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Submission to Review of Termination of Pregnancy Laws Queensland Law Reform Commission

Kate Galloway* and Jemima McGrath**

1. Summary of Submission, answering Consultation Questions

<i>Q</i>	<i>Question</i>	<i>Submission response</i>	<i>Section</i>
Who should be permitted to perform or assist in performing terminations			
Q1	Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?	As a medical procedure, qualified health professionals should be permitted to perform or assist in performing lawful terminations according to professional and clinical guidelines.	§5
Q2	Should a woman be criminally responsible for the termination of her own pregnancy?	No.	§4
Gestational limits and grounds; Consultation by the medical practitioner			
Q3–10	Gestational limits and grounds; Consultation by the medical practitioner	These are medical and clinical questions best dealt with through evidence-based clinical guidelines that inform medical practice, and not through the criminal law.	§6–9
Conscientious objection			
Q11–12	Should there be provision for conscientious objection? Are there any circumstances in which the provision should not apply? Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?	There should be a qualified provision for conscientious objection, subject to an obligation: <ul style="list-style-type: none"> • to timely referral to a health care provider who will supply the health service; • to provide the service regardless if there is no other geographically proximate practitioner; and • to provide the service regardless in the case of emergency. 	§10
Counselling			
Q13	Should there be any requirements in relation to offering counselling for the woman?	This is a medical and clinical question best dealt with through evidence-based clinical guidelines that inform medical practice, and not through the criminal law.	§9
Protection of women and service providers and safe access zones			
Q14	Should it be unlawful to harass, intimidate or obstruct: (a) a woman who is considering, or who has undergone, a termination of pregnancy; or (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?	Yes	§11
Q15	Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?	Yes	§11
Q16	Should the provision: (a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria	The provision should afford ministerial discretion as a flexible means of dealing with strategies from time to time of those who seek to harass, intimidate, or obstruct the provision or receiving of reproductive services. The guidelines to be followed in determining the extent of the safe access zone should	§11

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<i>Q</i>	<i>Question</i>	<i>Submission response</i>	<i>Section</i>
	should the Minister be required to apply when making the declaration?	reflect principles of reproductive justice. That is, although they should through their operation <i>protect</i> women and those carrying out the relevant services, ministerial discretion to enact a safe access zone would remove the power imbalance between those seeking to harass, intimidate, or obstruct, and the women involved. The overarching rationale is that failing to enact a safe access zone allows for circumstances that will prevent women from exercising their bodily autonomy	
Q17	What behaviours should be prohibited in a safe access zone?	Behaviours that may have the effect of harassing, intimidating, or obstructing a woman seeking reproductive health services or a person providing those services; and any activity designed to deter a woman from seeking reproductive health care at the facility associated with that safe access zone, or to deter a person providing those services entering the health care facility; and attempts to disseminate a view on reproduction in a safe access zone.	§11
Q18	Should the prohibition on behaviours in a safe access zone apply only during a particular time period?	They should apply at all times.	§11
Q19	Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?	Yes	§11
Collection of data about terminations of pregnancy			
Q20	Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?	Yes, subject to stringent data collection and dissemination requirements to ensure that a woman's identity cannot be reconstructed from the data.	§12

2. Focus and Definitions

- 2.1. This submission recognises diversity in gender amongst those capable of becoming pregnant. While this submission uses 'woman' throughout, it acknowledges the experiences of those who do not identify as female. It recommends that the law surrounding termination of pregnancy be framed to ensure that it accommodates reproductive justice for all who are pregnant.
- 2.2. This submission focuses on the empowerment of the self-determination of women to make decisions about their reproductive health as a hallmark of their equality as citizens.

3. Criminal Responsibility for Pregnancy Termination

- 3.1. In the liberal tradition embedded within Queensland's system of governance, the autonomy of individuals is paramount.¹ Autonomy manifests as various freedoms for the individual to determine their best life with minimal state intrusion. Yet the state itself determines the competence of individuals to exercise their freedoms.

¹ Derived from Enlightenment liberals eg: John Stuart Mill *On Liberty* (1859). See this in operation in Australian government, through assumption of a principle of limited governmental intrusion into private lives: Standing Committee of Attorneys-General Joint Working Group, *A Proposal for a National Model to Harmonise Regulation of Surrogacy* (2009).

Paradoxically, the state intervenes in the most intimate of circumstances to constrain individual freedom² yet in other areas is slow to afford protection against bodily incursions.³ This is notably the case in circumstances involving sex and gender.⁴

- 3.2. Traditionally, and in accordance with social norms derived from a patriarchal order, the state has upheld a social and legal paradox whereby women are both autonomous citizens equal with men,⁵ while at the same time are *incompetent* to make autonomous choices about various aspects of their lives⁶—especially their bodies.
- 3.3. The criminalisation of pregnancy termination is one such example. Underpinning the crime of procuring the termination of one’s own pregnancy is the assumption of women’s *incompetence* to exercise self-determination and autonomy in decisions about her bodily integrity.⁷ Once pregnant, the law constructs ‘woman’ as a different being⁸ and regulates her body accordingly. Morris and Nott point out that: ‘English law has denied personhood to the foetus, but tends to treat pregnant women as being in conflict, ie woman against foetus’.⁹
- 3.4. This opposition is recognised in arguments about the gestational stage permitted for termination, which assume the priority of a foetus over the woman.¹⁰
- 3.5. Opposition is implicitly embedded also where the interests and autonomy of the woman are considered as secondary to the interests of the state and other actors. Thus, the QLRC’s consultation paper prioritises the question of who should be permitted to perform or assist in performing an abortion¹¹—rather than commencing with the question of whether a woman should suffer criminal sanction in making a decision about her own body.

4. Decriminalisation and Reproductive Rights

- 4.1. Abortion can be considered one aspect of women’s reproductive rights. To the extent that the law provides criminal sanction for a woman who procures termination of her pregnancy, such laws breach women’s reproductive rights as well as her bodily autonomy.
- 4.2. Helpfully, London outlines four human rights principles underlying reproductive rights:
 - 4.2.1. Choice of whether and when to bear a child;
 - 4.2.2. Privacy of personal decisions about sexual intimacy and childbearing;
 - 4.2.3. Freedom from governmental interference in medical decisions made by an individual with her doctor; and

² Highlighted, for example, in *Wolfenden Report* Cmd. 247 (1957).

³ See, eg, the law’s struggle to deal with systemic sexual harassment and abuse evidenced by what has become known as the #metoo movement globally: Jessalyn Keller, ‘#MeToo Campaign Brings Conversation of Rape to the Mainstream’ *The Conversation* (25 October 2017).

⁴ Frances E Olsen, ‘The Family and the Market: A Study of Ideology and Legal Reform’ (1983) 96(7) *The Harvard Law Review* 1497.

⁵ See, eg, *Anti-Discrimination Act 1991* (Qld).

⁶ See, eg, Kate Galloway, ‘A Sense of Entitlement? The (Gender) Subtext of “Lifters not Leanners”’ (16 September 2013) <<https://katgalloway.blogspot.com.au/2013/09/a-sense-of-entitlement-gender-subtext.html>>; Kate Galloway, ‘Ending Feminised Poverty’ (2014) 24(17) *Eureka Street*.

⁷ See, eg, Katherine Kerr, ‘Queensland Abortion Laws: Criminalising One in Three Women’ (2014) 14(2) *QUT Law Review* 15, doi: <https://doi.org/10.5204/qutlr.v14i2.540>.

⁸ Anne Morris and Susan Nott ‘The Law’s Engagement with Pregnancy’ in Jo Bridgeman and Susan Millns (eds) *Law and Body Politics: Regulating the Female Body* (Dartmouth, 1995) 53, 55.

⁹ Ibid 56.

¹⁰ See, eg, ibid 42, [146].

¹¹ Queensland Law Reform Commission, ‘Review of Termination of Pregnancy Laws’ Consultation Paper, WP No 76 (December 2017), v, Questions 1 and 2.

- 4.2.4. Autonomy exercised through the freedom to make decisions about one's body.¹²
- 4.3. While not enshrined in law, the Queensland Parliamentary Committee on Surrogacy made recommendations based upon the concept of rights or freedoms to choose to have a child.¹³ Although couched in terms of 'parents' rather than women, this example illustrates the capacity of the law to comprehend the notion of reproductive rights.
- 4.4. The core question to be answered by this Review is therefore whether a woman should suffer criminal sanction for procuring her own abortion. We submit that a woman should *not* be criminally responsible for the termination of her own pregnancy. The remaining questions are subsidiary to the woman's right to be considered an agentic individual at law.

5. Who Might Lawfully Perform Abortions and When

- 5.1. Once the law accepts the woman as an autonomous citizen responsible for her bodily integrity, the question of abortion becomes a medical rather than a legal question.
- 5.2. On the assumption that termination of pregnancy, whether surgical or medical, is a medical procedure, then subject to clinical recommendation as to expertise, it becomes subject to the same regulation as other medical procedures. This is a clinical question beyond the scope of this submission, but in any event, does not require specific provision within the criminal law which otherwise deals with assault and offences by unqualified persons.
- 5.3. Further, clinical guidelines informed by medical ethics are best placed to dictate the circumstances of a termination, including as to:
- 5.3.1. Gestational stage;
 - 5.3.2. Woman's health;
 - 5.3.3. Foetal viability;
 - 5.3.4. Practitioner consultation; and
 - 5.3.5. Whether the termination is undertaken medically or surgically.
- 5.4. Where medical practice is guided by norms of decision-making in the patient's best interests and of harm-minimisation, it is appropriate for evidence-based clinical guidelines to inform practice, rather than the criminal law.¹⁴

6. Reproductive Justice

- 6.1. Merely enacting reproductive rights is not, however, sufficient to achieve reproductive *justice*. Thus, analysis of the extent to which the law might support reproductive rights, must consider the effect of power relations and differential resources.¹⁵ For example, one consistent effect of criminalisation of abortion is the

¹² Sarah London, 'Reproductive Justice: Developing a Lawyering Model' (2011) 13 *Berkeley Journal of African American Law and Policy* 71, 76.

¹³ Investigation into Altruistic Surrogacy Committee, Queensland Parliament, Report (2008), 18, 20. The Committee had been established to 'investigate and report to the Parliament on the possible decriminalisation and regulation of altruistic surrogacy in Queensland'. The recommendations resulted in the enactment of the *Surrogacy Act 2010* (Qld).

¹⁴ See eg, M Berer, 'Making Abortions Safe: A Matter of Good Public Health Policy and Practice' (2000) 78(5) *Bulletin of the World Health Organisation* 580; David A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, doi: [https://doi.org/10.1016/S0140-6736\(06\)69481-6](https://doi.org/10.1016/S0140-6736(06)69481-6); Lachlan J de Crespigny and Julian Savelescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201.

¹⁵ London, above n 12, 77. See also Barbara Baird, 'Decriminalization and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights* 197; L A Keogh et al, 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2016) *Journal of Family Planning and Reproductive Health Care* doi: 10.1136/jfprhc-2016-101541.

- likely availability of safe medical services to those who can pay, and the exclusion from safe medical services of those who cannot afford them.¹⁶
- 6.2. Power relations and resources are relevant not only in achieving equality of access to safe abortion, but also in considering the context within which a woman makes a decision to terminate her pregnancy.
 - 6.3. The socio-economic determinants of health are well rehearsed.¹⁷ Where abortion becomes a health issue, a woman's socio-economic circumstances therefore become relevant in making decisions about whether to proceed with a pregnancy. For the law to delimit circumstances that warrant termination¹⁸ will inevitably fail to comprehend the woman's experience of her circumstances. By contrast, as a medical or clinical matter, the health practitioner is best placed to advise based on what is appropriate to the woman in her circumstances.
 - 6.4. However, in the case of termination of pregnancy, it is ill-conceived to make assumptions about socio-economic determinants of women's health based upon standard demographic indicators such as place of domicile or household income. A woman whose outward appearance and location of her domicile might give the impression of access to financial means. However, as a consequence of gendered power dynamics within the household,¹⁹ she may not have access to sufficient economic resources to support a child, or to bear the costs of a termination.
 - 6.5. Specific to the reform of the law of termination of pregnancy, a framework of reproductive justice requires consideration of the effect of the law on the availability of relevant medical services to all Queensland women, including with reference to:
 - 6.5.1. Location of services;
 - 6.5.2. Age and therefore capacity to give consent to medical or surgical procedures;
 - 6.5.3. Access to relevantly qualified medical and allied health professionals;
 - 6.5.4. Privacy of service delivery; and
 - 6.5.5. Gender diversity in those who are pregnant.

7. Location of Services

- 7.1. As observed in the Consultation Paper, the majority of abortion services in Queensland are carried out by private providers. Consequently, terminations are relatively easy to access in many metropolitan areas, but are increasingly difficult to access in regional and in particular, in remote areas.
- 7.2. To the extent that abortion is currently permitted under the law, the current system thus discriminates indirectly between metropolitan and regional women.²⁰
- 7.3. Decriminalisation of terminations so that they become a health matter, will facilitate provision within the existing health network including to regional and remote women. This change in focus will bring medical resources within the reach of all Queensland women.

¹⁶ See, eg, Victorian Law Reform Commission, 'Law of Abortion' Final Report 15 (March 2008), Appendix One, [A28]; Caroline de Moel-Mandel and Julia M Shelley, 'The Legal and Nonlegal Barriers to Abortion Access in Australia: A Review of the Evidence' (2017) 22(2) *The European Journal of Contraception & Reproductive Health Care* 114, DOI: 10.1080/13625187.2016.1276162.

¹⁷ See, eg, Australian Institute of Health and Welfare, *Australia's Health 2016*, Chapter 4 'Determinants of Health' <<https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/determinants>>.

¹⁸ Such as those discussed in the QLRC Consultation Paper, 44–7.

¹⁹ See, eg, as originally observed in Jan Pahl, *Money and Marriage* (MacMillan, 1989).

²⁰ de Moel-Mandel and Shelley, above n 16.

8. Age

- 8.1. The question of capacity to give informed consent affects the law also. As the Consultation Paper points out,²¹ minors may be deemed capable of giving consent to a medical procedure. Where they are not, the Court may be asked to invoke its *parens patriae* jurisdiction to authorise the decision.
- 8.2. In Queensland, the decision of *Central Queensland Hospital and Health Service v Q* [2016] QSC 89 (26 Apr 2016) highlights the need for reform in this area. Although the 12-year-old girl seeking a termination of her pregnancy was deemed capable of consenting to the procedure, the relevant authorities sought the imprimatur of the Court, which in turn ordered that the girl's father be included in the decision-making—against the girl's express wishes that the father not be told.²²
- 8.3. The question is why this child was required to obtain a court order to secure medical attention, when surgery such as a tonsillectomy, or administration of drugs such as steroids or cancer drugs would not require the court's permission.²³ Involvement of the Court in this case adversely affected the girl, delayed her treatment and her suffering, and interfered with her bodily autonomy even as she was deemed to have capacity for self-determination.
- 8.4. Decriminalisation of abortion, coupled with a therapeutic approach and bounded by the norms and laws concerning informed patient consent and self-determination, would necessarily avoid Court intervention in such circumstances.

9. Access to Relevantly Qualified Professionals

- 9.1. Related to location of services is access to relevantly qualified professionals. In terms of reproductive justice, this requires considering contexts beyond health services per se, to the professional mix required to ensure equity of access to abortion services.
- 9.2. Notably, the Consultation Paper questions the need for counselling services as a prerequisite to obtaining a termination. As this submission identifies the need for a health-based approach rather than a legal approach, it does not propose mandating counselling as a pre-requisite. Instead, it suggests that counselling is a component of ensuring reproductive justice in terms of patient autonomy to make decisions about her own body, free from coercion that might occur within her social context. In other words, provision of relevantly qualified counsellors as integral to the process of offering advice to women seeking a termination, speaks to informed consent.
- 9.3. In attempting to paint a pro-choice approach to abortion as anti-women, some (effectively) suggest that abortion is a patriarchal tool designed to prevent women from exercising reproductive freedom—ie in giving birth. This submission recognises that abortion is indeed a tool involved in women's reproductive freedom. It might liberate women from the burdens of bearing, delivering, and raising a child as an expression of her bodily autonomy—but it might also be used as a tool of oppression where that woman desires to go ahead with her pregnancy.
- 9.4. The possibility of abortion being used coercively is no reason to criminalise the practice. Instead, it is reason to ensure that women are in a position to give informed consent to the procedure upon obtaining qualified advice, including counselling. In particular, women experiencing pressure, domination, or violence need the opportunity to work through their concerns until they are able to make an informed decision. That decision may well reflect her coercive circumstances, but counselling

²¹ Consultation Paper, 9.

²² Heather Douglas and Caroline de Costa, 'Time to Repeal Outdated Abortion Laws in New South Wales and Queensland' (2016) 205(8) *Medical Journal of Australia* 1, doi: 10.5694/mja16.00807.

²³ Kate Galloway, 'Abortion Before the Courts Again' (2016) 41(2) *Alternative Law Journal* 138.

offers the opportunity to make the decision on her own terms in light of her social context.

- 9.5. For this reason, the law should recognise, and clinical guidelines should reflect, that in light of gendered power dynamics and socio-economic determinants, consent to termination will in most circumstances be ‘informed’ where the woman has been afforded access to qualified counselling in reaching her decision.

10. Conscientious Objection

- 10.1. This submission recognises the moral stance of those who oppose abortion services. However, it submits that there is a balance to be achieved between the expression of such concerns and the autonomy of women seeking reproductive services.
- 10.2. Reproductive justice will inevitably require the support of public health services, ensuring equality of access for women.²⁴ This is one way to ensure that remote and regional women have access to health practitioners who do not hold conscientious objection to delivery of reproductive health services.
- 10.3. In terms of individual practice however, in accordance with the underlying principle of women’s agency over their bodily autonomy and in particular in the case of emergency, there are four constraints on the exercise of conscientious objection.
- 10.3.1. A health care provider cannot withhold reproductive services, including a termination, based on conscientious objection in an emergency where the woman’s life is in danger, or where there is a risk of grave harm to the woman.
- 10.3.2. A health care provider cannot withhold reproductive services, including a termination, based on conscientious objection where there are no other geographically proximate services. This addresses the inequality of access to reproductive services experienced by remote and regional women.²⁵
- 10.3.3. A health care provider who conscientiously objects to providing reproductive services including termination, must refer the woman, in a clinically timely way, to another geographically proximate health provider that will provide the relevant service.²⁶
- 10.3.4. Further, conscientious objection should be limited to those directly involved in delivering health services and not those in ancillary positions.²⁷
- 10.4. Notably, other jurisdictions have provided for conscientious objection,²⁸ predominantly in non-emergency situations.

²⁴ See, eg, discussion in Ronli Sifris, ‘The Legal and Factual Status of Abortion in Australia’ (2013) 38(2) *Alternative Law Journal* 108.

²⁵ See, eg, Keogh et al, above n 15; de Moel-Mandel and Shelley, above n 16; Mridula Shankar et al, ‘Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-sectional Study’ (2017) 41(3) *Australia and New Zealand Journal of Public Health* 309, doi: 10.1111/1753-6405.12641; Ronli Sifris, ‘A Woman’s Right to Choose’ in Paula Gerber and Melissa Castan (eds) *Contemporary Human Rights Issues in Australia* (Thomson Reuters, 2013) 251, 25; Victorian Rural Women’s Access to Family Planning Services Report (2012) <<http://whv.org.au/static/files/assets/c6ba5133/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf>>.

²⁶ See, eg, *Termination of Pregnancy Law Reform Act 2017* (NT), s11.

²⁷ The House of Lords applied a test of proximity in considering who was entitled to conscientiously object under the *Abortion Act 1967* (UK). It found that only those participating in the procedure had sufficient proximity to be excused based on conscientious objection. See *Janaway v Salford AHA* [1988] 3 All ER 1079.

²⁸ See discussion in, eg, Victorian Law Reform Submission, above, n 16. The Australian Medical Association did not support conscientious objection (at p114).

11. Privacy

- 11.1. A component of reproductive rights, privacy in abortion law reform is relevant in a number of ways:
 - 11.1.1. privacy from state intervention (§4 above);
 - 11.1.2. privacy from others influencing the decision she makes in consultation with her health care providers (§9 above);
 - 11.1.3. privacy from grandstanding or harassment in the vicinity of the clinic; and
 - 11.1.4. privacy from dissemination of her name, image, or personal details in connection with any reproductive service.
- 11.2. Questions 14–20 of this Review are relevant to the two latter forms of privacy.
- 11.3. In the interests of effectively providing health care services to women seeking a termination, it should be unlawful to harass, intimidate or obstruct both a woman who is considering, or who has undergone, a termination of pregnancy; and a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy.
- 11.4. In recognition that decriminalisation of pregnancy termination is not of itself sufficient to provide access for women needing termination services, Victoria, Tasmania and the ACT²⁹ have each enacted safe access zone legislation as a means of supporting women’s access to reproductive services. This submission supports the establishment of safe access zones.
- 11.5. Rather than establish the extent of a safe access zone in legislation, this submission supports ministerial discretion as a flexible means of dealing with strategies from time to time of those who seek to harass, intimidate, or obstruct the provision or receiving of reproductive services.
- 11.6. The guidelines to be followed in determining the extent of the safe access zone should reflect principles of reproductive justice. That is, although they should through their operation *protect* women and those carrying out the relevant services, ministerial discretion to enact a safe access zone would remove the power imbalance between those seeking to harass, intimidate, or obstruct, and the women involved.³⁰ The rationale is that failing to enact a safe access zone allows for circumstances that will prevent women from exercising their bodily autonomy.
- 11.7. As to the extent of the safe access zone, the relevant considerations must reflect a balance between the harm done to the women in accessing health care services, and the intrusion into the lives of those prevented from carrying out their activities within that zone: it is the area reasonably necessary to ensure access to reproductive services.
- 11.8. A principled approach to determining activities to be prohibited in the safe access zone would aim at any activity designed to deter a woman from seeking reproductive health care at the facility associated with that safe access zone, or disseminating a view on reproduction. In prosecuting her autonomy, a woman is entitled to access health services free from attempts to convince her otherwise. Those outside the relevant facility are not entitled to air their views in light of the availability of qualified health care expertise within the facility, and should be constrained by law from doing so.
- 11.9. As a feature of reproductive rights, the privacy of women using or approaching the facilities extends to dissemination of their images, names, and personal details

²⁹ See, eg, Heather Douglas and Katherine Kerr, ‘Abortion, Law Reform and the Context of Decisionmaking’ (2016) 25(1) *Griffith Law Review* 129, doi: 10.1080/10383441.2016.1201882.

³⁰ See, eg, Ronli Sifris, ‘State by State, “Safe Access Zones” Around Clinics are Shielding Women from Abortion Protesters’ *The Conversation* (30 November 2015) <<https://theconversation.com/state-by-state-safe-access-zones-around-clinics-are-shielding-women-from-abortion-protesters-51407>>.

electronically or otherwise. Creation or dissemination of such details should constitute an offence.

- 11.10. Ensuring a safe work environment for those providing health care services requires the same protection. Such provisions will also ensure that health care service provider staff can continue to carry out their work unmolested, ensuring continuity of service for women who need it.

12. Collection of data about terminations of pregnancy

- 12.1. Ensuring effective provision of reproductive services throughout the state requires data concerning the need for and delivery of such services. It is therefore appropriate to provide for collection of patient information but only where appropriate safeguards are incorporated. For example, anonymisation of patient records is imperative to ensure privacy both in terms of the possibility of reconstructing de-identified information, but also to protect against the possibility of unauthorised or unintended leaks.
- 12.2. Any data collection system must also cater for the likelihood of identification of patients in regional and remote areas. Such patients are likely to be readily identifiable with only minimal demographic information.