

Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

Discussion paper

This paper provides a background to the revision of termination of pregnancy legislation in the Northern Territory (NT). It sets out options and recommendations to bring the legislation in this area to a more contemporary model in line with interstate legislation, professional guidelines and standards, while at the same time acknowledging the unique challenges to clinical care presented by the geographical and population profile of the NT.

You are invited to provide feedback on this discussion paper

To provide feedback, please email written submissions to DOH.consultation@nt.gov.au by close of business 27 January 2017.

Background

Jurisdictions across Australia have been gradually reforming their legislation to allow women better access to termination of pregnancy services including medical termination. In Tasmania, Victoria and the Australian Capital Territory termination of pregnancy by a medical practitioner is no longer a criminal offence.

Termination of pregnancy is a criminal offence in the Northern Territory under the *Criminal Code Act* except if performed under the limited circumstances described in Section 11 of the *Medical Services Act* (the Act). Whilst contemporary in the 1970s when the Act was first drafted, there are specific elements of the current Act that have not kept pace with the changing nature of medicine, best practice in medicine, societal expectations, or legislation elsewhere in Australia.

Specific areas of the Act have been identified as limiting access to termination of pregnancy for women of the Northern Territory when compared with access for women living in other jurisdictions.

Treatment options for termination of pregnancy

Advances in medicine make it possible to perform terminations of pregnancy either surgically (with instruments) or medically (using drugs such as Mifepristone (RU486) and Misoprostol). These advances were not contemplated when Section 11 of the Act was drafted in the 1970s.

Mifepristone (RU486) and misoprostol have been available in Australia since 2006 through the Therapeutic Goods Administration (TGA) Authorised Prescriber Scheme. Mifepristone (RU486) and misoprostol were registered for medical termination of early pregnancy in 2012 and are now on the Pharmaceutical Benefits Scheme. In August 2012, the TGA granted approval for Marie Stopes International Australia to import mifepristone (RU486) and misoprostol into Australia through its subsidiary MS Health and to market/distribute the medication as MS2-Step.

For early termination of pregnancy (less than 9 weeks' or 63 days' gestation), mifepristone (RU486) and misoprostol are given 48 hours apart. This treatment is termed early medical termination of pregnancy. Women are prescribed MS2-Step by a Medical Practitioner who has completed the Marie Stopes education program. MS2-Step is dispensed by Pharmacists registered with Marie Stopes and the first medication (Mifepristone) is taken by the woman under supervision of the prescribing Medical Practitioner or a registered nurse or midwife authorised by the prescribing Medical Practitioner. In all Australian jurisdictions excepting for the Northern Territory, the woman may be given the second medication (Misoprostol) to take at home, providing she remains in close proximity to emergency surgical services. These two medications induce termination which has the same effect as a naturally occurring miscarriage. Under the current Northern Territory Act, both doses must be given to the woman in a hospital and she must remain there until the entire miscarriage is completed. This process may take between 3 days and 14 days, and as a consequence the majority of early terminations in the Northern Territory are completed as a same-day surgical procedure at either Alice Springs, Royal Darwin or Darwin Private Hospitals.

Difficulties with changing the *Medical Services Act* to improve safe access to termination of pregnancy for NT women

Legislative amendments to the Act proposed to date, and the accompanying professional and public debate, have focussed on increasing access to early (medication) termination of pregnancy. However, a comprehensive, contemporary approach requires robust legislation for gestations across all phases of pregnancy. Contemporary legislation requires: evidence based practice by health professionals who make decisions about when, how and where to implement treatment according to an assessment of the health and wellbeing of the woman within a framework of professional practice guidelines; an approach to consent for termination of pregnancy that is in line with consent for other medical procedures; provisions for both conscientious objection and referral to another practitioner who can provide appropriate services; and provisions for safe access zones in the vicinity of treatment facilities.

Amending the Act to achieve these requirements has been problematic for the following reasons:

- a) The Act primarily has application to the 'public health service', having specific definitions and other limitations which would require numerous complicated amendments if there were a change in policy as above.
- b) Any provisions for broadening treatment resulting in additional locations for terminations of pregnancy to occur outside a "hospital" would be limited to government facilities declared for this purpose.
- c) Substantial consequential amendments to the Private Hospitals Act and Private Hospitals Regulations (and subsequent compliance monitoring) would also be required to broaden the application of Section 11 of the Act to private day surgery facilities.
- d) Additional amendments to the Act and other legislation would be required to enable provision of termination of pregnancy services in private clinics or other facilities similar to those offering these services in other jurisdictions.

- e) Declaring a facility to be a suitable place under the Act would not necessarily address other clinical risks relating to the procedures. Any requirement for the health professional to make a decision taking these risks into account would require more complex changes and problematic amendments.

For these reasons, the preferred approach is to repeal section 11 of the Act, and to enact separate legislation specifically dealing with termination of pregnancy. Such an approach is in line with other jurisdictions and contemporary legislative practice. This approach would also involve minimal consequential amendment of the *Criminal Code Act* and would reduce the necessity for more numerous or complex consequential amendments to other Acts.

In order for new legislation to achieve the goal of improving Northern Territory women's access to safe termination of pregnancy services, the following considerations have been identified.

1. Definition of Termination of Pregnancy

Inclusion of a definition of 'termination of pregnancy' that includes both surgical and medical procedures would permit the use of a single term throughout the new Act, reducing the complexity of provisions. For example: '**termination of pregnancy** means intentionally causing the termination of a woman's pregnancy by: (a) using an instrument; or (b) using a medicine or a combination of medicines; or (c) any other means'.

2. Criteria for providing treatment

The Department of Health considers the inclusion of suitable assessment and decision making criteria for performance of a termination of pregnancy by suitably qualified medical practitioners would provide sufficient clarity for the purposes of the *Criminal Code Act*, to distinguish termination of pregnancy and an unlawful termination of pregnancy. It is considered these provisions will adequately protect women from criminal conduct and provide a framework for access to safe treatment options.

It is proposed that a termination of pregnancy may be performed between one week and not more than 23 weeks where the following requirements are met:

- Informed consent is given by the woman (or other appropriate person in law) regardless of gestation
- Information and counselling are provided about current choices and future contraceptive options
- Consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances regardless of gestation
- Decision making is based on holistic assessment of the woman involving formation of an opinion by:
 - one suitably qualified medical practitioner for gestations of not more than 14 weeks; and
 - two suitably qualified medical practitioners for gestations of more than 14 weeks and up to but not more than 23 weeks.

The Department of Health recommends inclusion of an obstetrician or gynaecologist as one of the two suitably qualified medical practitioners in cases of termination of pregnancy after 14 weeks because there is benefit in having a specialist consider the inherently greater risks involved.

The Department of Health also recommends that the term “assessment” is used in the legislation rather than the term “examination”, taking into account current and future developments in medical technology (such as the use of telemedicine) to ensure equity of access for women living in remote locations.

3. Suitably qualified medical practitioner

In the Northern Territory health care context it is not always possible for two medical practitioners to assess a woman, nor is it always possible for one of the two practitioners to have specialist qualifications in gynaecology or obstetrics. However, it is appropriate in certain circumstances for a single suitably qualified medical practitioner to be permitted to conduct the requisite assessments.

The Department of Health considers it is appropriate, for terminations of not more than 14 weeks’ gestation, that a single, ‘suitably qualified’ medical practitioner performs the physical examination to determine the gestation of pregnancy, complete the decision making process with the woman concerned and form an opinion about eligibility for termination of pregnancy.

The Department of Health recommends that a definition of ‘suitably qualified medical practitioner’ be included in the legislation, but that it should not be overly prescriptive or expressed in a way that fixes the measures for this at a particular point in time. Rather, it should allow for the legislation to remain contemporary by from time to time referencing professional standards, qualifications or assessments set by health practitioner training organisations or Medical Colleges.

For example:

suitably qualified medical practitioner means a medical practitioner who:

- (a) *is an obstetrician or gynaecologist; or*
- (b) *has completed a recognised training course within the last 2 years for the provision of advice, performing procedures and giving of treatment in the area of fertility control; or*
- (c) *has a valid credential prescribed by regulation.*

4. Prescribing, Supplying and Administering drugs that induce medical termination

The *Medical Services Amendment Bill 2015* proposed by the Member for Goyder included provisions for pharmacists to assist in the provision of medication for the purpose of medical termination of pregnancy. The *Victorian Abortion Reform Act (2008)* includes provisions for registered nurses as well as pharmacists to supply and administer drugs used for medical termination of pregnancy once prescribed by a medical practitioner. This provision improves access by women to termination of pregnancy, and protects the practitioner from criminal charges.

Drugs currently used to effect medical termination of pregnancy are listed as Schedule 4 (prescription only) according to the TGA Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP).

The *Medicines, Poisons and Therapeutic Goods Act* governs the prescription, supply and administration of drugs in the Northern Territory by pharmacists, registered nurses, registered midwives and nurse practitioners. With the aim of having 'stand alone' legislation enacted and consequential repeal of provisions relating to the termination of pregnancy from the *Criminal Code Act* it is recommended to include provisions within new legislation to adequately protect medical practitioners and other specified health professionals from prosecution from supplying and administering the relevant drugs.

The Department of Health recommends that wording of the provisions should be based on the Victorian legislation, for example:

A registered medical practitioner may issue a prescription for a drug or drugs to cause termination of pregnancy for

- a. a registered pharmacist to supply; and*
- b. a registered nurse, registered midwife or endorsed nurse practitioner to supply and administer*

It is pertinent to note that TGA-approved guidelines issued as part of MS Health certification requirements and in the product information apply to the use of MS-2Step (RU486). These mandate where the drugs can be held, who can supply the drugs, when the drugs can be prescribed and by whom, who can administer the drugs and the circumstances under which the woman should be cared for following administration (see Attachment 1).

The Department recommends that significant consideration should be given to mitigation of risks of supply and administration and recommends the application of guidelines (to be developed) to inform health practitioners in these areas.

5. Criteria for the most appropriate location of treatment and safe care

Location

The current Act has been interpreted and applied to require the woman to be a hospital inpatient for the duration of the treatment until expulsion of the products of conception. As a consequence, despite there being no legislative preclusion to medical termination, this interpretation has resulted in terminations of pregnancies most commonly being performed as a surgical procedure in the Northern Territory. There is anecdotal evidence that women travel interstate to access medical termination services.

Legislation varies nationally in regard to designation of facilities where terminations of pregnancy can be performed. South Australia and the Australian Capital Territory (ACT) limit the performance of terminations to prescribed facilities or hospitals. Western Australia requires the performance of terminations of pregnancies over 20 weeks in a prescribed facility. Victoria requires termination of pregnancies over 24 weeks to be conducted in a hospital. Other jurisdictional laws are silent on the location where terminations of pregnancies are to be performed.

There is evidence that medical terminations of not more than 9 weeks gestation, and surgical terminations of not more than 14 weeks gestation can be safely conducted outside a hospital setting, and in all jurisdictions except for the Northern Territory, this occurs.

Medical termination of pregnancy services most commonly occur in private clinics and day surgery centres with a variety of legislative controls in place to ensure compliance with best practice. There are a very small number of family planning/sexual health/GP clinics around Australia where medical termination of pregnancy services are provided. Most services are in capital cities, with a small number operating in regional centres.

Professional standards and guidelines

A number of professional standards and guidelines exist in relation to management of termination of pregnancy and the use of mifepristone (RU486) for early medical termination of pregnancy.

All medical practitioners must be certified by MS Health in order to prescribe mifepristone (RU486) and misoprostol for early medical termination of pregnancy. Pharmacies must be certified by MS Health to possess and supply the medications. MS Health sets out strict prescribing, drug administration and patient management criteria as conditions of medical practitioner certification.

The drug distributor also provides TGA-approved guidelines in its product information. These guidelines ensure care is provided to the woman beyond simply dispensing the medication, and set out that only certified doctors may prescribe the medications, that key clinical risks are excluded and that the woman must be able to access 24-hour emergency care.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has issued College Statements in relation to the management of termination of pregnancy and the use of mifepristone (RU486) for early medical termination of pregnancy. RANZCOG College Statements are updated periodically to reflect contemporary evidence based practice. RANZCOG College Statements set out professional standards and guidelines for medical practitioners who undertake terminations of pregnancies or use mifepristone (RU486) for early medical termination of pregnancy; and set out explicit expectations of the prescribing medical practitioner's role in the supervision and responsibility for arrangements for the entire process of termination of pregnancy including early medical termination of pregnancy.

The most recent 2015 RANZCOG College Statement states (C-Gyn 21,p2):

- *The prescribing practitioner must supervise and take responsibility for arrangements for the entire process of termination of pregnancy from administration of mifepristone through to confirmation of termination of pregnancy and completion of follow-up including implementation of a contraceptive plan.*
- *These arrangements must include 24 hour access to specific telephone advice and support and to provision of surgical uterine evacuation or other interventions required for the management of complications, for example through on call arrangements or in an emergency department resourced to respond to women's health needs (such as required for miscarriage care).*
- *Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care (in a service accepting this responsibility) from administration of mifepristone until termination of pregnancy is complete.*

The Australian Medical Association Northern Territory (AMA NT) advice is that *the woman is within two hours of a hospital when she takes the medication.*

In terms of terminations of pregnancy it is therefore important to consider how the requirement to reduce risks arising from remoteness may be addressed. This issue is crucial given the unique geographical distribution of gynaecological and emergency services, the highly mobile population of the Northern Territory, and the health/disease profile of Northern Territory women.

Options include:

1. *a regulatory response whereby clinics and facilities are licensed or regulated.* This would require an entirely regulatory framework and development of a system for assessment/approval, monitoring and enforcement which would in all likelihood be costly and resource intensive for little additional benefit;
2. *setting of facility or clinic standards and role delineation.* This has been the approach in South Australia, where a SA Health clinical advisory group has established minimal standards for the provision of termination of pregnancy services in facilities that are licensed and regulated;
3. *adoption of professional standards and guidelines by the practitioner.* This would require those issuing prescriptions to do so in compliance with the provisions of the Bill and following the professional standards and guidelines including MS Health certification requirements, RANZCOG College Statements and product information guidelines.

Given the evidence and contemporary practice, the Department of Health recommends adopting Option 3, by including specific criteria within the legislation for following professional standards and guidelines.

Adopting this option would mean that the decision about the location at which a termination of pregnancy could be conducted in the Northern Territory, whether this is in a clinic, hospital or home setting, would rest with the individual medical practitioner, his/her knowledge of the risks, access to emergency care and assessment of best practice in each particular circumstance, and that the medical practitioner must ensure that pre-and post-procedure counselling and support would be routinely available.

The National Law governing health professional practice would support the regulatory mechanism, with breaches of professional practice leading to notification to the relevant National Board via the Australian Health Practitioner Regulation Authority (AHPRA).

Option 3 also allows the provisions to remain contemporary into the future by utilising the consistent updating and improvement of medical and surgical practices and standards of care through the professional bodies. It is considered that professional standards and guidelines are more readily and easily responsive to changes than legislation. The preference is to keep the legislative provisions more high level and general by providing for reference to the professional standards and guidelines to govern the detail of procedure.

It is proposed that the Department of Health and a representative expert reference group develop appropriate best practice guidelines to be generally referred to by and accessible to health practitioners. These best practice guidelines would be applicable in all potential settings across the NT

including public and private hospitals, urban day surgery centres, family planning clinics, GP clinics, regional locations, and remote Primary Health Care Centres. The guidelines would include best practice management of women living in remote areas of the NT, women with disabilities and children in state care.

It is also proposed that the Department of Health produces consumer-oriented resources to inform consumers of access to termination of pregnancy services, similar to the Victorian Better Health Channel website.

It is also proposed that a rigorous evaluation and monitoring strategy be developed, including submission and analysis of data relating to women's safety.

6. Provision of services

The Top End Health Service and Central Australia Health Service currently provide termination of pregnancy services in NT public hospitals. As these termination of pregnancy services are delivered in the inpatient setting they are free at the point of care for Medicare eligible resident women. If legislation is broadened to allow termination of pregnancy services to be delivered in 'out of hospital' settings it is important for the NT Government to maintain access to affordable services for vulnerable women, irrespective of ability to pay. Accordingly, it is proposed that NT Health Services retain responsibility for ensuring that vulnerable NT women are able to access affordable termination of pregnancy services. Guidelines including requirements and eligibility criteria will be developed by the Department of Health.

7. Conscientious Objection

It is best practice to include provisions for persons involved in decision making or treatment to be able to conscientiously object, and if they are such an objector, to be relieved of any duty to terminate or assist in termination of a woman's pregnancy. In Victoria and Tasmania there is an additional requirement for a medical practitioner who conscientiously objects to performing a termination of pregnancy to refer the woman to a practitioner who is known not to hold such an objection. This provision aims to ensure that women are ensured access to appropriately qualified medical practitioners who are willing to provide a comprehensive range of family planning advice and services.

The Department of Health proposes that amendments in line with Victorian legislation would be appropriate. Victorian legislation states:

Clause 8 (1) 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.*

8. Safe Access Zones

Another legislative provision recently introduced in other jurisdictions provides for safe access zones preventing interference with a woman accessing a health service which provides termination of pregnancy services, or protesting against a service. For example, in 2013 Tasmania introduced Access Zones. In 2015 the Victorian *Public Health and Wellbeing Act 2008* was amended to include provisions for safe access zones around premises offering reproductive health services. The Australian Capital Territory also passed the *Health (Patient Privacy) Amendment Bill* in 2015 to include provisions for protected areas within which certain behaviour is prohibited.

The Department of Health recommends the inclusion of provisions within the new legislation to establish a safe access zone extending 150 metres from a place at which termination of pregnancy may be performed. Safe access zone provisions will prohibit a person from causing distress by intentionally harassing, intimidating, interfering with, threatening, hindering, intentionally communicating in relation to treatment in a way that is seen or heard by another person, or obstructing access to a woman entering or leaving the facility.

Consideration should be given to applying a penalty to those who breach the safe access zone provisions.

9. Informed consent to treatment

Section 11 of the *Northern Territory Medical Services Act* describes conditions relating to consent for women under the age of 16. These conditions require that consent of 'each person having authority in law' must be obtained before a lawful termination of pregnancy can be performed.

For example, where there are two parents or joint guardians, both persons must provide consent. This requirement is not consistent with the consent requirements for other medical or surgical procedures and is viewed as potentially restrictive to young women accessing termination, with the potential for this vulnerable group to seek unsafe or unsupervised terminations.

Legislative provisions in other jurisdictions are either silent on the matter beyond requiring consent is to be obtained, or describe the usual approach to consent, which relates to the capacity of an individual to provide informed consent. The Queensland maternity and neonatal clinical guideline sets the requirements for *Gillick* competence, which is generally used to determine whether a person under the age of 16 can provide her own consent.

A young person is considered *Gillick* competent when they achieve a sufficient understanding and intelligence to enable her to understand, retain the information provided, provide her own explanation of it which is sufficiently accurate about her medical condition, the consequences of it, the medical treatment options available, the consequences of the medical treatment and the risks associated with such treatment.

The Department of Health proposes that:

- 'Informed consent' be included as one of the criteria for providing treatment
- Informed consent be obtained in line with contemporary practice. An example of a guideline for obtaining informed consent used by the Northern Territory Health and Community Services Complaints Commissioner is included at Attachment 2
- The principle of *Gillick* competence for minors be included and measures for obtaining consent from a minor be included in accompanying guidelines that are developed to guide best practice under the provisions of the new legislation.

Thank you for your consideration of this important legislative initiative.

To provide feedback, please email written submissions to DOH.consultation@nt.gov.au
by close of business 27 January 2017.

ATTACHMENT 1

Early medication termination; MS-2Step: Mifepristone (RU486) and Misoprostol

Early medication termination of pregnancy is a two-step process using the combination of medications: mifepristone (RU486) and misoprostol, available for use as MS-2Step. Mifepristone (RU486) is administered first, followed 36 to 48 hours later by the administration of misoprostol.

Mifepristone is on the World Health Organisation list of essential medicines. In August 2012, following an extensive review the Therapeutic Goods Administration Authority granted MS Health marketing approval for Mifepristone Linepharma [RU486] and GyMiso® [Misoprostol] as a Schedule 4 Restricted medicine for termination of pregnancy up to nine weeks/63 days gestation [early medication termination].

Guidelines applying to the use of MS-2Step mandate where the drugs can be held, who can supply the drugs, when the drugs can be prescribed and by whom, who can administer the drugs and the circumstances under which the woman should be cared for following administration. For example:

- The drugs can only be:
 - Prescribed by a medical practitioner who has registered with MS Health, completed a medical education program and nominated a pharmacy to supply the drugs.
 - Supplied by MS Health to a MS Health registered pharmacy.
 - Dispensed by the pharmacy to a medical practitioner registered with MS Health or dispensed to a woman holding a prescription from a medical practitioner registered with MS Health.
- Prescribed to a woman who has a confirmed pregnancy of less than nine weeks/63 days gestation; documented informed consent to treatment; and who will remain within close proximity of a treatment centre until complete expulsion has been recorded.
- The prescribing practitioner must take responsibility for arrangements for the entire process of termination of pregnancy, which must include 24 hour access to specific telephone advice and support, and to provision of emergency obstetric care including surgical uterine evacuation or other interventions required for the management of complications. Patient care remains the responsibility of the medical practitioner during the entire medical termination of pregnancy process.
- Patients must return for follow up to confirm that termination of pregnancy has been successful 14-21 days after taking MS-2Step.
- Follow up intervention must be scheduled by the medical practitioner when medical termination of pregnancy has not been successful.

ATTACHMENT 2

The Health and Community Services Complaints Commissioner for the Northern Territory provides the following guidance about consent:

In non-emergency situations, providers of health services and community services have a responsibility to seek informed consent from users before acting. Accordingly, providers have a responsibility to:

- (a) seek consent that is specific to the care and treatment proposed, rather than a generalised consent to treatment;*
- (b) discuss the care or treatment options, and the possible material risks, complications or outcomes associated with each option, even when the care or treatment is lifesaving or sustaining;*
- (c) ensure the user understands the possible risks, complications or outcomes of refusing a particular care or treatment option;*
- (d) where relevant, explain the legal duties imposed on providers which prevent service users from refusing a type of care or treatment such as those imposed by the Mental Health and Related Services Act and the Notifiable Diseases Act;*
- (e) provide users with appropriate opportunities to consider their options before making a decision;*
- (f) inform users of their right to change their decision if they wish;*
- (g) accept the user's decision; and*
- (h) document the user's consent to care and treatment, including the issues discussed*

ATTACHMENT 3

Summary table showing differences between current legislation and proposed changes

Criminal Code		
Provision	Current Act	Proposed Act
Identify the applicable section	Termination of pregnancy is a criminal offence in the Northern Territory under the <i>Criminal Code Act</i> except if performed under the limited circumstances described in s11 of the Act	Termination of pregnancy is decriminalised when performed by a suitably qualified medical practitioner, but remains a criminal offence under other circumstances
Section 11 <i>Medical Services Act</i> repealed and provisions included in a new act		
Provision	Current Act	Proposed Act
Definition of 'treatment'	Medical treatment includes surgery	Now covered by definition of Termination of pregnancy.
Definition of 'termination of pregnancy'		termination of pregnancy means intentionally causing the termination of a woman's pregnancy by: <ul style="list-style-type: none"> (a) using an instrument; or (b) using a medicine or a combination of medicines; or (c) any other means;
Requirement for counselling about future contraception	Not included	Information and counselling are to be provided about future contraceptive options regardless of gestation.
Definition of suitably qualified medical practitioner	Not defined	suitably qualified medical practitioner means a medical practitioner who: <ul style="list-style-type: none"> (a) is an obstetrician or gynaecologist; or (b) has completed a recognised training course within the last 2 years for the provision of advice, performing procedures and giving of treatment in the area of fertility control; or (c) has a valid credential prescribed by regulation.

Provision	Current Act	Proposed Act
Directed health practitioners	Not included	Registered pharmacist, nurse or nurse practitioners ("directed practitioner") may prescribe, supply and administer medication in the performance of a medical termination of pregnancy of less than 14 weeks provided: (a) the suitably qualified medical practitioner has assessed the woman in accordance with the relevant provisions and has directed the health practitioner to prescribe, supply or administer the medicines; (b) the directed practitioner acts in accordance with professional standards and guidelines applicable to the medical practitioner in relation to all aspects of the treatment/procedure, support and location/access to emergency services
Criteria for assessment between 1 and not more than 14 weeks	Requires 2 medical practitioners, one of whom must be an obstetrician or gynaecologist unless not reasonably practicable	Requires 1 suitably qualified medical practitioner
Criteria for assessment between 14 and not more than 23 weeks	Requires 1 medical practitioner	Two suitably qualified medical practitioners
Criteria for assessment for no more than 14 weeks	The continuance of the pregnancy would involve greater risk to the woman's life or greater risk of harm 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 born, the child would be seriously handicapped because of physical or mental abnormalities	Consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances
Location of treatment for no more than 14 weeks	In a hospital	Suitably qualified medical practitioner must act in accordance with professional standards and guidelines. ¹

Provision	Current Act	Proposed Act
Criteria for assessment for no more than 23 weeks	The medical practitioner is of the opinion termination of the pregnancy is immediately necessary to prevent serious harm to the woman's physical or mental health	Consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances
Location of treatment for no more than 23 weeks	Not stated	Suitably qualified medical practitioner must act in accordance with professional standards and guidelines.
Consent for those aged 16 and over and deemed competent	The appropriate person consents to the giving of the treatment.	The appropriate person having authority in law provides informed consent to the treatment
Consent for those aged under 16 or otherwise incompetent	Each person having authority in law provides consent	The appropriate person having authority in law provides informed consent to the treatment
Standards of care	The medical practitioner, in giving medical treatment with the intention of terminating a woman's pregnancy, must give the treatment (a) with professional care; and (b) otherwise according to law.	Suitably qualified medical practitioner must act in accordance with professional standards and guidelines.
Conscientious objection	A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so	<ul style="list-style-type: none"> • A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so • A medical practitioner who conscientiously objects to performing a termination of pregnancy must refer the woman to a practitioner who is known not to hold such an objection.
Safe access zones	Not included	Establish safe access zones extending 150 metres from a place at which termination of pregnancy may be performed.

¹ These include MS Health certification requirements, RANZCOG College Statements and product information guidelines.