

26 June 2016

To: The Health, Communities, Disability Services and Domestic
and Family Violence Prevention Committee.

Submission re:

Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into
laws governing termination of pregnancy in Queensland.

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Background:

I am a Professor of Law at the University of Queensland.¹ I have been teaching and researching in criminal law in Queensland for over twenty years and have also practiced criminal law from time to time. Since 2008 I have been researching the effects, implementation and understanding of abortion law in Queensland. I support the Bill put forward by Mr Rob Pyne MP. The current Queensland legislative regime is dated, dishonest and demeaning to women and their doctors. I address the specific issues identified for consideration and feedback by the committee below.

1. Existing practices in Queensland concerning termination of pregnancy by medical practitioners:

Much of my understanding of medical practices around abortion in Queensland is based on my research (conducted with Doctors C deCosta-Qld and K Black-NSW) interviewing doctors about their practices. Various aspects of this research is reported in in peer reviewed journal articles.² I would be happy to provide copies of these articles to the inquiry on request. In this research doctors were approached on the basis that they were known to provide abortion services to women in Queensland (and also in New South Wales). 15 Queensland doctors took part in this study and were asked to comment on 10 common scenarios where women may request an abortion.

¹ I disclose that I am also a member of the Management Committee of *Children by Choice*. However I write this submission in my individual capacity as an academic.

² H Douglas, K Black, C deCosta, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20 *Journal of Law and Medicine* 560-576; C deCosta, H Douglas, K Black, 'Making It Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184-189; K Black, H Douglas, C deCosta, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55 (2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144-148

In this study we found that all of the Queensland doctors interviewed were aware that abortion is covered by criminal legislation. All were concerned about requirements to conform to state law when agreeing to provide abortion services to women, and about the possible constraints of these requirements on women's accessibility to abortion services. All respondents felt that socio-economic factors were very relevant in situations where women request abortion.

Most also reported finding the requirement to identify emotional distress demeaning to the women they cared for. Commonly doctors expressed frustration at having to invent concerns about mental health issues for women requesting a termination in order to bring the abortion within the law. Often this required doctors to ignore or reframe the woman's view of her circumstances. They generally agreed that the current legal situation in Queensland encourages doctors to refer patients to psychiatric assessments and to obtain second opinions that many of the doctors we spoke to stated were generally unnecessary. We argued in the articles published from this study that the current legal situation in Queensland perpetuates a long history of the law's tendency to discount women's views and experience.³

We also found that the Queensland legal approach appears to raise ethical concerns, including the possible compromise of the candidness of the doctor-patient relationship. On one level, unnecessary referrals, for example to mental health experts, are unethical as they suggest a failure on the part of the doctor to listen and to respect the views of the 'patient'.⁴ However, at the same time these practices are ethical as they are aimed at supporting the woman's decision about her health care: to have an abortion.⁵ As a direct result of the current legal situation many doctors who perform abortions in Queensland feel compromised; they are, in effect, obliged to make choices between competing ethical obligations.

All of the Queensland doctors interviewed in the study believed that Queensland abortion law is out-of-date with current medical practice, in particular with regard to the diagnosis of serious fetal

³ H Douglas, K Black, C deCosta, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20 *Journal of Law and Medicine* 560-576.

⁴ Australian Medical Council, *Good Medical Practice: A Code of Conduct for Doctors in Australia* at [3.3], 'Effective communication', <http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/39/02.pdf> viewed 6 July 2012.

⁵ Australian Medical Council, *Good Medical Practice: A Code of Conduct for Doctors in Australia* at [2.1.5], 'Recognising and respecting patients' rights to make their own decisions' <http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/39/02.pdf> viewed 6 July 2012.

abnormality, and that there is limited case law to assist doctors in a defence to a charge of abortion performed in this context.⁶

Most practitioners reported dismay for the many women who were not able to obtain an abortion on the basis of fetal abnormality alone because of the legal and policy restrictions in Queensland. Those interviewed considered the better option was to refer woman interstate- usually to Victoria- for termination. Several Queensland practitioners commented that this created a whole spectrum of difficulties for women including emotional and financial challenges. Some of the practitioners were clearly affected by the experience of their patients who were declined a termination in their state and required to travel interstate.⁷

Overall the study suggests that abortion laws in Queensland have an adverse impact on the way practice occurs even in very common first trimester abortion scenarios. Doctors interviewed had a very good understanding of the current law about abortion. Doctors generally agreed that, in order to perform an abortion lawfully, they were required to find that there would be serious danger to the woman's life or to her physical or mental health should the pregnancy continue. However, the concept of 'serious danger' was generally thought to be unclear and the perception that doctors had to ascribe a mental health problem to women seeking abortion was often challenging.⁸

2. Existing legal principles that govern termination practices in Queensland:

The law in Queensland is archaic and unclear. There is a very real need for modernisation of the law in Queensland. Below I consider these issues in more detail.

- ***The QCC provisions:***

I have read the summary of the provisions included on the Inquiry website⁹ and confirm the summary reflects my understanding of the relevant provisions. I note the ss224-226 QCC reflect the

⁶ See especially: C deCosta, H Douglas, K Black, 'Making It Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184-189

⁷ See especially: K Black, H Douglas, C deCosta, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55 (2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144-148

⁸ K Black, H Douglas, C deCosta, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55 (2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144-148

⁹ <https://www.parliament.qld.gov.au/documents/committees/HCDSDVPC/2016/AbortionLR-WRC-AB2016/14-infop-16June2016.pdf>

UK *Offences Against the Person Act* (1861) sections 58 and 59¹⁰ and that these provisions were repealed in the United Kingdom in 1967.

I would also emphasise that section 282 does not apply to women who seek / have an abortion.

- ***R v Bayliss; R v Cullen* (1986) 9 Qld Lawyer Reps 8 (Bayliss & Cullen)**

It is my understanding that the judge in *Bayliss & Cullen*, McGuire DCJ, found that the Menhennit J's ruling in the earlier Victorian case of *R v Davidson* [1969] VR 667 represented the law of Queensland.¹¹ Menhennit J's ruling stated:

For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him was (a) **necessary to preserve the woman from a serious danger to her life or her physical or mental health** (not merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.¹²

It is notable that the test in NSW for lawful abortion is wider than it is in Queensland. In NSW Levine DCJ found that social and economic factors were also relevant in a doctor's consideration of whether an abortion is lawful. Although McGuire DCJ was well aware of Levine DCJ's decision in the NSW case of *R v Wald* (1971) 3 DCR (NSW) 25, McGuire DCJ did not follow the expanded test.¹³ Therefore the main difference between the law regarding abortion in New South Wales and the law in Queensland is that abortions may be defensible in NSW in cases where the woman seeking an abortion claims that economic and social grounds underlay her request. In Queensland the decision must be based on physical and mental health concerns of the woman. In *Veivers v Connolly* [1995] 2 Qd R 326 at 329 de Jersey J stated that the dangers to health of the pregnant woman are not confined merely to the duration of the pregnancy.

It is also notable that neither s282 QCC nor the *Bayliss & Cullen* decision have anything to say about the health of the fetus and they are at best unclear about gestational limits. There is no legislation or

¹⁰ Those original provisions available here: <http://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents>

¹¹ *R v Bayliss; R v Cullen* (1986) 9 Qld Lawyer Reps 8 at 45; see also *K v T* [1983] 1 Qd R 396 .

¹² *R v Davidson* [1969] VR 667 at 672.

¹³ *R v Bayliss; R v Cullen* (1986) 9 Qld Lawyer Reps 8 at 26-27.

case law in Queensland that allows for the consideration of- for example- prenatal test results except where it impacts on the health of the pregnant woman.

- ***R v Brennan and Leach* (unrep, Dist Ct, Qld, 12-14 October 2010, Everson J).**

In 2010 the prosecution of Tegan Leach and her partner Sergie Brennan for abortion-related offences resulted in a jury acquitting the pair of the charges. This seems to be the only time in Commonwealth history that a woman has been charged with procuring her own abortion and it happened in Queensland under current law in very recent years.

Of importance in the case was Everson J's direction to the jury on the meaning of the term 'noxious' in sections 225 and 226 QCC. He directed that 'the question of whether the thing administered was noxious must be determined in terms of whether or not it was noxious to the pregnant woman, Leach, and not to any foetus which may or may not have been present at the time she took the drugs'.¹⁴ Leach had taken the drugs Mifepristone and Misoprostol which, according to expert testimony called by the Crown,¹⁵ were not 'noxious' to a (pregnant) woman. Both Brennan and Leach were acquitted.

As a result of the outcome in this case, some claimed that doctors performing medical abortions in Queensland could be confident that medical (as opposed to surgical) termination was allowed under Queensland law. However, many doctors were concerned that the fact that Leach and Brennan had been prosecuted at all suggested that the legal situation remained uncertain and a number of doctors working in public hospitals in Queensland withdrew their abortion services for a period of time in 2010.¹⁶

- ***Queensland v B* [2008] 2 Qd R 562**

In *Queensland v B* [2008] 2 Qd R 562 the court was asked to consider access to abortion for a 12-year-old girl with an intellectual disability who was 18 weeks pregnant. The court concluded (at [21]) that in the specific case doctors could rely on the duty of a person who has care of a child under 16

¹⁴ *R v Brennan and Leach* (unrep, Dist Ct, Qld, 12-14 October 2010, Everson J) at 42.

¹⁵ Dr Nicholas Fisk, a Brisbane fetal-maternal medical specialist and Crown expert witness, gave evidence to this effect: *R v Brennan and Leach* (unrep, Dist Ct, Qld, 12-14 October 2010, Everson J), trial transcript day 2, pp 2-4.

¹⁶ Andersen B, "Qld Women Forced Interstate for Abortions", *ABC News Online* (8 September 2009), <http://www.abc.net.au/news/2009-08-31/qld-women-forced-interstate-for-abortions/1412338> viewed 11 July 2012; E O'Shea, "Making Law and Making Social Change", *Right Now: Human Rights in Australia* (10 March 2011).

to “avoid danger to the child’s life, health or safety” which is specified in s 286 of the *Criminal Code*. Section 282 of the *Criminal Code* was not considered.

- ***Central Queensland Hospital and Health Service v Q [2016] QSC 89.***

The recent case of *Central Queensland Hospital and Health Service v Q* (the Q case) took a differing approach to B and this underscores the discrepancies and uncertainties inherent in the current law of abortion in Queensland.

In this case a 12 year old girl sought an abortion from her local GP and was referred to a Queensland public hospital. In the intervening month Q saw a GP, a social worker (several times), two specialist obstetricians, and a psychiatrist. All believed it was appropriate for Q to have an abortion because there were significant risks to her physical and mental health if the pregnancy was allowed to proceed. Q wanted an abortion. Q’s parents supported her decision. Despite this unanimous agreement on the appropriate response, the hospital applied to the Queensland Supreme Court to exercise its *parens patriae* jurisdiction (the legal doctrine that grants wide powers to the court to protect the welfare of children) to authorise the abortion. This resulted in the introduction of another professional into the decision making context - a litigation guardian who appeared for Q in the case. Q’s family was also brought back into contact with the Department of Communities, Child Safety and Disability Services who appeared as a friend of the court. While there are clear Queensland Department of Health guidelines¹⁷ setting out procedures for hospital decision making in cases like Q’s, the decision of the hospital to seek direction from the court underlines the fear and uncertainty around the legality of abortion in Queensland.

According to McMeekin J the Q case differed from *Queensland v B* [2008] 2 Qd R 562 (B) in four respects: Q was 9 weeks pregnant not 18 weeks like B; Q was a mature 12 year old and did not have an intellectual disability; there was strong risk of both physical harm (eg suicide and self-harm) and mental harm to Q (while for B physical risk was not present); surgery was also an option while for B it was not.

In the Q case Justice McMeekin pointed out there were two issues in the case: Q’s capacity to consent and the application of the criminal law. On the question of capacity and consent the judge found that Q had a good understanding of the risks associated with the procedures related to the abortion. However he also observed: ‘The fact is that very few 12 year olds could have the maturity

¹⁷ [Queensland Maternity and neonatal Clinical Guideline Therapeutic termination of pregnancy](#)

to comprehend the impact a decision like this might have on them in the longer term.’[32] Thus he accepted that it was appropriate for the court’s *parens patriae* jurisdiction to be invoked. This aspect of the Q decision has uncertain implications. This test for capacity to consent, suggested in the Q judgment, is arguably very high. Does the Q test apply to the hundreds of pregnant 12-14 year old women / girls who present to Queensland doctors requesting abortions each year? It is likely that many young women in this age group would not have the high level understanding inferred to be required in Q and thus court authorization may be viewed to be appropriate in order to have a lawful abortion (at least to be on the safe side). Such an approach would significantly increase the stress and trauma for young women and their treating doctors, extend the waiting time for the procedure (and thus gestation) and would have significant resource implications. This issue could be addressed if abortion was made a matter for the woman and her health care team in a context where the decisions were not made in the shadow of criminal law.

3. The need to modernise and clarify the law (without altering current clinical practice), to reflect current community attitudes and expectations:

Given that:

- around one in four¹⁸ women in Australia, and one in three women aged 20-29,¹⁹ will have an abortion at some time during their reproductive years;
- around 80,000 abortions take place in Australia every year²⁰ with around quarter of them taking place in Queensland²¹ (funded in part by medicare);²²
- around 80% of Australian people agree that a woman should have the right to terminate a pregnancy,²³

¹⁸ A Smith, et al, “Sex in Australia: Reproductive Experiences and Reproductive Health Among a Representative Sample of Women” (2003) 27 *Australia and New Zealand Journal of Public Health* 204; J Healey, “The Abortion Issue” (2005) 213 *Issues in Society* 41.

¹⁹ Family Planning, Victoria ‘Abortion in Victoria’ <http://www.fpv.org.au/sexual-health-info/sex-and-the-law/abortion-in-victoria/>

²⁰ A Pratt et al , *How Many Abortions are There in Australia? A Discussion of Abortion Statistics, Their Limitations, and Options for Improved Statistical Collection* (Research Brief No 9, 2004-2005, Parliamentary Library, Parliament of Australia, Canberra, 2005); Chan A and Sage L, “Estimating Australia’s Abortion Rates 1985-2003” (2005) 182 *MJA* 447.

²¹ Family Planning Queensland, *Abortion Statistics, 2005*, http://www.fpq.com.au/pdf/Abortion_statistics.pdf viewed 11 July 2012); Drabsch T, *Abortion and the Law in New South Wales* (NSW Parliamentary Library Research Service, Sydney, 2005) p 4.

²² K Petersen, “Early Medical Abortion: Legal and Medical Developments in Australia” (2010) 193(1) *MJA* 26 at 26.

²³ Victorian Law Reform Commission (VLRC), *Law of Abortion: Final Report* (Victorian Law Reform Commission, Melbourne, 2008) p 58; Betts K, “Attitudes to Abortion: Australia and Queensland in the Twenty-First Century” (2009) 17(3) *People and Place* 25 at 36; Read C, “The Abortion Debate in Australia” (2006) 35(9) *Australian Family Physician* 699.

- about 82% of doctors believe that women should have access to abortion services²⁴
- unplanned pregnancy is a reality, even where contraception is properly used²⁵ and
- women routinely have a variety of pre-natal screening tests in Queensland and Queensland Health recognises that terminations may be requested where certain results are advised²⁶

there is a clear need to modernise the law to reflect current community attitudes and expectations and medical practices. There is absolutely no doubt that most of the terminations that take place in Queensland each year do not meet the threshold tests established in the case law for lawful abortion in Queensland. Theoretically, at least, this means that the overwhelming majority of women who have a termination, most of the doctors who perform them and the staff who assist, including receptionists, pharmacists, anaesthetists etc are likely to be committing a criminal offence when they become involved in the overwhelming majority of terminations. Clearly the law does not reflect current practice or expectations. It is simply not true that the woman's mental or physical health is at serious risk if she does not have an abortion in relation to the overwhelming majority of abortions that take place each year in Queensland.

It should be no surprise that the QCC provisions about abortion fail to reflect current attitudes and experience. As noted earlier the current law in the QCC was introduced in 1899 and is based on the United Kingdom *Offences Against the Persons Act 1861* (sections 58 and 59). While the United Kingdom provisions were reformed significantly in 1967 – almost 50 years ago,²⁷ Queensland law has failed to catch up with the modern world. Ultrasound and the kind of pre-natal testing we have now were not possible in 1861. Developments in anaesthesia and surgical practice and the introduction of antibiotics now ensure that surgical abortion is a very safe procedure and new drugs including mifepristone and prostaglandins such as misoprostol have become widely available and also extremely safe.

²⁴ Marie Stopes International, *General Practitioners: Attitudes to Abortion* (Published by Marie Stopes International and prepared by Quantum Market Research, 2005) p 5.

²⁵ *Efficacy of contraceptive methods* by Family Planning Alliance Australia, 2014. Available online [pdf] at http://familyplanningallianceaustralia.org.au/wp-content/uploads/2014/11/FPAA_Efficacy_SCREEN.pdf.

US studies show unplanned pregnancy is the major contributor to abortion: K Pazol et al, 'Abortion Surveillance-United States- 2010' (2013) 62 (8) *MMWR Surveillance Summary* 1-44.

²⁶ Queensland Government, 'Genetic Health Queensland: Prenatal screening and testing' available at: <https://www.health.qld.gov.au/ghq/docs/prenatal-brochure.pdf>

²⁷ See House of Commons, 'Abortion Law, Report' 2009: <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04309#fullreport> although there continues to be discussion of further reform in the UK.

Indeed in Queensland screening tests for fetal abnormalities are now routinely offered to all pregnant women, and funded by Medicare; the implication is that if a serious abnormality is detected the woman can be offered termination of pregnancy. Indeed pamphlets provided by Queensland Health suggest that termination will be an option.²⁸ The recent introduction of Non-Invasive Prenatal Testing, a high-level screening test, means more accurate information about the health of the fetus is available early in pregnancy to women and their partners, with the possibility of earlier and safer termination if requested.²⁹ The practice of selective reduction of the number of fetuses in multiple pregnancies, to maximise the chances of a healthy birth, is also becoming more common.³⁰ Current Queensland abortion law provides no guidance in relation to fetal gestation or the relevance of fetal abnormality in relation to lawful abortion.

Community expectations about women's autonomy and their right to make decisions about their lives and bodies were very different in 1899. In 1899 when the abortion provisions were introduced in Queensland, women did not yet even have the right to vote.

4. Legislative and regulatory arrangements in other Australian jurisdictions including regulating terminations based on gestational periods.

Abortion was decriminalised in the ACT in 2002, there are no gestational limits identified in the legislation. I am not aware of any issues arising in the ACT with respect to later term abortions. ACT is a very small jurisdiction and although anecdotally there are some second trimester abortions undertaken in public hospitals, requests for third trimester terminations are extremely rare. In the ACT abortion is now primarily a health issue rather than a matter for criminal law and regulated in the same way as other medical procedures. Notably in circumstances where an abortion is undertaken by a doctor without the woman's consent or where a person caused serious injury or harm to the woman as a result of insufficient care or skill there could be a prosecution under criminal laws. This would be the case in other jurisdictions as well.

²⁸ Queensland Government, 'Genetic Health Queensland: Prenatal screening and testing' available at: <https://www.health.qld.gov.au/ghq/docs/prenatal-brochure.pdf>

²⁹ Caroline deCosta, 'Abortion law, abortion realities' (2008) 1(6) *James Cook University Law Review*; L Hui et al, 'Clinical implementation of cell-free DNA based aneuploidy screening: perspectives from a national audit' (2015) 45 *Ultrasound in Obstetrics and Gynecology* 10.

³⁰ Colleen Davis and Heather Douglas, 'Selective reduction of fetuses in multiple pregnancies and the law in Australia.' (2014) 22(1) *Journal of Law and Medicine* 155.

However if the committee is of the view gestational limits need to be identified in abortion law the Victorian approach would seem to provide the most practical and safe model. In 2007–08, the VLRC undertook a comprehensive review of abortion regulation across Australia. In light of the findings of that report the Victorian parliament introduced reforms which place decision-making responsibility with the woman, or the woman and her doctor, and service availability with the medical profession. Victorian legislation could serve as a model for reform in Queensland.

The Victorian Law is summarised below:³¹

- Abortion can be performed by a medical practitioner on request up to 24 weeks.
- Registered pharmacists and nurses can supply drugs to cause an abortion to a woman who is not more than 24 weeks pregnant.
- After 24 weeks, abortion can be performed if two medical practitioners reasonably believe the abortion is “*appropriate in all the circumstances.*”
- In deciding whether it is appropriate, must have regard to all relevant medical circumstances and the woman’s “*current and future physical, psychological and social circumstances.*”
- Doctors have a right of conscientious objection, but must refer the woman to another doctor in the same specialty who is known not to have a conscientious objection.
- The only specific abortion offence remaining in the *Crimes Act* covers abortions performed by unqualified people.
- Access zones are protected.³²

Statistics are not formally available in Victoria so claims about numbers of terminations there would be difficult to confirm. In South Australia where legislation requires the collection of statistics the overwhelming majority of abortions take place in the first trimester. One would expect statistics to be similar elsewhere. The South Australian health Department reports that in 2013, 91.9% percent of terminations were performed within the first 14 weeks of pregnancy.³³

Only 2.0% (n94) of abortions in South Australia in 2013 were performed at or after 20 weeks gestation. Of those 94 cases, fifty percent (n47) of abortion performed at or after 20 weeks

³¹ *Abortion Law Reform Act 2008.*

³² *Public Health and Wellbeing Amendment (Safe Access Zones) Bill 2015*- passed November 2015.

³³ These statistics are collected in South Australia in 2013; see Pregnancy Outcome Unit, *Pregnancy Outcome in South Australia 2013* (SA Health) see p12

gestation were for fetal reasons³⁴ (eg: chromosomal abnormalities; other fetal abnormalities detected or suspected prenatally; or exposure during pregnancy to drugs, which may cause fetal abnormalities.) Despite these low numbers it is important to have access to the procedure at later gestation.

Women's Health Victoria has explained the complex situations in which abortions might take place after 24 weeks gestation. Their statement sets out a number of reasons why, even though it is extremely rare, access to abortions after 24 weeks is extremely important for women:³⁵

- 'There is severe foetal abnormality;
- There has been a traumatic change in circumstances e.g. woman is diagnosed with a very serious illness;
- The woman has been unable to access support earlier or has delayed seeking an abortion due to complex personal circumstances, for example family violence or failure of anticipated emotional or economic support;
- Continuing with the pregnancy puts the woman's health or life at serious risk e.g. the woman is suicidal;
- The woman has not recognised that she is pregnant. These are often younger women, whose bodies are still developing, and pre- and peri- menopausal women, who do not expect to be pregnant at this stage of their lives. A woman may not recognise or may be in denial that she is pregnant due to experience of trauma (e.g. rape, incest), intellectual disability or mental illness.
- In some cases, the woman has made a decision to have an abortion earlier in her pregnancy, but has experienced difficulties accessing abortion due to lack of services (for example in rural areas), unaffordability etc.'

Thus it is very important to ensure abortion at any stage is legally possible and realistically accessible. The Victorian requirement for two doctors to support the decision from 24 weeks gestation should ensure sufficient checks and balances.

³⁴ These statistics are collected in South Australia in 2013; see Pregnancy Outcome Unit, *Pregnancy Outcome in South Australia 2013* (SA Health) see p12
<http://www.sahealth.sa.gov.au/wps/wcm/connect/62e89b004aca1fd38486dc0b65544981/15116.1+Pregnancy+Outcomes+Report+A4-FINAL.pdf?MOD=AJPERES&CACHEID=62e89b004aca1fd38486dc0b65544981>

³⁵ Women's Health Victoria, 'Fact Sheet Abortion After 24 weeks' p2
http://whv.org.au/static/files/assets/639c6f2c/Abortion_after_24_weeks_Q_A_.pdf

In terms of legal reform in Queensland it is argued that two doctors, and not doctors specifically selected from an identified panel of 6 (as in WA model) , would provide sufficient protection in the decision making process about post 24 week plus abortions. It is important that the two medical doctors involved in such decision making are not required to have specific qualifications such as a specialist gynaecologist (as in Tasmanian model). The Victorian model would be the most simple and easier to implement across Queensland. The requirements for panels and specialists to be involved is expensive, may cause delays and would risk developing a two tiered system where wealthier women in the more populated parts of Queensland have much greater access to abortion services than their poorer sisters in the rural and remote parts of the state where access to numbers of doctors and specialists is more difficult.

5. Provision of counselling and support services for women.

While I agree that pre and post abortion counselling should be freely available and offered to women seeking a termination and / or who have had an abortion should they request it, I do not believe it should be mandatory.

The Victorian Law Reform Commission (VLRC) examined this question in some depth (see especially pp118-126)³⁶ and determined that Victorian abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling. The VLRC pointed out that counselling is different to the doctor's duty to advise on the nature of the procedure and the risks associated with any procedure. A counsellor does not 'suggest, advise or persuade' [8.62]. The VLRC referred to research undertaken by Marie Stopes that found that 75% of women did not wish to speak to a counsellor [8.84].

The World Health Organisation (WHO) has produced policy guidance around abortion and states that:

Every pregnant woman who is contemplating abortion should receive adequate relevant information and be offered counselling from a trained health-care professional with comprehensive knowledge and experience of different methods of abortion.³⁷

³⁶ Victorian Law Reform Commission (2008) *Law of Abortion: Final Report*, Victorian Law Reform Commission.

³⁷ World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 36

Notably the WHO guidelines make a clear distinction between information, that should be *received* and counselling that should be *offered*. WHO does not recommend mandatory counselling in its policy guidance.

6. Other issues:

The following claims have been unsubstantiated by reliable research:

1. Women who have abortions are more likely to commit suicide than those who don't have abortions / abortion causes long term depression in women

In this context see research conducted by the RANZCOG and referenced by the VLRC report that stated:

[P]sychological studies suggest: there is mainly improvement in psychological wellbeing in the short term after termination of pregnancy; there are rarely immediate or lasting negative consequences; there may be an association between termination of pregnancy and some adverse mental health markers: these may reflect pre-existing conditions.³⁸

Research has not been able to establish any causal relationship between psychiatric illness and self-harm being higher among women who have had an abortion (VLRC [8.88]). Indeed mental health issues, where they exist, appear to be the continuation of existing mental health problems rather than associated with abortion.³⁹

2. There is an increased risk of breast cancer for women following abortion.

There is no evidence of a connection between breast cancer and abortion.⁴⁰

³⁸ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005) 4; quoted by VLRC at [8.87]. See also Brenda Major et al, 'Abortion and mental health: Evaluating the Evidence' (2009) 64 (9) *American Psychologist* 863 at 885.

³⁹ PKB Dagg, 'The psychological sequelae of therapeutic-abortion – denied and completed' (1991) 148 *American Journal of Psychiatry* 578–585; B Major et al. 'Abortion and mental health evaluating the evidence.' (2009) 64 *American Psychologist* 863.

⁴⁰ V Beral et al. 'Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83 000 women with breast cancer from 3.6 countries' (2004) 363 *Lancet* 1007; M Melbye et al. 'Induced abortion and the risk of breast cancer' (1997) 336 *New England Journal of Medicine* 81

3. Many women experience serious complications from abortion:

Serious complications are rare when abortion is provided according to clinical guidelines.⁴¹ Indeed abortion that is provided according to clinical guidelines is much safer for the pregnant woman than carrying a pregnancy to term.⁴² The World Health Organisation guidance identified that women should receive information about abortion procedures including that she is likely to experience menstrual like cramps, pain and bleeding.⁴³ South Australian statistics for 2013 identify that in only 2.5% of all cases were there complications associated with the termination.⁴⁴ Complications associated with abortion might actually be even further reduced from their already low incidence with decriminalisation. This is because decriminalisation may result in better training for doctors and greater willingness of doctors to carry out abortions. Decriminalisation may thus result in women being able to access abortions closer to where they live, more quickly and therefore at an earlier gestation; they may feel less stigmatised about their decisions, also resulting in abortion at earlier gestation, further reducing the possibility of complications.

4. Numbers of abortions will increase if the law is changed / there has been a significant increase in the rate and number of abortions in Victoria since the 2008 reforms:

Accurate statistics on abortion numbers are difficult to find in Australia however there is some evidence that numbers of abortions are decreasing overall - this may have something to do with the increased uptake of long acting contraceptives.⁴⁵ The World Health Organisation confirms that legal restrictions on abortion do not result in fewer abortions. It confirms that laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. Rather the WHO identifies that the main effect of legalising abortion is to simply shift the procedure to being legal.⁴⁶

⁴¹ D Costescu et al, 'Medical Abortion' (2016) 38(4) J Obstet Gynaecol Can 366-389 – concludes: 'medical abortion is safe and effective'.

⁴² EG Raymond and DA Grimes, 'The comparative safety of legal induced abortion and childbirth in the United States' (2012) 119 *Obstetrics and Gynecology* 215

⁴³ World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 36.

⁴⁴ These statistics are collected in South Australia in 2013; see Pregnancy Outcome Unit, *Pregnancy Outcome in South Australia 2013* (SA Health) see p56

<http://www.sahealth.sa.gov.au/wps/wcm/connect/62e89b004aca1fd38486dc0b65544981/15116.1+Pregnancy+Outcomes+Report+A4-FINAL.pdf?MOD=AJPERES&CACHEID=62e89b004aca1fd38486dc0b65544981>

⁴⁵ Family Planning Victoria, Abortion in Victoria <http://www.fpv.org.au/sexual-health-info/sex-and-the-law/abortion-in-victoria/>

⁴⁶ World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 90

Domestic violence and abortion.

There is a clear link between domestic violence and abortion. Domestic violence is common among women having abortions, with between 6% and 22% reporting recent violence from an intimate partner. Concern about violence is a reason some pregnant women decide to terminate their pregnancies.⁴⁷ Partners may pressure women emotionally, psychologically, or physically into an unwanted pregnancy in order to keep her tied to an abusive relationship. Some have identified 'reproductive coercion' as a form of domestic violence. This may manifest as:

- the male partner convincing his female partner that he will leave her if she does not become pregnant;
- the male partner engaging in birth control sabotage (such as destroying birth control pills, pulling out vaginal rings etc);
- the male partner exercising financial control, so as to limit access to birth control – particularly long-acting birth control which can be quite expensive⁴⁸ - and;
- the male partner insisting on unprotected sex or rape.⁴⁹

Some women report increased violence during pregnancy and this poses significant health risks to the woman and the developing fetus. In this context abortion can be a safety mechanism and can also help to minimise the woman's entanglement with an abusive partner making leaving the violence more of a real option.⁵⁰ Restricting abortion provision is likely to result in more women being unable to terminate unwanted pregnancies, potentially keeping them in contact with violent partners, and putting women and their children at risk.

⁴⁷ Audrey Saftlas et al, 'Prevalence of Intimate Partner Violence Among and Abortion Clinic Population' (2010) 100(8) *American Journal of Public Health* 1412; Christina Pallitto et al 'Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO multi-country study on Women's Health and Domestic violence' (2013) 123 (3) *International Journal of Gynaecology and Obstetrics* 3.

⁴⁸ Kirsten Black, Bateson, Deborah and Harvey, Caroline, 'Australian women need increased access to long acting reversible contraception' (2013) 19(5) *Medical Journal of Australia* 317.

⁴⁹ Elizabeth Miller et al, 'Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy' (2010) 81 *Contraception* 316; Elizabeth Smith 'Domestic Violence in Pregnancy' (2008) 3 *International Journal of Childbirth Education* 23.

⁵⁰ Karuna Chibber et al, 'The Role of Intimate Partners in Women's Reasons for Seeking Abortion' (2014) 24(1) *Women's Health Issues* e131; Lynn Meuleners et al, 'Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence: A population based study in Western Australia, 2002-2008' (2011) 11(70) *BMC Pregnancy and Childbirth* 1; Karuna Chibber et al, 'The Role of Intimate Partners in Women's Reasons for Seeking Abortion' (2014) 24(1) *Women's Health Issues* e131, e133-e134.

Conscientious objection⁵¹

Conscientious objection to abortion, usually by health service providers, is often raised in abortion law reform debates and there has recently been significant discussion of the limits of conscientious objection in Australia.⁵² While conscientious objection impedes women's access to abortion, many argue that disallowing it is inconsistent with freedom of conscience and religion. Clarifying and identifying appropriate limits on conscientious objection have been central to abortion law reform in Australia.

When abortion law was reformed in Victoria in 2008 a conscientious objection clause was included in the new legislation.⁵³ Under the Victorian legislation the objection can be held by a registered health practitioner (for example a nurse or a doctor) and must be communicated to the pregnant woman. Furthermore the Victorian legislation requires the health practitioner to refer the woman to an alternative health practitioner who does not have an objection. The provision also requires the health practitioner to undertake or assist in an abortion where the abortion is an emergency and the abortion is necessary to preserve the life of the pregnant woman. The Victorian branch of the Australian Medical Association has developed a fact sheet for practitioners with a conscientious objection recommending that objecting practitioners treat the situation in the same way as a conflict of interest and refer to women to a family planning clinic.⁵⁴ Tasmanian reforms in 2013 included a similar conscientious objection clause to Victoria although the provision there extends to counsellors who are also required to refer on if they object.⁵⁵

I submit that new legislation should include a provision on conscientious objection similar to the Victorian provision. A health practitioner should be allowed to object to providing abortion services but should be required to refer women to a service where the woman can obtain information and referral to an abortion provider. There should be an exception to this general approach: where the woman's life is in danger the health practitioner should be required to provide/ assist with the provision of the abortion if the procedure is required to save her life. This approach would be consistent with the AMA's guidelines for managing conscientious objection.

⁵¹ This section is extracted in part from Heather Douglas and Katherine Kerr, 'Abortion, Law Reform and the Context of Decision-making.' (2016) *Griffith Law Review* forthcoming.

⁵² See generally Anne O'Rourke et al (2012) 'Abortion and Conscientious Objection: The New Battleground' 38 *Monash University Law Review* 87.

⁵³ *Abortion Law Reform Act 2008* (Vic) s 8.

⁵⁴ AMA Victoria (2008). Australian Medical Association (AMA) Victoria (2008) 'Conscientious Objection to Termination of Pregnancy- Information for GPs' http://amavic.com.au/icms_docs/160608_Abortion_-_conscientious_objection_template_and_information_for_GPs.pdf

⁵⁵ See also *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7.

Safe Access zones

Women who access abortion services, and those who work in them, are often intimidated, harassed and sometimes harmed by protesters.⁵⁶ Laws which create an exclusion or buffer zone for protesting around clinics are sometimes referred to as 'bubble laws'. Safe entry to a clinic for an abortion is clearly an access issue in a very practical sense. In Australia, bubble laws have been argued to limit the implied right to political communication although the High Court has found in other contexts that limits can be placed on political communication where they are for some overriding public purpose, such as safe access to health service.⁵⁷ Recent abortion law reform in Australia has focussed on access zones. In its 2008 review of abortion law, the Victorian Law Reform Commission ('VLRC') heard submissions about the need for a legislative response to the harassment issue and encouraged the Attorney General to consider options.⁵⁸ Seven years after the VLRC report safe access zones have been introduced in Victoria⁵⁹ zones of 150 metres around abortion clinics. Tasmania has also introduced safe access zones round clinics⁶⁰ and most recently the ACT has also introduced safe access zones.⁶¹ I recommend safe access zones should be part of any new Queensland regulatory model.

Conclusion:

I agree with those who call for better sex education, better education and information around contraceptive use – including long acting contraceptives- and more support for pregnant women and new mothers. These aims are perfectly consistent with the decriminalisation of abortion.

The World Health Organisation (WHO) notes that 'legal restrictions have lead many women to seek services in other countries/states, which is costly, delays access and creates social inequities.'⁶²

⁵⁶ Rebecca Dean and Susie Allanson 'Abortion in Australia: Access Versus Protest' (2004) 11 *Journal of Law and Medicine* 510.

⁵⁷ See Paige Darby 'Research Note on Exclusion Zones in Australia', Victorian Parliamentary Library Service (2015); *Levy v Victoria* (1997) 189 CLR 579, at 619.

⁵⁸ Victorian Law Reform Commission *Law of Abortion: Final Report*, Victorian Law Reform Commission, (2008) at 140.

⁵⁹ *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015*

⁶⁰ *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9.

⁶¹ *Health (Patient Privacy) Amendment Act 2015* (ACT).

⁶² World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 90. For an analysis of these guidelines see Joanna Erdman et al, 'Updated WHO guidance on safe abortion: Health and Human Rights' (2013) 120 *International Journal of Gynecology and Obstetrics* 200-203.

These concerns have been regularly reported in Queensland⁶³ where abortions are almost always performed in private clinics at significant cost to the individual. This can be contrasted to South Australia where approximately 97% of terminations were performed in metropolitan public hospitals in 2013.⁶⁴ In Queensland we also know that some women have to travel long distances- usually to Victoria- to receive the abortion services they need. This can be a very traumatic experience.

As noted by the WHO: 'International, regional and national human rights bodies and courts increasingly recommend decriminalization of abortion...'⁶⁵ If Queensland shifts to legislative model that allows abortion on request it will join 57 countries, 'representing 40% of the world's women, that allow abortion on request of the pregnant women'⁶⁶. While I support Rob Pyne's Bill to simply decriminalise (similar to the ACT approach), I appreciate that Parliament may decide to create a regulatory regime around abortion and if this is the case in my view Victoria provides the model for the best approach.

As I stated at the outset, the current Queensland legislative regime is dated, dishonest and demeaning to women and their doctors. It's time for Queensland to catch up to world best practice and decriminalise abortion.

⁶³ See for example: H Douglas, K Black, C deCosta, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20 *Journal of Law and Medicine* 560

⁶⁴ These statistics are collected in South Australia in 2013; see Pregnancy Outcome Unit, *Pregnancy Outcome in South Australia 2013* (SA Health) see p12

<http://www.sahealth.sa.gov.au/wps/wcm/connect/62e89b004aca1fd38486dc0b65544981/15116.1+Pregnancy+Outcomes+Report+A4-FINAL.pdf?MOD=AJPERES&CACHEID=62e89b004aca1fd38486dc0b65544981>

⁶⁵ World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 87

⁶⁶ World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2012) http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 90