be made without duress or coercion); the person giving it must have capacity to give it; it must be informed (with discussion of maternal risks); it must cover the procedure to be performed, and it must be current. A woman may withdraw her consent at any time prior to the procedure being performed. More detail can be found at the Consent to Treatment Policy.

Capacity to consent

Section 334(4) of the *Health (Miscellaneous Provisions)* Act 1911 (WA) provides that where it is impracticable for a woman to give informed consent, the performance of an abortion will be justified (without such consent) if, and only if:

- serious danger to the physical or mental health of the woman concerned will result if an abortion is not performed; or
- the pregnancy of the woman concerned is causing serious danger to her physical or mental health.

The informed consent required under s.334 *Health (Miscellaneous Provisions)* Act 1911 (WA) can only be given by 'the woman concerned', unless it is impracticable as stated above. This means that a guardian, even where formally appointed under the Guardianship and Administration Act 1990 (WA) to make treatment decisions on behalf of a woman, cannot provide the required consent on behalf of the woman (see the decision of the State Administrative Tribunal (SAT) - KS and CL 2015 WASAT 9). Note, however, that a person's capacity can vary depending on the proposed treatment. Depending on the facts of a case, a woman may not have capacity in respect of some treatment decisions, but the SAT, in examining all the facts of the case, may determine she has sufficient capacity to provide informed consent in relation to a proposed abortion.

Accordingly, if a medical practitioner is faced with a situation where an abortion is proposed for a woman who potentially lacks decision-making capacity, it is recommended that the medical practitioner seeks urgent legal advice or, in the case of adults, makes an urgent application for a hearing at SAT (for SAT to review the decision-making capacity of 'the woman concerned').

Dependant minors

Section 334(8) of the *Health (Miscellaneous Provisions)* Act 1911 (WA) states:

8. For the purposes of this section —

a) subject to subsection (11), a woman who is a dependant minor shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed that the performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed;

b) a woman is a dependant minor if she has not reached the age of 16 years and is being supported by a custodial parent or parents; and

c) a reference to a parent includes a reference to a legal guardian.

When is a young person not considered a dependant minor?

If the young person is under 16 years and is not being supported by a custodial parent, the requirements for dependant minors outlined above do not apply.

The legislation does not define what is meant by 'supported'. However, it could be reasonable to interpret it as referring primarily to financial support and a child living away from home who is not financially dependent on her parents would not be a 'dependant minor'.

When minors are considered independent, the WA legislation on abortion is the same as for people over 16 years of age.

Dependant minors and parental involvement

It should be noted that the legal requirement is only that a custodial parent is given the opportunity to participate in counselling/consultation. Whether or not this opportunity is taken is a matter for them. The medical practitioner should be satisfied that the custodial parent has been informed and invited to become involved in counselling and consultations. Alternatively, a dependant minor may make an application to the Children's Court to waive this requirement, see below.

Medical practitioners should note that it is only in informing the custodial parent and giving them the opportunity to participate in consultation that an exception to normal patient confidentiality exists. In all other aspects related to the abortion and care the usual requirements of medical practitioner/patient confidentiality apply (i.e. that confidentiality is maintained by the medical practitioner except where the dependant minor has consented to the release of information).

Some points to consider:

- Where a medical practitioner considers that a patient may be under the age of 16 years, it is strongly recommended that the medical practitioner seek some proof of age.
- Where the young person is under the age of 16 years, it will also be necessary for a medical practitioner to determine whether or not they are being supported by a custodial parent.
- If the custodial parent is provided with the necessary information and has been given the opportunity to participate in counselling and consultations the decision to proceed with referral is the decision of the young person.
- It is possible that a dependant minor may be able to give the necessary informed consent, even if this is not consistent with the custodial parent's views.

Obtaining a Children's Court Order

The decision as to whether to inform the custodial parent, or to seek to vary this requirement by applying to the Children's Court under section 334(9) of the *Health (Miscellaneous Provisions)* Act 1911 (WA) is one for the dependant minor herself to make.

The requirements of law in relation to dependant minors may be varied by an order of the Children's Court under Section 334(9) of the *Health (Miscellaneous Provisions)* Act 1911(WA) which states:

> A woman who is a dependant minor may apply to the Children's Court for an order that a person specified in the application, being a custodial parent of the woman, should not be given the information and opportunity referred to in subsection (8)(a) and the court may, on being satisfied that the application should be granted, make an order in those terms.

How is a Children's Court order obtained?

Free legal assistance for those who decide to pursue this option is available from the Children's Court Protection Service. Their contact details are in the resources section at the end of this booklet. This service will assist the woman with applications to the Children's Court, including helping with the completion of a form available from the Court and accompanying the woman to Court to put her case to the Magistrate.

How is the medical practitioner involved in the Children's Court order?

Medical practitioners can be guided by a legal service, which the young person may consult, as to the information and actions required in relation to the court process. In such cases, the medical practitioner will usually be asked to provide a letter which contains an assessment of the maturity of the young person and her social circumstances in so far as they may be known to the medical practitioner. Such a letter would generally be provided by the legal service to the magistrate for the purpose of assisting the magistrate to make a decision on the application. The application is generally heard within a few days by a Magistrate and a decision made.

If the magistrate makes an order that a custodial parent should not be given the information and opportunity referred to in section 334(8)(a) of the *Health (Miscellaneous Provisions)* Act 1911(WA), then informed consent can be given by the woman as long as the usual requirements of section 334(5) of the *Health (Miscellaneous Provisions)* Act 191 (WA) have been met.

Medical practitioners should note that in this situation extra support may be required, especially where there is little family support. However, it is also important that medical practitioners keep in mind that any decision to apply to the Children's Court is ultimately one for the young person to make, not the medical practitioner.

Dependant who is unable to give informed consent

Section 334(4) of the *Health (Miscellaneous Provisions)* Act 1911 (WA) provide that where it is impracticable for a woman to give informed consent, the performance of an abortion will be justified without such consent where:

- serious danger to the physical or mental health of the woman will result if an abortion is not performed; or
- the pregnancy of the woman is causing serious danger to her physical or mental health.

If a medical practitioner is concerned about the capacity of a woman to give consent for referral, it may be appropriate to apply to the Children's Court for permission for the abortion to be carried out. A referral to a legal service may be required in such situations.

Pregnancy following sexual assault

Unwanted pregnancy may be the result of a recent sexual assault. If there is disclosure of a sexual assault it is important to listen to and believe the victim.

Points to consider:

- Determine accurate gestation. An ultrasound will confirm gestation and allow correlation with alleged date of incident.
- Ask the patient if they would like a referral to sexual assault counselling. This can be done through the Sexual Assault Resource Centre (SARC), Family Services or Sexual Health Quarters.
- Contact SARC duty officer on 08 6458 1820 if you would like more individualised advice.
- Ask the patient if they would like police involvement. Note that products of conception can be used as DNA evidence and this can be requested by police and taken as evidence.
- It is possible that the patient is at ongoing risk of harm. Follow the **Shared Maternity Care** provider (WA) - Referral Pathway for Family and Domestic Violence (page 12-13) to screen for FDV and complete the appropriate risk assessment.
- For more information on sexual assault, see the **Sexual Assault Resource Centre** website which has information for clients and health professionals.

Under 18 years of age

If the medical practitioner has a reasonable belief that a person under 18 years of age has been sexually abused, a mandatory report to the Child Protection Unit is required, even when the patient is considered a mature minor. See **Mandatory reporting of child abuse and neglect | Child Family Community Australia (aifs.gov.au)**

Self-managed abortion with unregulated medication

With the increased availability of abortion medicines via the internet it is possible medical practitioners will see women who have attempted, or intend to attempt, self-managed abortion without clinical supervision [1].

It is important that women are aware of the need for medical supervision and appropriate medications for safe and effective abortion. Some online abortion medications are unregulated and may be counterfeit [2]. Risks include failed treatment, health risks to the woman and risk to subsequent pregnancies [3]. If a woman has used unregulated medication for a self-managed abortion, she should be encouraged to seek medical treatment.

Requirement to notify the Chief Health Officer

Any medical practitioner who performs an abortion must notify the Chief Health Officer of the event within 14 days of the abortion being performed. This includes medical practitioners who provide medical abortions or surgical abortions in community settings. Such notifications are not required by the medical practitioner making the referral for abortion.

Notification must be made using Form 1 – Notification by Medical Practitioner of Induced Abortion. **https://datalibrary-rc.health.wa.gov.au/surveys/?s=CAR9J78MRT**

If a paper version of the form is preferred, or for more information required, contact Maternal and Child Health, Data Management, Information and Performance Governance Unit on 9222 2417 or **birthdata@health.wa.gov.au**

For more information, see **https://ww2.health.wa.gov.au/Articles/A_E/Abortion-Notification-System**

Ethical obligations

Understanding your obligations

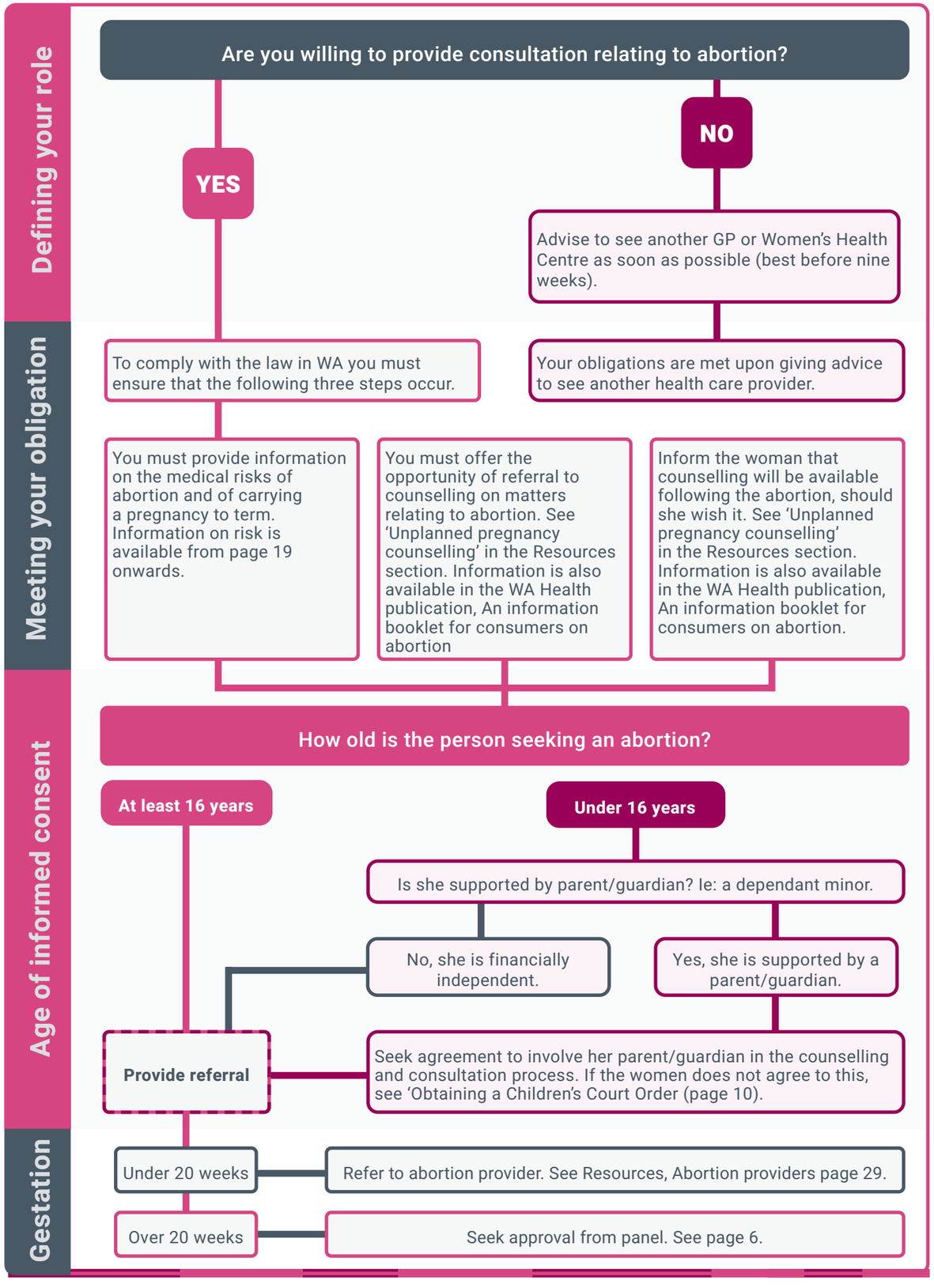
Medical practitioners are not required by legislation to participate in consultation and referral for abortion. However, they should be aware of their obligations as outlined in the Australian Health Practitioner Regulation Agency (AHPRA) and Medical Board of Australia's Good Medical Practice: a code of conduct for doctors in Australia.

The relevant sections of the Good medical practice: a code of conduct for doctors in Australia 2020 include:

> **3.4 Decisions about access to medical care** Your decisions about patients' access to medical care must be free from bias and discrimination. Good medical practice involves:
>
> **3.4.1** Treating your patients with respect at all times.
>
> **3.4.2** Not prejudicing your patient's care because you believe that a patient's behaviour has contributed to their condition.
>
> **3.4.3** Upholding your duty to your patient and not discriminating against your patient on grounds such as race, religion, sex, gender identity, sexual orientation, disability or other grounds, as described in antidiscrimination legislation.
>
> **3.4.6** Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues of your objection, and not using your objection to impede access to treatments that are legal. In some jurisdictions, legislation mandates doctors who do not wish to participate in certain treatments, to refer on the patient.
>
> **3.4.7** Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or directly participate in that care.

If a medical practitioner cannot provide the services requested, it may be appropriate to refer the client to a suitable service. Such services are listed under the resources section of this booklet.

Quick reference guide



Abortion and pregnancy information

Methods of induced abortion

A pregnancy may be ended using surgical or medical techniques or a combination of both.

Medical abortion

Medical abortion refers to the use of medication to terminate a pregnancy.

The registration by the Pharmaceutical Benefits Scheme of Mifepristone for use in Australia for early medical abortion has enabled abortion provision up to 63 days of gestation in an outpatient environment [(4)]. General practitioners and hospital doctors can only prescribe Mifepristone for this purpose after successfully completing an online course provided by the PBS sponsor, MSI Australia **(www.ms2step.com.au)**.

Medical abortion involves the use of two agents - Mifepristone, a synthetic anti progesterone, and Misoprostol, a prostaglandin analogue. The procedure involves oral Mifepristone which inhibits the action of progesterone in maintaining the pregnancy and therefore cause the embryo and placental sac to separate from the wall of the uterus. Misoprostol, taken 24-48 hours after Mifepristone, induces contractions, cervical opening and causes the evacuation of contents of the uterus.

The combination of Mifepristone and Misoprostol for women in early pregnancy results in complete abortion in 95 percent of cases [(5)]. The other 5 percent of women may need surgical evacuation for retained products of conception [(4)].

Medical abortion can be offered in a primary care setting or through a clinic (see Abortion Providers in Resources). After nine weeks gestation medical abortion is not available in the community but may be available as a hospital inpatient [(4)].

Women undergoing medical abortion will have medical supervision and access to surgical treatment if required. Having a further procedure may incur a further cost.

Surgical abortion

Surgical methods include suction curettage (vacuum aspiration) or dilation and evacuation (D&E). Aspiration techniques can generally be used up to 12 to 14 weeks; however, as gestation increases, safe removal requires cervical preparation and a combination of techniques to remove the products from the uterus [(6)]. Surgical abortion is available in licensed day surgery clinics and in hospitals.

Availability of medical and surgical abortion

- Suitability for medical or surgical abortion requires consideration of a range of factors including gestation; the woman's individual circumstances (eg: psychological impacts, social support); medical conditions; and the choice of abortion provider. All evidence indicates that both medical and surgical abortion are safe. The specific type of abortion provided (medical or surgical) will be determined by an individualised assessment. Possible adverse effects are outlined below.
- Routine abortion is generally provided through private abortion clinics in the community. The provider may offer early medical abortion as an outpatient or a choice of medical or surgical abortion at a clinic[(7)].
- Women and Newborn Health Service (King Edward Memorial Hospital) does not provide a routine abortion service; however, it does have an abortion service to assist patients who are unsuitable for private abortion clinics due to:
  - Medical co-morbidities
  - Anaesthetic issues
  - A fetal abnormality identified in this pregnancy
  - Social circumstances that exclude them from community based abortion providers
  - Being aged 14 years or less
- Any young woman under 14 years of age requesting an abortion should be referred to King Edward Memorial Hospital. This is a specialised service available to all young women under 14 years from across WA.
- Women with restricted financial circumstances that would preclude them from accessing private abortion providers may also be referred to King Edward Memorial Hospital for assistance. This will involve a consultation conducted via telephone between the Pregnancy Choices and Abortion Care Co-ordinator and the woman via a referral from their GP.

See the resources section at the end of the booklet for a list of abortion providers.

Risks of induced abortion

The following sections are an evidence-based summary of the literature on the risks of abortion and of continuing the pregnancy to term.

All of the available evidence indicates that induced abortion both via medical or surgical methods, especially in early pregnancy, is a low-risk procedure [6]. The risks of death and serious complication with induced abortion are lower than the risks of carrying a pregnancy to term [8, 9].There are many issues for women to consider when deciding to have an abortion. The medical risks of abortion and continuation of pregnancy is one part of this potentially complex decision.

Short-term risks and complications of medical and surgical abortion

- **Mortality risk**

  Both medical and surgical abortion are safe procedures. At all gestational ages, major complications and mortality are rare [10].

  The risk of maternal death from an induced abortion performed by a trained clinician is much lower than carrying a pregnancy to term [6]. However, mortality increases with gestational age, from 0.1 per 100 000 at eight weeks gestation to 8.9 per 100 000 at 21 weeks [6].

- **Morbidity risk**

  Despite increased risk with gestational age, rates of complication remain low and are comparable between medical and surgical methods of abortion [6, 10].

- **Haemorrhage**

  The risk of haemorrhage following abortion is low [10, 11]. Estimates of haemorrhage following vacuum aspiration in the first trimester range from 0 to 3 per 1000 cases [11]. The risk of blood transfusion following a medical abortion is approximately 0.1 percent [12]. Risk increases with increased gestation for both medical and surgical abortion [6].

- **Infection**

  Routine prophylactic antibiotics are offered to women who are undergoing surgical abortion as recommended by the World Health Organisation and the Royal College of Obstetrics and Gynaecology (RCOG). Infection occurs in 0 to 2 percent of cases of surgical and less than 1 percent of cases in medical abortion [6, 10, 13].

- **Retained products of conception**

  Medical and surgical methods are generally effective in completing the abortion; however, there is a small risk (less than 2 in 100 for surgical and 5 in 100 for medical) of the need for further intervention to complete the procedure [14, 15].

- **Failure of abortion**

  Both medical and surgical abortion carry a small risk of failure to end the pregnancy (1 or 2 in 100), resulting in a further procedure [14, 16]. The risk of failure is higher in very early pregnancy. For terminations performed by suction curettage, there is a three-fold higher failure rate for those performed before seven weeks gestation compared with those performed at seven to 12 weeks gestation [17]. There is some research to suggest that failure of medical abortion increased with the woman's age and gestation [5].

- **Rhesus isoimmunisation**

  The administration of Rh (D) Immunoglobulin (Anti-D) can reduce the risk of sensitisation and adverse consequences in subsequent pregnancies. Guidelines for the use of Rh (D) Immunoglobulin (Anti-D) in obstetrics by the Royal Australian and New Zealand College of Obstetricians and Gynaecologist (RANZCOG) state that all Rh (D) negative women (who have not actively formed their own Anti-D) should be offered Anti-D at medical or surgical abortion within 72 hours of the procedure [18].

  There is no international consensus on the use of Anti-D in the first trimester [10]. During the COVID-19 pandemic, RANZCOG recognised that testing and administering Anti-D potentially adds delay and barriers to care. The college provided a revised statement, based on the National Institute for Health and Care Excellence (NICE) guideline 2019, to recommend that rhesus status determination and Anti-D are not required for early medical abortion up to 10 weeks [19].

- **Bleeding and cramping (medical abortion only)**

  As medical abortion involves the expulsion of products of conception, women should expect to start bleeding within a few hours of administration of the second medication. Some pain and cramping are also to be expected. The amount of bleeding is greater with medical abortion than surgical and appears to increase with gestational age [20]. Other common adverse effects include nausea, weakness, headache, and dizziness [12].

- **Effects of prostaglandins (surgical only)**

  Cervical priming with prostaglandins reduces the risk of damage to the cervix. Where prostaglandins are used, such as for cervical priming, they can be associated with side effects such as diarrhoea, nausea, vomiting, dizziness, warm flushes, chills or headaches or pain caused by contractions [21, 22].

- **Complications related to anaesthesia (surgical abortion only)**

  A range of anaesthetics, analgesics and techniques can be employed during an abortion, including general anaesthetic, conscious sedation and local anaesthesia. The preferred option depends on gestation, technique, the woman's preferences and the expertise of the service provider.

  In Western Australia the most common technique during surgical abortion is conscious sedation, otherwise known as "twilight sedation", which is associated with less post-operative nausea and vomiting [23] and earlier recovery from anaesthesia [24].

Conscious sedation is a state of depressed consciousness that allows protective reflexes and the airway to be maintained. Patients can respond appropriately to physical and verbal stimulation and some memory of what has occurred is possible, but it is usually not distressing. Midazolam, Fentanyl and Propofol are commonly used. Midazolam may temporarily impair the acquisition of new information (anterograde amnesia), while having little effect on previously stored information (retrograde amnesia) [25].

Although less common than when general anaesthesia is used, drowsiness and dizziness can occur after this method [26]. Anxiolytics and narcotics used for conscious sedation may cause respiratory depression, especially when they are used together with higher medication doses. There is a risk that the woman may lose her ability to protect her airway [27].

In pregnancies less than 12 weeks gestation the procedure is low risk and usually takes under 15 minutes. The risk of anaesthetic complications is therefore low, but as with all anaesthetics, risk may be increased in the presence of obesity, smoking, diabetes and other chronic illnesses.

- **Injury**
- Uterine perforation (surgical abortion only)

  The risk of uterine perforation is low (0.2- 0.8 percent) although it increases with advancing gestation [6].
- Cervical trauma (surgical abortion only)

  Risk of cervical trauma is linked to gestation age and provider experience and may occur as part of the procedure [6]. Cervical priming is recommended by organisations such as the National Institute of Health Care and Excellence to prevent injury to the cervix and uterus [28, 29].
- **Complications of induced abortion at 12 to 19 weeks**

  While second trimester abortions are safe, there is an increase in complications with increasing gestation. Both medical and surgical methods can be used; however, more training is required for surgical abortion at this gestation [30]. The main complication of second trimester medical abortion is retained products of conception causing ongoing bleeding [31] or necessitating anaesthetic procedure.

Long-term complications

The following section provides a brief review of the evidence relating to long-term complications after an abortion. It focuses on three issues: future reproduction, breast cancer and psychosocial outcomes.

- **Effect on future reproduction**

  The possible long-term adverse effects of abortion on future reproduction can be of particular concern to women. Many women plan to have children in the future. They should be assured that abortion is not associated with an increased risk of infertility [32].

  The following rare complications can impact adversely upon future fertility: cervical weakening, scarring and stenosis, Asherman's syndrome, post-infection fallopian tube damage, and hysterectomy following post-abortion complications [33-35]. Induced abortion has been associated with a small increased risk of subsequent preterm birth. This increases with the number of abortions [36].
- **Breast cancer**

  Abortion is not associated with an increase in breast cancer [36]. While there was previously conflicting evidence, it has now been clearly demonstrated that there is no increased risk [37].
- **Psychological consequences**

  Women request abortions for multiple and complex reasons related to their individual circumstances that can include socioeconomic status, age, health, parity, marital status, reproductive coercion and intimate partner violence [38, 39].

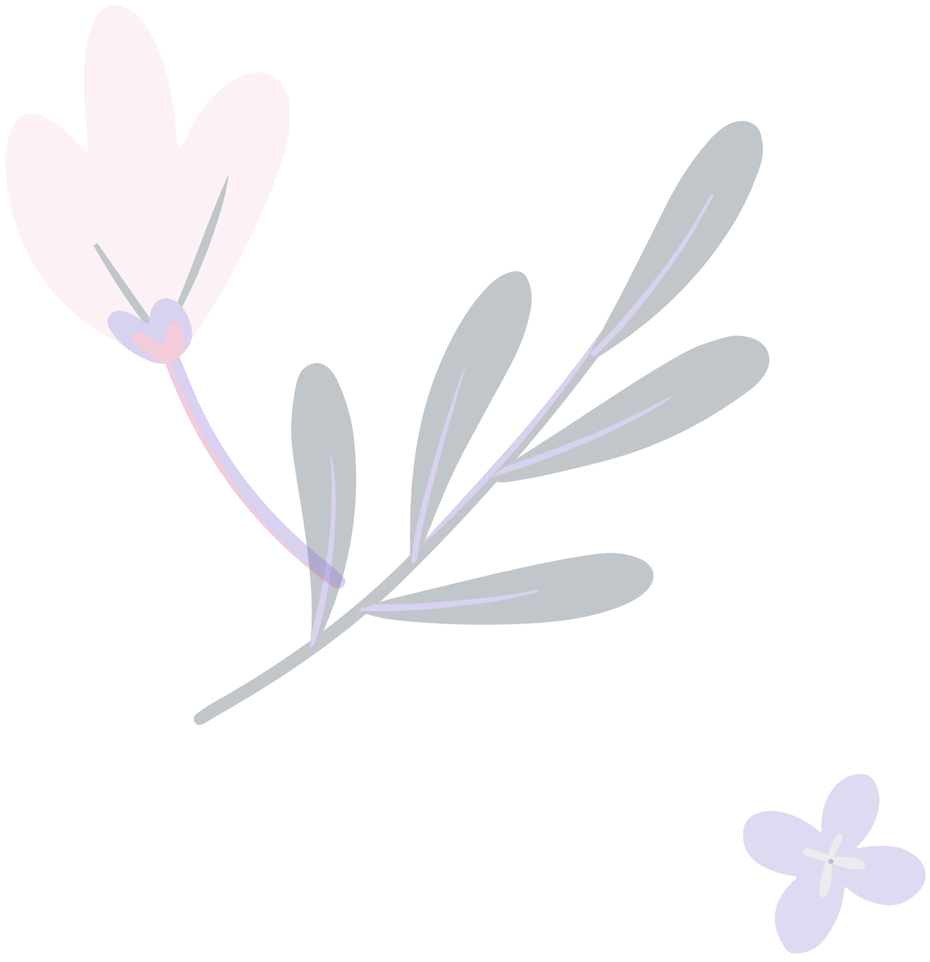
  Historically there has been some concern that women who have an abortion will suffer lasting adverse emotional or mental health consequences. However, there is no evidence to suggest this is the case. While it can be expected that women will experience a range of emotions in relation to an abortion, there is no evidence linking abortion to short or long-term negative emotions. Studies indicate that relief is the most common short-term emotion experienced following an abortion; however, all emotions in relation to an abortion decline in intensity with time [40]. Emotions related to abortion are also the product of the individual and social context that the woman is part of, rather than the procedure itself [41]. It is important to be aware of the stigma that can be associated with abortion as this can impact on women's wellbeing [42].

  The American Psychological Association Task Force on Mental Health and Abortion noted that many studies into psychological outcomes of abortion were methodologically flawed. The Turnaway Study addressed the flaws of earlier research by collecting data on baseline mental health conditions and outcomes following either an abortion or a birth when abortion was wanted but denied [43]. The study followed women for five years, with twice yearly interviews to assess their psychological wellbeing. Being denied an abortion was associated with a greater risk of experiencing adverse psychological outcomes. However, psychological wellbeing improved over time, so that both women who had received and those who had been denied an abortion had similar outcomes [43].

The psychological outcome of abortion is optimised when women are able to make decisions based on the complexities of their own intimate partner relationships, and their lives and values [(44)]. Women exposed to intimate partner violence are more likely to have an unintended pregnancy [(45)] and those who go on to give birth with an unintended pregnancy are more likely to be the victim of violence from the male involved in the pregnancy than those who have an abortion [(46)].

Medical professionals can assist by being aware that women seeking an abortion might have been exposed to violence or require mental health care for factors that preceded the request for termination [(47)].

See KEMH Women's Health Strategy and Programs **Family and Domestic Violence Toolbox** for more information on intimate partner violence and resources.



Risks of carrying a pregnancy to term

Pregnancy and birth are for the majority of healthy women 'low risk' events. There are, however, risks associated with pregnancy, birth and the puerperium.

Mortality risk

Maternal deaths in Australia are rare but healthy women do still die in pregnancy and following birth.

In the decade from 2009 to 2018, there were 251 women reported to have died during pregnancy or within 42 days of the end of pregnancy with a maternal mortality rate of 6.7 deaths per 100 000 women giving birth. Maternal deaths are categorised as either direct or indirect. Direct deaths are the result of obstetric complications or pregnancy or its management, while indirect deaths are the result of conditions without an obstetric cause but that were aggravated by the pregnancy.

The most frequent causes of maternal death in the decade 2009-2018 was pre-existing cardiovascular disease and non-obstetric haemorrhage, then suicide [(48)]. The most frequent causes of direct maternal death in the same period were thromboembolism and obstetric haemorrhage.

Morbidity

As the rate of maternal mortality has declined in high-resourced countries over the past 50 years, there has been increased emphasis on maternal morbidity. It has been suggested that maternal morbidity is underestimated as there is a tendency to focus on obstetric complications during labour and birth, such as haemorrhage, sepsis, hypertensive disorders and obstructed labour, while other issues such as depression, incontinence, sexual health issues and pelvic girdle pain are underreported [(49)].

In an attempt to construct a shared understanding of maternal morbidity, the World Health Organisation's Maternal Morbidity Working Group has defined maternal morbidity as "any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman's wellbeing and/or functioning" [(50)]. However, there is currently no standard classification or national database for the collection of morbidity data. Maternal morbidity varies in both duration and severity and covers a wide range of diagnoses ranging from the near death of a woman from complications during pregnancy or childbirth, to non life-threatening illness that impacts on wellbeing more broadly [(50)].

A recent Australian study used the Victorian Perinatal Data Collection (VPDC) database to examine risk factors associated with maternal morbidity and found that lower socioeconomic status, Indigenous status, older maternal age and clinical factors such as primiparity, coexisting medical conditions, previous caesarean section and previous pregnancy loss all increase the likelihood of severe maternal morbidity [(51)].

Pregnancy and birth data from the Midwives Notification System, which compiles information on all births in Western Australia, recorded pregnancy complications in 30.3 percent of women [52]. In 2015, hypertension occurred in 4.1 percent of pregnancies, while the most common complication in those who have given birth were gestational diabetes (8.8 percent) and premature rupture of membranes (3.5 percent) [52]. However, longer term consequences following birth that largely remain uncaptured, such as post traumatic-stress disorder, postpartum depression, physical and emotional disabilities and sexual dysfunction, may lead to a significant reduction in quality of life [53].

Other risks associated with pregnancy

Pre-existing problems can be exacerbated by pregnancy. However, only a small proportion of women within the obstetric population have a pre-existing disease.

Women at higher risk of medical and obstetric complications include those with the following factors:

- Obesity
- Diabetes and other endocrine diseases
- Cardiovascular diseases
- Asthma and other chronic respiratory diseases
- Depression
- Other systemic and chronic illnesses
- Smoking, alcohol and other drug consumption in pregnancy
- Previous obstetric complications

Complications in pregnancy and birth range from minor symptoms, such as heartburn, to more serious events, such as major haemorrhage, sepsis, pulmonary embolus, and cardiac failure.

Table 1: Overview of medical risks of abortion and continuing the pregnancy

Risks common to pregnancy and abortion	
Topics	**Suggested discussion points**
Process	Blood tests, pregnancy tests, ultrasound, costs
Delivery/procedure	Haemorrhage, infection, retained products of conception Drug reactions Injury to the uterus and cervix
Anaesthetic issues	Method (general anaesthetic, local anaeshetic or twilight sedation) and possible associated risks Conscious (twilight) sedation: Generally associated with less risk than with general anaesthetic but uncommonly respiratory depression can occur and some memory of the event may remain General anaesthesia: Nausea, fever and rare anaesthetic complications
Effects of pregnancy	Rhesus incompatibility, medical complications
Risks of pregnancy only	
Topics	**Suggested discussion points** (examples only, not a complete list)
Medical risks of pregnancy such as:	Hyperemesis, pre-eclampsia, spontaneous miscarriage, antepartum haemorrhage, placenta praevia and rare complications such as a molar pregnancy
Pre-existing systemic diseases	Cardiovascular, respiratory, endocrine, genitourinary and other systemic diseases can place the pregnant woman at greater risk during pregnancy and these diseases can be exacerbated by pregnancy
Fetal conditions	Antibody-incompatibilities, congenital conditions
Physical complications of delivery such as:	Tears to cervix, vagina and perineum due to delivery process and assistance from birthing staff Obstructed labour, Caesarean section and its complications
Problems following delivery	A number of complications can arise, such as: • Depression, PTSD, sexual dysfunction • Infection, of urinary or genital tract or breast • Secondary haemorrhage • Thromboembolic disease, dyspareunia due to scar tissue from tears or episiotomy • Long-term damage to pelvic floor supports with potential for prolapse of uterus, bowel and bladder
Risks of abortion only	
Short term problems	Failure of termination requiring further procedures
Longer term problems	Longer term problems of miscarriage and preterm birth in subsequent pregnancies can occur with multiple induced abortions

Adoption

Information on adoption is provided as some women may wish to consider adoption as an alternative to parenting or abortion.

Adoption practices are shaped by society, culture, religion, politics and economics and have changed over time. Adoption has significantly declined in Australia for a variety of reasons, including increased support for single parent families, the emergence of family planning and legislative changes which provide alternative legal options. There were 310 adoptions in Australia in 2018-19; 57 were adopted from overseas and 253 were adoptions within Australia. Of these, 211 were known child adoptions (ie: adopted by a step parent, relative or carer) and 42 were local adoptions. There has also been a significant shift away from the secrecy that was associated with adoption to a transparent system which focuses on the needs of the child [(54)].

Since 1995, all adoptions in Western Australia have occurred within a policy of 'openness' where the birth mother is involved in each aspect of the adoption. Current research indicates that continued contact increases the birth mother's satisfaction with the process [(55)].

The Turnaway Study, a five-year longitudinal study of 956 women seeking abortion care in the United States of America, including 231 women denied abortion due to gestational limit, found that amongst women seeking abortion, adoption is infrequently chosen [(56)].
It has been suggested that women tend to choose adoption when there are fewer options available [(56)]. Women should be advised that abortion, parenting, exploration of kin support and adoption are all potential options [(55)].

For more information on adoption see the ***Department of Community Development, 'Pregnant and considering adoption for your child?'***

Guidelines for medical practitioner counselling

Counselling about the medical risk of termination and pregnancy is required as part of obtaining informed consent. However, counselling for matters relating to the termination of pregnancy and carrying a pregnancy to term must be offered but is not required. The medical practitioner can complete the counselling themselves. Medical practitioners are able to complete non-directive pregnancy counselling training, which will enable them to access Medicare benefits for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 792, 4001, 81000, 81005 and 81010. Medical practitioners can access **non-directive pregnancy counselling training** through the Royal Australian College of General Practitioners.

For medical practitioners who look after women considering abortion and provide general health care, it is useful to understand general counselling approaches and principles.

- Every woman who has an unintended and/or unwanted pregnancy requires access to counselling that is confidential and is responsive to her social, emotional and cultural circumstance.
- Counselling must be non-directive and non-judgemental, delivered by professionals who are aware of their own values and attitudes and are ready to refer to another practitioner if there is a conflict which may prejudice the counselling process.
- The purpose of counselling is to assist the woman (and partner where appropriate) to clarify issues surrounding the pregnancy and to come to a decision about the pregnancy outcome and how it is to be achieved.
- Women should be given the opportunity to tell their story, paying attention to their relationships, their support networks and their beliefs about abortion. This process clarifies special needs, vulnerabilities and issues in the decision.
- Options which can be discussed are: a) continuing with the pregnancy, parenting the child alone or with her partner; b) continuing the pregnancy and relinquishing the child for adoption/fostering; and c) abortion. Include consideration of emotional consequences for all three options.
- In exploring options, help the woman to identify her strengths, her social resources, her belief systems, her needs, issues relating to significant others, and the short and long-term implications of the decision, as well as practical considerations.
- Women who remain ambivalent or undecided should be offered further counselling

Once a decision and plan are made, the woman should be assisted with the implementation and any potential consequences. It is essential that adequate notes are made for clinical and legal purposes.

Resources

Abortion providers

Clinics have different criteria, such as gestation age and medical or surgical abortion. The specific type of abortion provided (medical or surgical) will be determined by an assessment of the individual clinical needs of the patient. Please refer to HealthPathways WA for private abortion providers for early medical abortion.

Metropolitan

Fremantle Women's Health Centre (medical)
114 South Street
Fremantle WA 6160
Phone (08) 9431 0500

MSI Australia Midland (medical and surgical)
Free for patients in the St John of God Midland Public Hospital catchment area.
8 Sayer St
Midland WA 6056
Phone 1300 003 707

Nanyara Medical Group (medical and surgical)
2 Cleaver Terrace
Rivervale WA 6103
Phone (08) 9277 6070

Sexual Health Quarters (SHQ) (medical)
70 Roe Street,
Northbridge WA 6003
Phone (08) 9227 6177

Women's Health and Family Services (medical)
www.whfs.org.au
Phone (08) 6330 5400
Freecall 1800 998 5400
(free call outside of Perth metro area)
227 Newcastle Street,
Northbridge, WA 6003

Metropolitan Public Hospitals

Fiona Stanley Hospital (medical and surgical)
- » Conditions that would preclude access at community clinics

11 Robin Warren Drive
Murdoch WA 6150
Phone (08) 6152 2222

King Edward Memorial Hospital (medical and surgical)
- » Conditions that would preclude access at community clinics
- » Less than 14 years old

Pregnancy Choices and Abortion Care Co-ordinator at King Edward Memorial Hospital (KEMH)
KEMH.Referrals@health.wa.gov.au
Phone (08) 6458 2222
Fax (08) 6458 1031

Country WA

Abortion services are available at some private General Practices and medical centres throughout country WA. The following health regions provide medical or surgical abortions usually with a referral from a General Practitioner.

MSI Australia (medical)
Via telehealth 1300 405 568
This service may be an option in many country areas but requires that the patient has access to 24-hour medical care within two hours of home.

Kimberley Health Region

Broome Hospital (medical and surgical)
Robinson Street
Broome WA 6725
Phone (08) 9194 2222

Derby Regional Hospital (medical and surgical)
67 Clarendon Street
Derby WA 6728
Phone (08) 9193 3214

Kununurra Hospital (medical and surgical)
96 Coolibah Drive
Kununurra WA 6743
Phone (08) 9166 4222

Pilbara Health Region

Hedland Health Campus (medical and surgical)
2-34 Colebatch Way
South Hedland WA 6722
Phone (08) 9174 1000

Mid West

Geraldton Health Campus (surgical)
51-85 Shenton Street
Geraldton WA 6530
Phone (08) 9956 2222

Goldfields

Kalgoorlie Health Campus (surgical)
15 Piccadilly Street
Kalgoorlie WA 6433
Phone (08) 9080 5888

South West

Choices Southwest (medical and surgical)
Dunsborough Medical Centre
4/54 Dunn Bay Road
Dunsborough WA 6281
Phone (08) 9746 3300
www.choicessw.com.au

Unplanned pregnancy counselling

Inform if requesting unplanned pregnancy counselling so that the appointment is prioritised. The below services have received funding from the Department of Health to provide non-directive unplanned pregnancy counselling.

Desert Blue Connect (Geraldton)
www.desertblueconnect.org.au/service/unplanned-pregnancy-counselling/
Phone (08) 9964 2742

Goldfields Women's Health Care Centre (Kalgoorlie)
www.gwhcc.org.au/services/unplanned-pregnancy-counselling/
Phone (08) 9021 8266

Sexual Health Quarters (SHQ)
www.shq.org.au/clinic/unintended-pregnancy/
Phone (08) 9227 6177

South West Women's Health & Information Centre (Bunbury)
www.swwhic.com.au/services/
Freecall 1800 673 350
(08) 9791 3350

Legal services

Legal Aid

Children's Court Protection Service (for assistance with applications to the Children's Court)
Phone (08) 9218 0160

Youth Legal Service

Perth Metro (08) 9202 1688
yls@youthlegalserviceinc.com.au
www.youthlegalserviceinc.com.au

Women's Health Services

Desert Blue Connect (Geraldton)
www.desertblueconnect.org.au
Phone (08) 9964 2742

Fremantle Women's Health Centre
www.fwhc.org.au
Phone (08) 9431 0500

Ishar Multicultural Women's Health Services (Mirrabooka)
www.ishar.org.au
Phone (08) 9345 5335

South Coastal Women's Health Services (Rockingham)
Phone (08) 9550 0900

Women's Health and Family Services (Northbridge and Joondalup)
Phone (08) 6330 5400
Freecall 1800 998 5400
(freecall outside of Perth metro area)
www.whfs.org.au

Women's Health and Wellbeing Services (Gosnells)
Phone (08) 9490 2258
www.whfs.org.au

Bunbury

South West Women's Health & Information Centre
Phone (08) 9791 3350
Freecall 1800 673 350
www.swwhic.com.au

Kalgoorlie

Goldfields Women's Health Care Centre
Phone (08) 9021 8266
www.gwhcc.org.au

Port Hedland

Hedland Well Women's Centre
Phone (08) 9140 1124
www.wellwomens.com.au

Tom Price

Nintirri Centre (Tom Price)
Phone (08) 9189 1556
0456 802 061
www.nintirri.org.au

Mental Health Services

Beyond Blue
Phone 1300 224 636
www.beyondblue.org.au/get-support/get-immediate-support

Lifeline
Phone 13 11 14
www.lifeline.org.au

Diverse sexualities and genders

Another Closet
www.anothercloset.com.au

Living Proud
www.livingproud.org.au/about

Qlife
Freecall 1800 184 527
www.qlife.org.au/get-help

Sexual Health Quarters (SHQ)
70 Roe Street
Northbridge WA 6003
Phone (08) 9227 6177
www.shq.org.au

Other resources

Adoption Services
5 Newman Court
Fremantle WA 6160
Phone (08) 9286 5200
Freecall 1800 182 178
and ask to speak to the local adoptions duty officer.
www.wa.gov.au/organisation/department-of-communities/pregnant-and-considering-adoption-your-child

King Edward Memorial Hospital – Pregnancy Choices and Abortion Care Co-ordinator
KEMH.Referrals@health.wa.gov.au
Phone (08) 6458 2222 (weekdays)
Fax (08) 6458 1031
www.kemh.health.wa.gov.au

Sexual Assault Resource Centre (SARC)
Crisis counselling over the phone from 8.30am to 11pm any day of the week.
You can also request a counselling appointment.
Phone (08) 6458 1828
Freecall 1800 199 888

Women's Domestic Violence Helpline
Support and counselling for women experiencing family and domestic violence, including referrals to women's refuges.
Phone (08) 9223 1188
Freecall 1800 007 339

Appendix A

Suggested further information points for counselling on the processes involved

Abortion

Topics	Suggested discussion points
Pre-abortion process	Blood tests, pregnancy tests, ultrasound, costs
Abortion	
Anaesthetic issues	Method (GA, LA or twilight) and possible associated risks
Procedure: Type	Medical – Mifepristone & Misoprostol Surgical – suction/vacuum aspiration
Procedure: General	Waiting period, duration of procedure, recovery time, where performed
Post abortion	
Additional support	Resources on where to access more information about counselling, pregnancy and adoption

Pregnancy

Topics	Suggested discussion points
Pre-delivery	
Pregnancy care process	• Blood tests, pregnancy tests, ultrasound, costs • Schedule of visits • Antenatal care options • Costs involved
Delivery	
Additional supports	Resources on where to access more information about counselling, pregnancy and adoption
Postnatal	Resources on where to access more information about counselling, postnatal care

Appendix B

Abortion referral process template

Abortion/termination of pregnancy referral

Patient details

Patient circumstances

To ensure the patient is free from coercion, see her alone and discuss: ☐ Circumstances of pregnancy, eg: contraception, assault ☐ Family and community support ☐ Options with unintended pregnancy, ie: continuation of the pregnancy, abortion and adoption ☐ Her relationship with her partner If patient is under 16 years of age seek agreement for her parent/guardian to be involved in the counselling process.	**LMP:** Pregnancy test results to date (ie: urine, serum, ultrasound) **Obstetric history:** STI screen offered: ☐Yes ☐No Cervical screening history/offer if due:

Informed consent for referral to abortion services

It is a legal requirement that informed consent for referral to abortion services is obtained by a general practitioner who is not the doctor performing or assisting with the abortion. This is done by:

- Providing information about the medical risks associated with having an abortion and continuing with the pregnancy
- Offering a referral for counselling prior to the abortion and for continuing with the pregnancy (Note: medical practitioners may also provide this counselling however an offer of referral must be made)
- Informing the patient that counselling is available post-termination or post-delivery

Abortion/termination of pregnancy referral

Have you:

☐ Explained both medical and surgical methods of abortion?

☐ Referred to the family services coordinator at KEMH if she has financial concerns in obtaining an abortion? KEMH.referrals@health.wa.gov.au or fax 6458 1031, telephone contact via switchboard (08) 6458 2222, and ask for family services coordinator.

☐ Discussed contraception?

☐ Arranged follow-up for seven to 14 days after the abortion?

Note that clinics have different criteria and different costs. See **Health Pathways**. Referrals for patients with medical or surgical comorbidities, under 14 years of age and those who are unsuitable for external clinics should be made to King Edward Memorial Hospital (KEMH).

Notification by medical practitioner of induced abortion

Guide for completing E-form version of Form 1, Notification by medical practitioner of induced abortion

To complete and submit the E-form, go to:

- Link available under “Related Links” at: https://ww2.health.wa.gov.au/en/Articles/N_R/Notification-of-terminations-of-pregnancy-induced-abortion, and
- https://ww2.health.wa.gov.au/Articles/A_E/Abortion-Notification-System.

To seek more information, go to https://ww2.health.wa.gov.au/Articles/A_E/Abortion-Notification-System - this website has contact details, including email address or phone number of maternal and child health team, for assistance if required.

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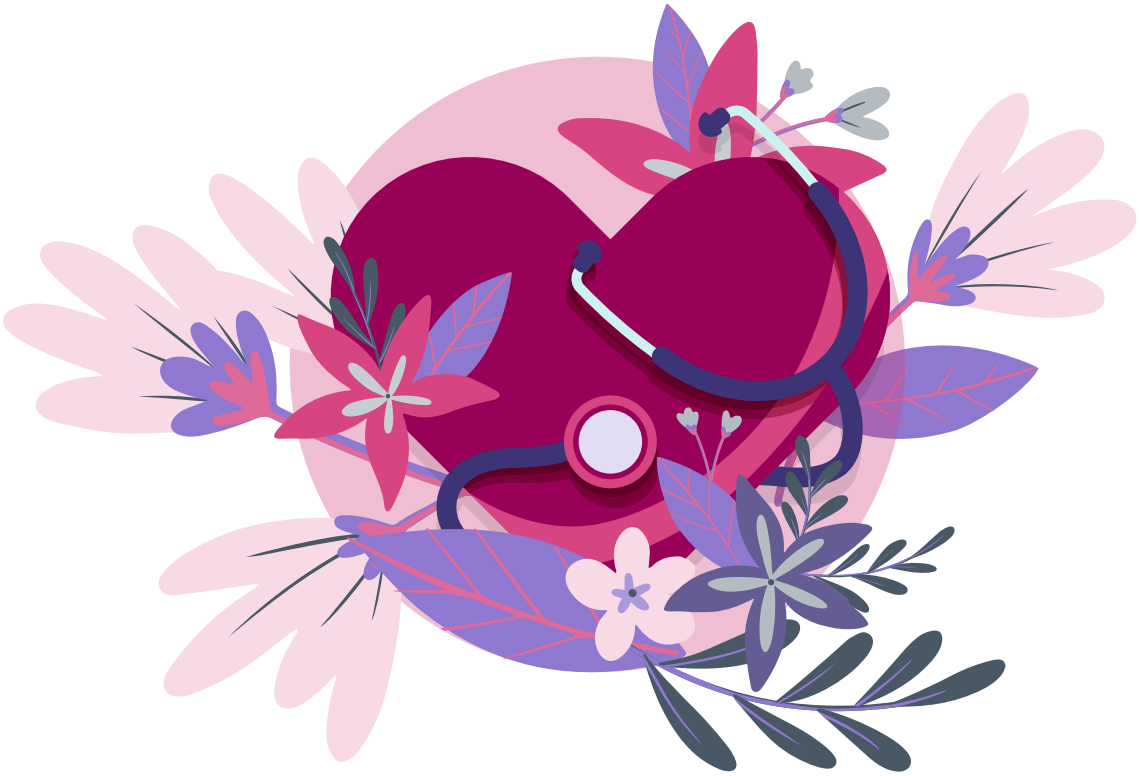

Abortion care:

Information and legal obligations for medical practitioners

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Thank you for not smoking or vaping.

Ask a staff member about free nicotine therapy
to help your cravings during your hospital stay.

This document can be made available in alternative formats on request.

This booklet is to be updated annually

WNHS4496_0423