INQUIRY INTO THE TERMINATION OF PREGNANCY BILL 2018 (QLD)

SUBMISSIONS BY ANNA WALSH[1], MICHAEL QUINLAN,[2] & MICHAEL MCAULEY[3]

1. Thank you for the opportunity to make submissions to the Committee regarding the Termination of Pregnancy Bill 2018 (Qld). We are lawyers with a keen interest in abortion law. With post-graduate qualifications in bioethics or theology, we have collectively written and spoken extensively on abortion law reform in various jurisdictions throughout Australia, the importance of permitting conscientious objection for health professionals opposed to abortion, and the constitutional validity of safe access zones laws.

2. Both Anna Walsh and Professor Michael Quinlan made individual submissions to the Queensland Law Reform Commission ('QLRC') into its Review of Termination of Pregnancy Laws, and Anna Walsh was a speaker at the Australian Summit on Abortion Law Reform at Queensland Parliament House in March 2018. Our submissions acknowledge the QLRC's Consultation Paper of December 2017, and Report No 76 of June 2018. We restrict the focus of our submissions to issues contained within clauses 5, 6, 8 and 15 of the Bill.

3. Underpinning these three areas of concern runs a common thread about freedom and respect for diversity of belief. Abortion is the destruction of human life and is therefore a moral issue. Whilst the state can make abortion standard healthcare through legislation, some people may disagree. In a free society, they are entitled to disagree, and must not have their right to manifest their disagreement violated unless this is necessary and there is strong evidence that their disagreement harms the community and that infringing their rights is a proportionate response to this harm. The authors support the retention of the current laws on abortion. The purpose of this submission it to provide considered critique of the Bill and raise concerns in three areas we believe require either significant amendment or ought to be completely omitted.

CLAUSES FIVE AND SIX: ABORTION BEFORE AND AFTER 22 WEEKS GESTATION

4. As the Attorney-General and Minister for Justice confirmed in her second reading speech, this Bill demonstrates an historic change in legal policy about abortion. It changes the long held position in various Queensland laws; that the unborn child has moral value regardless of its gestational age and lack of legal personhood; that the termination of its life by any person is a serious crime; and that its termination by a medical practitioner is a principled exception to murder only when done to save the mother's life.

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5. Citing the need to recognize a woman's autonomy, and our human rights obligations to support women's rights to reproductive health,[4] clause five (5) of the Bill permits a medical practitioner to terminate a foetus of not more than 22 weeks gestation for any reason the pregnant woman deems appropriate. Thereafter, clause six (6) permits abortion up to birth provided two (2) medical practitioners agree it is reasonable in all the circumstances, with the clause setting out various issues the medical practitioner must consider.

6. The concept that a viable foetus has a greater value or interests than a non-viable one does not reflect evidence-based medicine. Rather, as the QLRC noted, it reflects the discomfort many Australians feel with late term abortion. The selection of 22 weeks as the threshold for abortion on demand was 'pragmatic',[5] because it sits below the age of viability, and coincides with Queensland's Clinical Services Capability Framework for Public and Licensed Health Facilities, and the processes used at Royal Brisbane and Women's Hospital.[6]

7. Viability outside the womb may be enhanced by the availability of skilled staff and technology. As such, there may be conflicting ages of viability based upon where a child is born. In Australia, selecting an upper limit for abortion on demand is achieved through political compromise. This is reflected in the fact that none of the five jurisdictions in Australia that endorse gestational age limits for abortion has chosen 22 weeks, with the thresholds ranging from 16 weeks in Tasmania to 28 weeks in South Australia.[7]

8. The point of these remarks is to highlight the fact that to disagree with the Bill's ideology about when and why abortion is appropriate is neither irrational nor inconsistent with evidence based medicine. Just as the decision to undergo abortion is, as noted by the Attorney-General in her second reading speech, 'never an easy option' and one that 'no-one makes lightly', it should not be surprising that requiring a registered health practitioner to perform or participate in the act of abortion is also a difficult decision on their part.

9. The object of the Bill is to provide clarity to women, health professionals, and the community about when abortion is lawfully permitted. Whilst it is arguable that clause five (5) achieves this object by having one threshold for abortion on demand based on the gestational age of the fetus, clause 6(3) permits a medical practitioner to perform an abortion after 22 weeks without a second opinion from another medical practitioner if the request is made in the context of an emergency.

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[4] There is no human right to abortion. Whilst some human rights committees have chastised certain nation states for not having liberal abortion laws, the content and scope of a nation's reproductive healthcare remains a matter for domestic legislation and policy.

[5] QLRC Report [3.183].

[6] QLRC Report [31.86]-[3.192]. These sections of the QLRC report are highlighted in the Explanatory Memorandum to the Bill.

[7] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s4; *Criminal Code Consolidation Act 1935* (SA) s82A(8).

10. With 'emergency' not defined in schedule 1 of the Bill, it could be interpreted either narrowly or broadly. A plain reading of the full text of the clause suggests it permits a subjective assessment by the relevant medical practitioner as to whether abortion is necessary to 'save the woman's life or the life of the unborn child'. However it is unclear whether the emergency that saves the woman's life is an imminent threat of significant harm to her actual life, or a risk of less magnitude that includes the avoidance of harm to her physical or mental health.[8]

11. Precedent for a broad interpretation of the phrase 'saving the woman's life' can be found in the Queensland abortion case law, which over time, saw concerns for the woman's mental health as sufficient to justify abortion.[9] The absence of a clear definition of emergency is problematic for health practitioners who have a conscientious objection to abortion. This is because clause 8(4) provides that a registered health practitioner's freedom to decline to perform abortion does not limit any duty they owe to provide services in an emergency.

12. To provide clarity, the concept of an emergency abortion needs to be defined. Contravention of clause 8 can be used in notifications or referrals under the *Health Practitioner Regulation National Law*, or a complaint to the *Health Ombudsman Act 2013* concerning professional conduct or performance. As abortion is the termination of human life, a duty to perform it notwithstanding a conscientious objection should only occur in the context of a narrow definition of emergency that favours the significant risk of the imminent loss of the woman's life. Such a definition of emergency should be inserted into Schedule 1.

CLAUSE EIGHT: CONSCIENTIOUS OBJECTION BY HEALTH PRACTITIONERS

13. Conscientious objection to abortion, which is also not defined in Schedule 1 of the Bill, is a contentious issue. Australian law recognizes respect for patient autonomy as part of the ethics of modern medicine,[10] in that patients can rely upon this principle to refuse treatment on themselves that a doctor may believe is in the patient's best interests.[11] However, generally speaking, the law does not permit a patient to use this principle to demand that a doctor provide or facilitate a health service that contravenes the doctor's belief that the service is not medically indicated, and/or is harmful to the patient.

14. Clause 8 of the Bill requires registered health practitioners with a conscientious objection to abortion to refer or transfer the patient's care to another registered health practitioner who in the first practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of abortion; or a health service provider where, in the first practitioner's belief, abortion, or the service requested, can be provided by another registered health practitioner who does not have a conscientious objection to abortion.

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[8] The Oxford dictionary defines 'emergency' to be a serious, unexpected and often dangerous situation requiring immediate action. This does not assist with interpreting emergency in the present context.
[9] See, *State of Queensland v B* [2008] 2 Qd R 562; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87.
[10] See, *Rogers v Whitaker* (1992) 175 CLR 479.
[11] See, eg, *Brightwater Care Group Pty Ltd v Rossiter* (2009) WASC 229; *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

15. Neither 'refer' nor 'transfer' are defined in Schedule 1 of the Bill. Clause 6.3 of the Medical Board of Australia's 'Good Medical Practice: A Code of Conduct for Doctors in Australia' notes that referral usually involves a transferring of responsibility for the patient's care for a defined time and for a particular purpose, such as care outside the doctor's area of expertise, to another doctor or healthcare professional.'[12] This suggests referral is a formal process but again, more clarity is required in the Bill, as it may make a difference to an objector.

16. Assuming it is a formal process, requiring the conscientious objector to refer to a willing provider assumes there is a normative distinction between direct and indirect participation. There is no evidence that health practitioners that have a conscientious objection to abortion agree that such a distinction even exists. An absolutist position, it either denies or dismisses diversity of belief within the medical profession, and demands that doctors be obedient to the state and conform their professional conscience to its ideology about healthcare.

17. At its heart, laws imposing mandatory referral destroy the notion of individual rights and beliefs, with conscientious objection taking on a social dimension.[13] Using the Utilitarian definition of beneficence, the good the doctor must do for his or her patient is replaced by the good the medical profession should do for society. The aim of such laws is to normalize abortion as healthcare through the indoctrination of the medical profession, with a flow on effect into the community. In imposing Utilitarian ethics on all doctors, it is hard to escape the conclusion that doctors are reduced to mere technicians or service providers

18. Given it is the doctor's individual freedom that may be infringed by this clause, the issue needs to be determined from their perspective, not that of other doctors who support abortion and who find it unintelligible that a doctor would refuse to refer. The impact of forcing a person to perform acts against conscience has been documented in various studies that support the finding of moral distress, including one from Norway that explores the experiences of seven (7) doctors who referred to abortion against conscience.[14]

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[12] See, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for doctors in Australia*, <http://www medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.

[13] See, eg, Nancy Berlinger, 'Conscience Clauses, Health Care Providers, and Parentin *From Birth to Death and Bench to Clinic: The Hastings Centre Bioethics Briefing Book for Journalists, Policymakers and Campaigns* (Garrison, NY: The Hastings Centre, 2008), 35; cf Nicholas Tonti-Filippini, *About Bioethics – Philosophical and Theological Approaches* (Connor Court, 2011) 19, 20.

[14] See, Eva M Kibsgaard Nordberg, Hege Skirbekk and Morten Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?' (2014) 15 *BMC Medical Ethics* 15; Michael Quinlan, 'When the State requires doctors to act against their conscience: the religious freedom implications of the referral and the direction obligations of health practitioners in Victoria and New South Wales" (2016) *Brigham Young University Law Review* 101.

19. In Australia, whilst there are no published studies that document the impact of health professionals acting against conscience, Anna Walsh is conducting a qualitative study on 30 doctors in New South Wales and Victoria who have a conscientious objection to abortion.[15] Preliminary findings are that the majority of respondents object to not just referral but other peripheral acts such as paperwork for abortion, and medical tasks such as inserting a cannula to ensure venous access for fluids or medication to be used during the abortion.[16]

20. Assuming that compelling a doctor with a conscientious objection to abortion to refer to a willing provider burdens their human rights, the state is required to prove that referral is necessary. A doctor's referral is not required to access abortion in Queensland. There are no restrictions on the advertising of abortion services in Queensland, with information freely available on the Internet. Women who are up to nine (9) weeks pregnant can order medication for medical abortion over the Internet and have it delivered to their door within 24 to 72 hours.[17]

21. It is true that there may be geographical hurdles for people living in rural and remote areas where there is no abortion clinic nearby, or where medical abortion is prohibited because the fetus is beyond nine weeks gestation. This can lead to intrastate travel with consequential social and financial losses. However limited service is hardly a novel situation in remote areas. Additionally, even if a referral were provided, when the woman can obtain an abortion in the city is a supply and demand issue.

22. Referral is a gesture. Refusing to refer arguably does not impede timely access to abortion, as referral will not ensure immediate access to abortion. It is unclear whether decriminalizing abortion will lead to more doctors willing to perform abortion, and travel to geographical places where the demand is high. However forcing referral dilutes the strength of a doctor's conscientious objection, and their moral condemnation. This is often argued as an important compromise to ensure the patient does not experience 'dignitary harm'.

23. The need to avoid dignitary harm is supported by notions of respecting autonomy and practicing 'value-neutral medicine'.[18] Whilst arguably foreseeable, dignitary harm is not subject to a reasonable person test, and not constrained by the need for proof. If one accepts that refusing to affirm the patient's decision to undergo abortion by providing a referral may cause the patient dignitary harm, there must still be a coherent argument as to why a doctor must alter their behavior so as to avoid this harm.

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[15] The Human Research and Ethics Committee of the University of Notre Dame Australia have approved this study.

[16] The Explanatory Memorandum to the Bill notes that clause 8 does not extend to administrative, managerial, or other tasks ancillary to the provision of termination services (pg 9).

[17] See <https://www.tabbott.org.au> and https://mariestopes.org.au.
Medical abortion pills can be ordered from the Tabbott Foundation or Marie Stopes. Catering to women who are up to nine weeks pregnant, and reside in country or rural areas, the only requirement is that the woman live within two hours of a medical facility in case of an emergency, and where the law does not permit abortion on demand, the provider must consider abortion to be suitable.

[18] Francis J. Beckwith and John F. Peppin, 'Physician Value Neutrality: A Critique' (2000) 28(1) *Journal of Law and Medicine* 67, 68.

24. The fact of dignitary harm cannot be the basis of a complaint about a doctor's professional conduct. This is because doctors must exercise independent professional judgment when deciding what is in the patient's best interest when providing medical care.[19] Accordingly, where the patient's request involves an illegal service, or where the request is not medically indicated, or is known to be harmful to the patient, a doctor would contravene international ethical standards of conduct in acceding to the request merely to respect the patient's autonomy.

25. The fact that other jurisdictions of Australia, or indeed countries overseas, have seen fit to place limits on when a health professional may decline to participate in an abortion because of a conscientious objection is hardly a sufficient reason for Queensland to follow suit. We are told that the Palaszczuk government is committed to informed, effective, evidence based policy. Whether clause 8 achieves the correct balance between freedom of conscience and the need to deliver timely health care requires further exploration and research.

26. Imposing mandatory referral without knowing whether women's dignity is harmed by a refusal to refer, and how health practitioners will be negatively impacted is reckless. There is no requirement that an abortion on demand framework must involve mandatory referral laws. Three jurisdictions in Australia have both decriminalized abortion when performed by a doctor in accordance with certain legislative criteria, but have preserved the health professionals' freedom to decline to participate in abortion.[20]

27. As the QLRC Report itself recognises there are a range of community attitudes towards abortion.[21].We should similarly expect our medical professionals to have a range of views about abortion if they are representative of the patients whom they treat. Imposing mandatory referral may impact on the willingness of health professionals with a conscientious objection to abortion entering the profession and undermine the representative nature of the health profession and the impact this may have upon patient care is unknown.

28. Keeping abortion in private health facilities reduces potential conflict. Doctors who choose to work in private abortion clinics willingly facilitate the patient's request for abortion. The impact of abortion being offered in public hospitals must be considered. In a free society that respects diversity of belief, compelling individuals to act against their conscience is not the way to resolve problems with the supply and demand. Before imposing mandatory referral, the state must consider less restrictive means to achieve reasonable access to abortion.

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[19] World Medical Association, International Code of Medical Ethics, adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 <https://wma net>.
[20] See, *Health Act 1993* (ACT) ss82-4; *Health Act 1911* (WA) s334(3); *Criminal Law Consolidation Act 1935* (SA) s82A.
[21] QLRC Report[2.134]-[2.138.]

CLAUSES 11-15: SAFE ACCESS ZONES AROUND ABORTION CLINICS

29. Clause 15 is partly modelled off the Victorian Act. With its ambiguous language, it has a potentially wide ambit of operation. It not only infringes the fundamental rights and freedoms of people to protest about abortion outside an abortion clinic and, potentially, to engage in political communication on this topic, but extends to silent prayer vigils outside a clinic, or those who stand outside clinics with information about options other than abortion in order to empower women to make an informed decision about their pregnancy.

30. To qualify as a necessary and reasonable infringement of individuals' rights, Parliament should be satisfied that there is evidenced based research that can identify what activities occur outside abortion clinics in Queensland, prove that these activities cause harm to women that can be differentiated from any harm consequent to undergoing abortion, and conclude that these activities represent a genuine public health risk that can only be controlled by the proposed insertion of these particular safe access zone laws.

31. The objects of Part 4 of the Bill set out in clause 11, are to ensure that a person's entitlement to access an abortion clinic is respected, and that their safety and wellbeing, privacy and dignity are protected when entering or leaving it. However Part 4 appears to assume as a fact that the presence and activities of people outside abortion clinics in Queensland are a source of harm to people entering. Justice and fairness demand that this assumption be scrutinized, and all stakeholders affected by this proposed law be invited to present their perspective.

32. A democratic society permits the expression of different viewpoints on controversial or moral issues. If the state takes a particular position on such an issue in its law, it must not punish those who disagree with it, nor embed a presumption into other laws that the issue is resolved and everyone must conform to the state's position. The claim that the expression of viewpoints causes harm to others is a novel proposition. Such an allegation must be supported by evidence with a metric for assessing harm.

33. Clause 15(1) of the Bill prohibits conduct that relates or could reasonably relate to abortion and would be visible or audible to another person in or entering the clinic, and would be reasonably likely to deter a person from entering or leaving the clinic or requesting or undergoing an abortion or performing or assisting with an abortion. With its wide language, the clause is worrying and sets a low bar given that clause 15(2) provides that there need not be an actual person who is deterred from the actions mentioned. Absurd results may follow.

34. Not measured against a standard such as the 'reasonable person', a plain reading of the text of clause 15(1) suggests that a sensitive person who hears or sees prohibited conduct about abortion, including a conversation not meant for them, is sufficient to conclude that a person has committed a crime punishable by up to one year's imprisonment. This is an extreme and unjustified violation of freedom of speech. Family or friends accompanying women into or out of abortion clinics would be unable to discuss a re-thinking of abortion when in the zone.

35. Yet clause 15(3) permits an exception for prohibited conduct by clinic employees. The cleaner employed by the abortion clinic, therefore, may talk about abortion in the zone and potentially cause a woman to re-think her decision but not be caught. The lack of logic in providing a blanket exception for clinic employees displays an absurd presumption in the Bill; that only people employed by an abortion clinic can be trusted to say the 'right' things about abortion that does not cause the 'wrong' kind of harm to a woman's health.

36. People walking past a clinic in the zone, and wearing apparel that associates them with a pro-life view, would be engaging in prohibited conduct. So too would pregnancy counselling services situated within the zone that have signage. It is not enough for supporters of the Bill to say that it will not be used to prosecute law-abiding members of the community who happen to express pro-life views in the zone, and are overheard by those entering or leaving an abortion clinic. They can give no assurance in this regard.

37. Elsewhere at clause 16(2), the Bill makes exceptions for reasonable excuse. Therefore, the absence of an exception for clauses 15(1)(2) must either be poor drafting, or a clear indication that Parliament seeks to interpret the provision harshly. We do not support the need for safe access zones around abortion clinics, however should it pass, we support the reasonable amendments proposed by Mr. Damien Tudehope MP during the Parliamentary debate on the NSW Public Health Amendment (Safe Access to Reproductive Health Clinics) Bill 2018.[22]

38. There are a number of groups in Queensland that organize regular prayer vigils which they distinguish from protesting or demonstrating, and which perform sidewalk counselling. Sidewalk counselling is an activity which informs women of choices other than abortion, and offers practical help and assistance to women who may feel that they have no other choice than to undergo abortion, and who are in great turmoil or distress when considering abortion as a viable option for their personal circumstances. [23]

39. For some women, abortion is not an exercise of free choice, but rather the product of coercion or domestic violence producing emotional sequelae including post abortion grief. In addition, the decision to undergo abortion may be made without the woman in question having any knowledge of organizations designed to support women in a decision to continue pregnancy, and who provide emotional, financial and medical support. There is a real question as to what level of information, support and referral, counsellors at private abortion clinics give women who fall into this category.

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[22] NSW, *Parliament Debates*, House of Representatives, NSW 7 June 2018, 12:13 (Damien Tudehope).

[23] In *McCullen et al v Coakley, Attorney General of Massachusetts et al* 573 US (2014), the United States Supreme Court struck down safe access zone laws in Massachusetts and accepted evidence that a significant number of women were assisted by sidewalk counsellors, and had chosen a different path.

40. The Clinical Services Capability Framework for Public and Licensed Private Health Facilities and its companion Manual for Termination of Pregnancy (version 4.3) notes that psychological counselling is provided to women pre-abortion. Evidence that such counselling has been provided must be placed with the patient's documents, with a copy of the report provided to the treating medical practitioner. Where the medical practitioner provides the counselling, documentation must be included in the patient's medical record.

41. It is concerning that the medical practitioner performing the abortion may also provide the pre-abortion counselling. There is a clear conflict of interest. If we are to be satisfied that the Bill provides for the safe access of abortion to women, then there must be persuasive evidence that private abortion clinics provide adequate 'all options' internal counselling or make adequate external referrals, and that the community as a whole benefits from the criminalizing of sidewalk counselling on the basis that it causes more harm than help.

42. The constitutional validity of laws creating safe access zones around abortion clinics in Victoria and Tasmania is subject to an appeal to the High Court of Australia, which will be heard in October 2018.[24] The basis of the appeal is whether it infringes the implied freedom of political communication that has been found to exist in the Commonwealth's Constitution, which would invalidate any state laws to the extent that they interfere with this freedom. Therefore these cases are closely connected to Part 4 of the Bill and relevant to discussion.

43. In the High Court constitutional challenge, the Attorney General for the state of Victoria in support of the Act, relied upon affidavit evidence and medical studies from two medical experts who claimed the activities of persons outside clinics were a cause of harm to women entering to obtain abortion. This evidence was relied upon to uphold the validity of the Act at first instance, with the Magistrate satisfied that individuals accessing abortion premises would be targets of intrinsically harmful behaviours on the part of anti-abortion protesters.[25]

44. The state's experts were not cross-examined about their evidence and no evidence from health professionals, or medical studies, was submitted by the defence in response to these affidavits. Valid and reliable medical studies documenting a causal connection between persons outside abortion clinics and harm suffered by women entering to obtain an abortion is relevant to the 'importance of the purpose' pursued by the legislature, which is central to the third question of the implied freedom of political communication test.[26]

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[24] *Clubb v Edwards and Attorney General for Victoria* (No. M46 of 2018).
[25] *Edwards v Clubb* (Unreported, Magistrates' Court of Victoria, Magistrate Bazzani, 6 Oct 2017, Case Number G12298656).
[26] *McCloy v New South Wales* (2015) 257 CLR 178 at 194–5 (French CJ, Kiefel, Bell, Keane JJ). as modified in *Brown v Tasmania* (2017) 91 ALJR 1089 at [104].

45. The third question requires a Court that has found the purpose of a legislative provision to be legitimate to ask whether the law is 'reasonably appropriate and adapted to advance that legitimate object in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government?'[27] The third stage requires that the law is 'adequate in its balance' which is 'a criterion requiring a value judgment, consistently with the limits of the judicial function, describing the balance between the importance of the purpose served by the restrictive measure and the extent of the restriction it imposes on the freedom'.[28]

46. There are significant problems with the claim that harm may be caused by individuals outside abortion premises. The authors of the studies[29] fail to acknowledge that some individuals outside abortion premises may help women to continue their pregnancy and potentially avoid significant emotional harm from undergoing an abortion due to lack of resources. The focus of the studies is on only the potential harm that might be caused by individuals outside abortion premises and this undermines the value of their evidence.

47. Limitations to the medical studies before the High Court include:

    a. The limited amount of medical evidence provided to support claims of harm:
    b. The excessive reliance on one abortion premise, the Fertility Control Clinic in East Melbourne;
    c. The failure of the evidence to account for the diversity of individuals outside abortion premises;
    d. The failure to consider that the overseas studies relied on may be not be applicable to an Australian setting;
    e. The failure to consider that adverse emotional reactions may be due to the stress of any medical procedure and a termination of pregnancy in particular;
    f. The absence of control groups in most of the studies;
    g. The difficulty in accurately comparing a patient's typical emotional state with their emotional state while at abortion premises;
    h. The possibility that third parties may influence an individual's perception of individuals outside abortion premises;
    i. The possibility that a patient's support person may have compromised the reliability of data obtained;
    j. The possibility that biased terminology may have compromised the reliability of data obtained;
    k. The possibility that author bias may have compromised the reliability of data obtained; and
    l. The possibility that the reliability of data in the studies may have been compromised if it was obtained while the research participant was still affected by sedation.

5 September 2018

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[27] *Brown v Tasmania* (2017) 91 ALJR 1089 at [104].
[28] *McCloy v New South Wales* (2015) 257 CLR 178 at 195 (French CJ, Kiefel, Bell, Keane JJ).
[29] Diane Foster et al, "Effect of abortion protesters on women's emotional response to abortion" (2013) 87 *Contraception* 81; Graeme Hayes and Pam Lowe, "'A Hard Enough Decision to Make': Anti-Abortion Activism outside Clinics in the Eyes of Clinic Users" (Aston University, September 2015); Katrina Kimport, Kate Cockrill and Tracy A Weitz,'Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics'(2012) 85 *Contraception* 204.