

Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia

L A Keogh,¹ D Newton,² C Bayly,³ K McNamee,⁴ A Hardiman,⁵
A Webster,⁶ M Bismark⁷

For numbered affiliations see end of article.

Correspondence to

Dr Louise Keogh, Centre for Health Equity, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, VIC 3010, Australia; l.keogh@unimelb.edu.au

Received 20 May 2016
Revised 7 August 2016
Accepted 7 November 2016
Published Online First
2 December 2016

ABSTRACT

Introduction In Victoria, Australia, abortion was decriminalised in October 2008, bringing the law in line with clinical practice and community attitudes. We describe how experts in abortion service provision perceived the intent and subsequent impact of the 2008 Victorian abortion law reform.

Methods Experts in abortion provision in Victoria were recruited for a qualitative semi-structured interview about the 2008 law reform and its perceived impact, until saturation was reached. Nineteen experts from a range of health care settings and geographic locations were interviewed in 2014/2015. Thematic analysis was conducted to summarise participants' views.

Results Abortion law reform, while a positive event, was perceived to have changed little about the provision of abortion. The views of participants can be categorised into: (1) goals that law reform was intended to address and that have been achieved; (2) intent or hopes of law reform that have not been achieved; (3) unintended consequences; (4) coincidences; and (5) unfinished business. All agreed that law reform had repositioned abortion as a health rather than legal issue, had shifted the power in decision making from doctors to women, and had increased clarity and safety for doctors. However, all described outstanding concerns; limited public provision of surgical abortion; reduced access to abortion after 20 weeks; ongoing stigma; lack of a state-wide strategy for equitable abortion provision; and an unsustainable workforce.

Conclusion Law reform, while positive, has failed to address a number of significant issues in abortion service provision, and may have even resulted in a 'lull' in action.

Key message points

- ▶ While experts agreed that law reform had been positive, they did not think it had significantly changed practice.
- ▶ Perhaps coincidentally, the perception of experts was that access to public surgical abortion and post 20-week abortion had shrunk since law reform. In order to address a number of outstanding issues, the development of a statewide strategy for the provision of services and a plan to address workforce shortages is recommended.

INTRODUCTION

Worldwide, a slow trend towards the liberalisation of abortion laws has been observed since the 1960s,^{1 2} with some suggesting that the trend may have slowed since the late 1980s.³ Despite the overall trend, however, according to Finer and Fine, 39% of people still live in countries with highly restrictive abortion legislation, and even in countries with legal abortion, strategies designed to reduce access have been introduced.² For example, in the USA, the introduction of mandatory counselling and waiting periods has significantly disrupted women's access in some states,² and in Italy there is a positive regional correlation between delay in abortion and the number of doctors who claim their right to conscientious objection.⁴

In Australia, while abortion is a commonly performed medical procedure, experienced by an estimated 80 000 women each year,⁵ and in the main



▶ <http://dx.doi.org/10.1136/jfprhc-2016-101676>



CrossMark

To cite: Keogh LA, Newton D, Bayly C, et al. *J Fam Plann Reprod Health Care* 2017;**43**:18–24.

considered socially acceptable,^{6–8} laws relating to abortion still vary across state and territory jurisdictions.⁹ In Victoria, abortion was only decriminalised in October 2008, bringing the law in line with clinical practice and community attitudes.¹⁰ The Abortion Law Reform Act 2008¹⁰ renders abortion provided by registered health practitioners (defined in the Act) a matter for health regulation, like other health care, removing criminal sanctions from women seeking abortion and qualified health practitioners providing it. While legal status alone does not imply accessible services, there is evidence that the legal status of abortion does affect the practice of doctors and their willingness to provide abortion services.^{11 12} Legal status is also assumed to contribute to women's experience of stigma, and the associated negative psychological outcomes.^{13 14} In this article we explore the link between the legal status of abortion and its accessibility, by describing the practical impact of the 2008 Victorian law reform on abortion provision, and women's experience of accessing abortion services, from the perspective of experts.

Prior to law reform in Victoria, abortion was regulated under the Crimes Act 1958. Under this Act it was a criminal offence to bring about, attempt to bring about, or assist a person to bring about, an unlawful termination of pregnancy. The circumstances in which termination of pregnancy was lawful had been left to judicial determination. In practice, women were able to lawfully seek a termination of pregnancy by a medical practitioner in certain circumstances, but there were barriers to access related to costs, rural and regional location and gestation, particularly in the public health system.¹⁵

With the enactment of the Abortion Law Reform Act 2008 (Vic), and amendment of Part 3 of the Crimes Act 1958 (Vic), it is legal for any woman in Victoria who is no more than 24 weeks' pregnant to obtain an abortion from a registered medical practitioner. The definition of abortion in the Act includes both surgical and medical (drug-induced) abortion. After 24 weeks, abortion can be performed only if the medical practitioner reasonably believes it is appropriate in all the circumstances, that is, having regard to all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances. They must have consulted at least one other medical practitioner who also believes it appropriate. A health practitioner who has a conscientious objection to providing abortion is not required to provide abortion services but must refer any woman seeking information about abortion services to another health practitioner, in the same profession, who does not object (Box 1).

Abortions conducted after 20 weeks of pregnancy are considered to be more complicated both ethically and medically. According to Black and colleagues, many of the abortions conducted after 20 weeks in New South Wales and Queensland are performed

Box 1 The purpose of Section 8

Section 8, the Abortion Law Reform Act

- ▶ Section 8 sets out the action that must be taken by registered health practitioners who have a conscientious objection to abortion (Abortion Law Reform Act, 2008). Any health practitioner who is asked to advise a woman about abortion, or perform, direct, authorise or supervise an abortion, and who has a conscientious objection to abortion must; (1) inform the woman that they have a conscientious objection; and (2) refer the woman to another health practitioner, in the same profession, who the practitioner knows does not have a conscientious objection to abortion.
- ▶ This section ensures that a health practitioner with a conscientious objection to abortion is not discriminated against. It also ensures that the beliefs of the health practitioner do not affect the ability of their patients to access healthcare. In cases of emergency, registered medical practitioners and registered nurses cannot rely on the conscientious objection disclosure provisions and may be required to perform an abortion if it is necessary to preserve the life of the pregnant woman.

following prenatal genetic testing for fetal abnormalities.¹² Their qualitative research with abortion providers in these two states has shown that in practice, access to abortions after 20 weeks in public hospitals may be delayed at least in part because of the requirement to involve an ethics committee. They found that "Twenty-one of the 22 practitioners or their colleagues had to refer women interstate to have an abortion because the ethics committee would take too long to convene" (p. 146). Given the legal change in Victoria, there should be fewer barriers to abortion up to 24 weeks, at least from a legal standpoint. However, there has been little analysis of access to abortion after 20 weeks in Victoria following law reform, and it is unclear whether law reform has affected the decision-making process for these abortions in public hospitals, or the availability of trained clinicians willing or able to perform these abortions.

In Australia, abortion services have historically been marginalised within the wider medical community and this was thought to be at least in part because of a lack of clarity under the law. The legal status of abortion would be expected to impact on the willingness of doctors and nurses and counsellors to work in the area,¹¹ the reporting and monitoring of services, the adoption of best practice and training and professional development,¹⁶ as well as the experience of stigma and shame for both women and providers. However, it is unclear how much impact law reform alone – without associated health policy change mandating

access to services – can have on attitudes towards, or availability of, abortion. In this study we explore how experts in abortion service provision perceive the intent and subsequent impact of the 2008 Victorian abortion law reform on their practice.

METHODS

In order to explore the impact of the 2008 abortion law reform on abortion provision in Victoria we conducted a qualitative study with experts in abortion. A qualitative approach was chosen as a paucity of robust abortion statistics¹⁷ precluded a quantitative analysis of changes in provider behaviour. We purposively sampled for the individuals with the most experience of abortion service provisions pre and post law reform – individuals with experience at each stage of abortion service delivery and working in Victoria.

The interviews took place between October 2014 and April 2015 prior to the introduction and passage of a bill to enforce ‘safe access’ zones around abortion clinics, passed in November 2015.¹⁸

Individuals were invited to take part in this study if they were known to work in abortion service provision, and were identified through our professional networks and snowball sampling. We sampled for participants from urban and regional services, from a range of service providers (including, at a minimum, medical practitioners, nurses, counsellors and service managers), and from both private and public services, hospitals and stand-alone clinics. Nineteen experts were invited to take part in the study and all agreed to participate (Table 1). Saturation was reached in relation to the theme ‘intent and achievements of law reform’ for the sampling strategy we used. Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee.

Participants took part in a semi-structured interview either face-to-face or over the telephone (participant’s choice). The interview covered participants’ experiences providing abortion services, their role in the 2008 law reform, their views of both the intent and outcomes of abortion law reform, and remaining challenges. They were also asked about their experience of medical abortion and their views on the role of general practitioners in provision.^{19 20} Interviews were conducted by DN, and lasted between 30 minutes and 2 hours; de-identified audio-recordings were transcribed verbatim. Initial reading of the data was conducted by DN and LAK and four broad themes were identified from the data. LAK then used a progressive process of classifying, comparing, grouping and refining groupings of text segments to create further classifications in one of the broad themes (intent and achievements of law reform).²¹ In order to ensure reliability, DN independently checked the further classification developed by LAK. Discrepancies were discussed and a mutually agreeable interpretation was reached. Due to concerns

Table 1 Characteristics of the study participants

Characteristic	Participants (n) (n=19)
Gender	
Female	15
Male	4
Organisation*	
Sexual and reproductive health service	7
Hospital	
Public hospital	5
Private hospital	1
General practice	3
Community health service	2
Reproductive health service	2
Sexual health service	1
Young person’s health service	1
Professional role	
General practitioner	5
Obstetrician/gynaecologist	4
Medical practitioner	3
Service manager	3
Primary health care nurse	2
Psychologist	1
Sexual health physician	1
Geographical location	
Metropolitan	11
Regional/rural	8

*Participants could work in more than one organisation.

about potentially identifying participants, individuals quoted in this paper are referred to by number only, with no identifying details.

RESULTS

One overarching sentiment was present in all interviews: abortion law reform, while a positive event, had changed little about the practical provision of abortion, and that much ‘unfinished business’ remained. Participants felt that progress had stalled since law reform, and they were concerned about outstanding issues like protesters, access and a sustainable workforce.

“To be perfectly honest, the law reform has not impacted that much on our practice.” [P19]

“And I think then there was almost a bit of a vacuum post that reform, around people making a noise or talking about abortion ... And then I think in a conservative government, as our State Government, who weren’t the government that got the reform through, has been hard too. So I think everyone has been quiet, and we haven’t had a government that could really – that was going to be supportive of that.” [P10]

The detailed views of participants can be categorised into five main themes: (1) goals that law reform was intended to address and that have been achieved; (2) intent or hopes of law reform that have

Table 2 Summary of participants' perspectives on the intended and unintended consequences of abortion law reform in Victoria, Australia

Theme	Quote
Section 1. Intended and achieved	
Position abortion as a health issue rather than a legal issue	The climate, or the culture, the philosophical or moral background is clearer and very positive. [P01] The intent of the law reform as I understand it was to validate and make legal the current experience. So it was to acknowledge that women are having terminations and that they're requesting termination of their own volition and that that's not illegal. [P12]
Shift the power in decision making from doctors to women	It has taken away that difference about abortion and the doctor being the one who decided if it was in the patient's right interest ... it's made it much more of a conversation rather than a decision making on the part of the doctor – if that makes sense. [P12] I think it was to put reproductive rights back in the hands of the women, but it is primarily to get it out of the criminal code. And it did do that, I think it has done that. [P10]
Increase clarity and safety for doctors providing abortion	Was it achieved? Yes. I feel very comfortable now doing what I do, as prior to the reform I felt a bit uncomfortable doing what I was doing. You had to look over your shoulder every minute. [P18] The immediate change unexpectedly was that I felt a huge sense of relief ... When the decrim went through I really felt something go off my shoulders in terms of 'well no one can ever call me a criminal'. It made me realise that that ambiguity was actually at play for health providers. [P05]
Section 2. Hope (or intent) of law reform and not achieved	
Increase access to abortion	Well the intent of the Law Reform was to take it away from the criminal code, and it achieved that. Did it make abortion more accessible? Of course not. [P09] I think the intent hopefully was accessibility, but I don't think it's been achieved. [P11]
Decrease stigma (for doctors and women)	I guess what I hoped though was that it would over the years feed into destigmatising the area, feed into abortion being considered a normal aspect of women's reproductive health care and fertility choices and be seen as just part of a normal gamut of people trying to be in control of their fertility.... Yes, so I'm hoping that that destigmatisation – I think that will be kind of a slowish process. [P05] The reason I felt that that was done was so that there wasn't sort of that stigma attached to having an abortion But I still believe that there is that, you know sort of that stigma attached to having an abortion, and that's why a lot of practitioners won't or don't, sort of aren't interested in becoming providers for medical terminations as well. [P13] I still think there's as much stigma around it. No one wants to say they're having an abortion or tell people. [P03]
Section 3. Unintended negative consequence	
Section 8 increased the legitimacy of 'opting out' of abortion provision	One of the things in the abortion law reform is the 'opt out' clause and institutions have taken that on board. There's nothing that says an institution can opt out but institutions have grasped it to say there's the 'opt out' clause so we don't have to provide a service. It doesn't say that. It just says that if the clinician doesn't want – yeah. [P12]
Section 4. Coincidences	
Reduced public provision	Since abortion law reform access to public services has shrunk. It's not getting better. It's shrunk. [P12] If you live 4 hours from Melbourne it doesn't matter, the legality of your reasoning of why you need a termination does not matter at all when you can't get one. [P11]
Reduced provision of late abortion	I suppose I've seen a narrowing of services. A few years ago women were able to privately access post-24week abortions but they can't anymore unless it's – like I'd say it's extremely rare and it would be for a severe fetal abnormality. [P03]
Introduction of medication abortion	I suppose the shift has been the availability of medication abortion which I suppose is unrelated to the legislation. [P03] I think the thing that's probably made it a little bit more accessible is the availability of the medical termination I think rather than the actual law itself. [P06]
Section 5. Unfinished business	
Presence of protesters at abortion clinics	I was very aware that sadly it would not change many of the issues that are big issues in terms of abortion provision. So it would not deal with the access issue of being harassed and intimidated by extremists. [P05]
Lack of a state-wide strategy for abortion provision	What is happening now is because the health department or the government doesn't have a strategy, and there has been no change to the development of abortion services from a state perspective. Then it has to be up to individual practitioners and organisations and that's what's happening now ... The context has lifted a bit and that has made it more feasible but there's still no overall strategy so it's very slow. [P01]
Sustaining the workforce	There's no new providers or anything popped out of the woodwork, nothing whatsoever. And the providers that there are, are getting very old. [P09] One of our main problems is trying to recruit practitioners to work for us. It's incredibly difficult to get somebody – general practitioners, specialists, anybody, to join the service, to see it as something that they want to do... None of us are getting any younger, and a lot of practitioners are in their late 60s, early 70s ... so at some stage there's going to be a problem. [P19]

not been achieved; (3) unintended consequences; (4) coincidences; and (5) unfinished business.

There was strong agreement that three key goals of law reform had been achieved: positioning abortion as a health issue rather than a legal issue; shifting the power in decision making from doctors to women; and increasing clarity and safety for doctors. All agreed these goals had been achieved, leading to more comfortable consultations with women, and a sense of relief for providers who no longer felt the stress of legal uncertainty (Table 2, Section 1).

However, on two issues – increased access and decreased stigma – there were differing views as to whether addressing these issues was a core purpose of law reform, or only a hoped-for side effect of law reform. All agreed that either way, these issues had not been resolved. Participants agreed that at present, in Victoria, access had not improved following law reform – indeed, some felt it had shrunk – and that stigma remains for both women and providers (Table 2, Section 2).

Some described an unintended negative consequence of law reform relating to what they called the ‘opt out’ clause (Section 8 of the Act). As described above, this clause allows health practitioners to state a ‘conscientious objection’ to abortion, and refer women to an alternate health practitioner. A few participants felt this clause had increased the legitimacy of ‘opting out’ of abortion provision, and that as a consequence of this clause, whole institutions could justify not providing abortion services (Table 2, Section 3).

Three coincidences (things that occurred following law reform, but were not directly linked to law reform) were: reduced public provision; reduced provision of abortion after 20 weeks of pregnancy; and the introduction of medical abortion. Participants consistently reported these changes, but did not see them as a consequence of law reform, more as coinciding with law reform. Most expressed concern about the reduced access to surgical abortion and abortion after 20 weeks in Victoria, and were positive about the role of medical abortion in increasing access since its introduction (Table 2, Section 4).

There was strong consensus that there was ‘unfinished business’ in the provision of abortion services; presence of protesters at abortion clinics; the lack of a state-wide strategy for abortion provision; and the sustainability of the workforce. They felt that time and patience, as well as political will, would be required for these issues to be addressed in the future. Some felt that there had been a lack of progress made following law reform, and that those wanting change were biding their time until there was a more supportive political context for addressing the remaining issues.

DISCUSSION

This research presents experts’ views on the impact of abortion law reform on service provision. These

experts, responsible for designing and/or delivering abortion services to women in a range of settings, are well placed to describe the impact of the change in law on the everyday practice of abortion. Due to the lack of routine data collection on abortion provision in Victoria, we are dependent on experts’ accounts to describe the impact of law reform. These experts perceived a coincidental reduction in public service provision and provision of abortion after 20 weeks, yet we are unable to confirm this finding. The voices of these individuals provide an important perspective on the state of services and on the changes that have occurred over the 7 years since law reform. Due to the timing of the ‘safe access’ zones legislation, we were unable to determine the impact of this change on their practice. Further research incorporating the voices of women using abortion services, policy-makers and hospital administrators would be a valuable addition to this debate, as would analysis of data on abortions performed over time.

While all participants felt law reform had been a positive move, there was variation in how much they had anticipated would be achieved by law reform. Some had expected little change, except to the culture and sense of legal security for doctors. Others had hoped that law reform would lead to better access and reduced stigma over the longer term. While a few felt that change had commenced, none felt that these additional goals had been fully met in the intervening 7 years, and all expressed concern about a number of outstanding issues. This finding accords with research on access to abortion in developed countries, which has found that legal reform is only one aspect of ensuring access, with a “lack of local services, especially in rural areas, the need to travel, negative attitudes and lack of training opportunities” all constraining access to abortion, even where law reform has occurred²² (p. 170).

Of particular concern to these experts was the lack of availability of abortion for women over 20 weeks’ pregnant. While Victorian law now offers a clear and simple legal framework for providing abortions up to 24 weeks, this research suggests that other barriers continue to limit provision even in situations where the legal criteria could be met. Barriers could include hospital policies that result in limited access¹² or a lack of services willing to offer this procedure due to the added complexity, cost and fear of legal consequences.^{12 23} This is perhaps unsurprising given that historically, abortions performed after 20 weeks have been the subject of tense ethical, medical, political and social debate in Australia and internationally. Lee and Ingham²⁴ report that in the UK, access to abortions after 12 weeks has become a policy concern, with attention paid to processes for streamlining referral for second-trimester abortions and ensuring the local services provide access to abortion up to 24 weeks.

Similarly, the public provision of surgical abortion in Victoria was considered by many to have shrunk

following law reform, once again indicating the need for law reform to be followed by policy and practice changes that enforce the intent of the law and ensure the delivery of the services the community needs. In England and Wales, 98% of abortions are funded by the National Health Service, even if provided in the private sector, as health policy mandates access to abortion.²⁵ The Law Reform Commission reported in 2008, that in Victoria, Australia: one-third of abortions occur in public hospitals and two-thirds in private practice; the choice to provide abortions is left up to individual services; and there is no policy mandating access.¹⁵

The increased availability of medical abortion was considered to be a coincidental and positive change in provision, and was considered especially beneficial in regional centres or regional areas where surgical services were not available. However, medical abortion was seen to form only part of the suite of services needed to meet the needs of all women, and was not seen as replacing the need for surgical abortion services.

The outstanding issues raised by these experts indicate the limited impact of law reform in this contested area of medical practice and highlight the need for a state-wide strategy to ensure equitable and sustainable access to services. The strategy could define adequate service provision, support appropriate training and workforce development, and ultimately help to reduce stigma.

CONCLUSION

This study suggests that decriminalisation of abortion in Victoria has been a necessary but not sufficient step towards ensuring that women have equitable access to safe and appropriate abortion services. The law change has been viewed enviously by other states and other countries that still operate under antiquated criminal laws; however, continued action from a range of stakeholders is needed to address remaining barriers if Victoria is to deliver accessible, sustainable abortion services.

Author affiliations

¹Associate Professor, Gender and Women's Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria, Australia

²Research Fellow, Gender and Women's Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria, Australia

³Senior Clinical Adviser, Women's Health, The Royal Women's Hospital, Melbourne, Victoria, Australia

⁴Medical Director, Family Planning Victoria, Melbourne, Victoria, Australia

⁵Manager, Pregnancy Advisory Service, The Royal Women's Hospital, Melbourne, Victoria, Australia

⁶Senior Policy and Health Promotion Officer, Women's Health Victoria, Melbourne, Victoria, Australia

⁷Associate Professor of Law and Public Health, Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria, Australia

Funding The research was funded by the Brenda Jean Brown Trust.

Competing interests None declared.

Ethics approval The University of Melbourne.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- Boland R, Katzive L. Developments in laws on induced abortion: 1998–2007. *Int Fam Plan Perspect* 2008;34:110–120.
- Finer L, Fine JB. Abortion law around the world: progress and pushback. *Am J Public Health* 2013;103:585–589.
- Boyle EH, Longhofer W, Kim M. Abortion liberalization in world society, 1960–2009. *Am J Sociol* 2015;121:882–913.
- Bo M, Zotti CM, Charrier L. Conscientious objection and waiting time for voluntary abortion in Italy. *Eur J Contracept Reprod Health Care* 2015;20:272–282.
- Pratt A, Biggs A, Buckmaster L. *How Many Abortions are there in Australia? A Discussion of Abortion Statistics, Their Limitations, and Options for Improved Statistical Collection*. Canberra, Australia: Department of the Parliamentary Library, 2005. <http://www.aph.gov.au/library/pubs/rb/2004-05/05rb09.pdf> [accessed 15 May 2016].
- de Crespigny LJ, Wilkinson DJ, Douglas T, et al. Australian attitudes to early and late abortion. *Med J Aust* 2010;193:9–12.
- de Visser RO, Badcock PB, Simpson JM, et al. Attitudes toward sex and relationships: the Second Australian Study of Health and Relationships. *Sex Health* 2014;11:397–405.
- de Costa CM, Russell DB, Carrette M. Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *Med J Aust* 2010;193:13–16.
- de Costa C, Douglas H, Hamblin J, et al. Abortion law across Australia – a review of nine jurisdictions. *Aust N Z J Obstet Gynaecol* 2015;55:105–111.
- Abortion Law Reform Act. 2008. http://www.austlii.edu.au/au/legis/vic/consol_act/alra2008209.txt [accessed 15 May 2016].
- de Costa C, Douglas H, Black K. Making it legal: abortion providers' knowledge and use of abortion law in New South Wales and Queensland. *Aust N Z J Obstet Gynaecol* 2013;53:184–189.
- Black KI, Douglas H, de Costa C. Women's access to abortion after 20 weeks' gestation for fetal chromosomal abnormalities: views and experiences of doctors in New South Wales and Queensland. *Aust N Z J Obstet Gynaecol* 2015;55:144–148.
- Norris A, Bessett D, Steinberg JR, et al. Abortion stigma: a reconceptualization of constituents, causes, and consequences. *Womens Health Issues* 2011;21(3 Suppl.):S49–S54.
- Shellenberg KM, Moore AM, Bankole A, et al. Social stigma and disclosure about induced abortion: results from an exploratory study. *Glob Public Health* 2011;6(Suppl. 1):S111–S125.
- Victorian Law Reform Commission. *Law of Abortion: Final Report*. Melbourne, Australia: Victorian Law Reform Commission, 2008.

- 16 Mulligan EC. Striving for excellence in abortion services. *Aust Health Rev* 2006;30:468–473.
- 17 de Costa CM, Douglas H. Abortion law in Australia: it's time for national consistency and decriminalisation. *Med J Aust* 2015;203:349–350. Erratum in: *Med J Aust* 2015;203:389.
- 18 Public Health and Wellbeing Amendment (Safe Access) Bill. 2015. [http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/98a1f30bce0e1b51ca257ea5007be99d/\\$FILE/581PM6bi1.pdf](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/98a1f30bce0e1b51ca257ea5007be99d/$FILE/581PM6bi1.pdf) [accessed 15 May 2016].
- 19 Newton DC, Bayly C, McNamee K, *et al.* “...a one stop shop in their own community”: medical abortion and the role of general practice. *Aust N Z J Obstet Gynaecol* 2016; 21 July 2016, Epub ahead of print. doi:10.1111/ajo.12507
- 20 Newton D, Bayly C, McNamee K, *et al.* How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers. *Aust N Z J of Obstet Gynaecol* 2016;56:523–529.
- 21 Fossey E, Harvey C, McDermott F, *et al.* Understanding and evaluating qualitative research. *Aust N Z J Psychiatry* 2002;36:717–732.
- 22 Doran F, Nancarrow S. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. *J Fam Plann Reprod Health Care* 2015;41:170–180.
- 23 Jones BS, Weitz TA. Legal barriers to second-trimester abortion provision and public health consequences. *Am J Public Health* 2009;99:623–630.
- 24 Lee E, Ingham R. Why do women present late for induced abortion? *Best Pract Res Clin Obstet Gynaecol* 2010;24:479–489.
- 25 Department of Health. *Abortion Statistics, England and Wales: 2015. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales.* 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529344/Abortion_Statistics_2015_v3.pdf [accessed 15 May 2016].

Can family planning physicians help prevent a largely incurable disease?

There is increasing evidence that ovarian cancer predominantly originates in the fallopian tube. There may be opportunities to prevent ovarian cancer by offering women who are undergoing sterilisation removal of their fallopian tubes, rather than clipping. The Royal College of Obstetricians and Gynaecologists (RCOG) and international guidelines are increasingly recommending that healthcare professionals consider this when counselling women for sterilisation.

We are conducting a very brief survey of healthcare professionals involved in referring women for sterilisation, to gain an insight in their current knowledge, practice, and views on this new approach. We would be enormously grateful for 5 minutes of your time to complete this survey.

Please contact us by e-mail (hlb43@cam.ac.uk) if you are willing to take part. We will send you a link to the survey, and would be happy to provide you with additional information about the project.

Many thanks for your support.

Helen Bolton, Subspecialty Trainee in Gynaecological Oncology, Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK