Submission on Termination of Pregnancy Bill to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Dear Health Committee,

What follows is a brief response to particular aspects of the bill. In short, my opinion is the bill should be rejected and the current legislation adequately balances women's reproductive rights with the rights of the fetus (with some differences on specific issues). I am happy to expand on my responses by appearing before the Committee or supplying further written submissions if that is deemed appropriate. Thank you for your consideration.

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(Submitting in a private capacity)

First, the bill allows termination for up to 22 weeks for any reason. This allows sex-selection abortions, which are usually made to terminate females.[1] For a bill which claims to support women, allowing sex-selection abortion seems incongruent. The threshold should be much earlier (e.g. the first trimester) to exclude the possibility of termination on the basis of sex. It is not purely a question of women's autonomy or facile slogans such as 'my body, my choice'. Everyone's body is regulated to the extent that our choices do not inflict unnecessary harm on others. For example, it is unlawful to intentionally kill another person. This might restrict bodily autonomy and choice, but the restriction is appropriate to prevent harm (deprivation of another's right to life). In a similar way, an early limit for lawful

[1] [redacted]

termination reflects the fact that (at the very least) the fetus is a developing human person with a right to life. At most the fetus is an actual human person. Though the fetus is intellectually and experientially limited, with complete dependence on the mother, they are a separate living individual entity worthy of protection – just as a 1 day old baby, a severely disabled person, or an extremely elderly person is intellectually and experientially limited with complete dependence on others. The vulnerability of such persons calls for their legal protection. The limit should be early and related to the first trimester of pregnancy. The primary reason given for 22 weeks is fetus viability. However, there has already been a situation where a premature baby of 21 weeks and 4 days has survived to their current age of 3 years.[2] Therefore if viability is the reason for 22 weeks this must be moved earlier. Moreover, viability will only improve as medical knowledge and technology increases, and therefore again the threshold should be much earlier. Consequently the concept of 'viability' is too ambiguous and lends itself to manipulation in the sense that viability depends on individual circumstances and available medical technology. Related justifications for 22 weeks such as current medical practice and the service capability framework will also be updated with improved medical knowledge and technology, and therefore should not be determinative.

Second, the bill allows termination over 22 weeks if necessary to save the woman's life or if recommended by a medical practitioner based on all relevant medical circumstances, and the woman's current and future physical, psychological and social circumstances. This would still allow sex-selection abortion. It would also allow termination on the basis of serious fetal abnormality or disability. This is problematic. What is a 'serious' abnormality? Any kind of abnormality could be viewed as serious and often it is not known what kind of impact it will have on the child's quality of life until after they are born and grow. It is not a risk worth taking to terminate on this basis. If the abnormality is indeed fatal, death will occur naturally without human facilitation. There is also the possibility of misdiagnosis or the child having a reasonable quality of life even with that abnormality. For the same reason we do not terminate the lives of those with serious disabilities, this should not be a permissible ground for termination.

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Moreover, there is an implicit presumption in these considerations that termination is appropriate. The presumption should instead be that termination is not appropriate unless the mother's life is in imminent danger. This is the only factor which would outweigh the fetus' right to life. Pregnancy and birth are physically and mentally stressful processes and it is almost inevitable that some negative physical and mental effects will occur. Having a baby will have significant social and economic impacts. These considerations are consequently far too broad and in effect allow termination on demand. Any physical, mental, social or economic consequences of pregnancy and birth (if not life-threatening) do not outweigh the right to life for a fetus. As a society we do not condone the taking of life because it will be more convenient for us. If we did, there is no logical reason why such a principle could not apply to terminating newborns or those with severe physical or intellectual disabilities. We need to support those who are tasked with taking care of the dependent and vulnerable rather than callously 'eliminating the problem'. Perhaps the Government could look at making adoption easier.

The medical practitioner must consult another medical practitioner who agrees. The safeguard of another opinion is helpful in the abstract. However, it is very easy to get the support of another doctor through a simple phone call where the second doctor has not even seen or consulted with the patient. More significantly, there are no safeguards in the bill to guarantee independence on the part of the second opinion. There is a financial incentive for abortion providers to procure abortions, which undermines systemic requirements and the provision of comprehensive information. There are also no safeguards against abortion coercion (where an abusive partner or other party may force the woman to seek an abortion against her will).[3] This undermines genuine choice.

Third, a registered health practitioner can conscientiously object to providing an abortion but must disclose the objection and refer the woman to another practitioner or provider who is willing to provide the abortion. This concession is important. However, it still compels complicity on the part of a registered health practitioner by forcing them to participate in a termination through compulsory reference. It might be objected that the termination is not

[3] [redacted]

guaranteed because it is simply a referral and consequently it cannot burden conscience. However, the bill specifies that the practitioner must believe the alternative practitioner can provide the service and does not have a conscientious objection. It follows that if a conscientiously objecting medical practitioner has a belief that a termination is likely to happen as a result of the referral, this may well burden their conscience. A genuine provision for conscientious objection would allow a health practitioner to completely abstain from the process.

Moreover, the conscientious objection does not extend to hospitals or institutions because according to the QLRC "freedom of thought, conscience and religion is a personal and individual right".[4] This is actually incorrect. Article 18 of the International Covenant on Civil and Political Rights, protected free exercise of religion under s 116 of the Australian Constitution, and the majority of scholarship on this question agree that freedom of thought, conscience and religion is a group right as well as an individual right. This right should be protected to allow institutions to conscientiously object to providing abortions. Not doing so could have major implications for religiously based hospitals which conscientiously object to providing abortions, including closures (which would detrimentally affect vulnerable women far more than simply allowing them to decline to provide abortions). I can provide further references on this point if the Committee requests.[5]

Finally, the bill's establishment of safe access zones of 150m outside abortion clinics to prevents any conduct relating to abortions and which might deter a person from seeking an abortion. This effectively outlaws 'sidewalk counselling' which undermines providing comprehensive information resulting in genuine choice. From a legal perspective, it is unconstitutional. Given the recent finding in *Brown v Tasmania*, the fact the targeted conduct may well already be illegal would probably mean the implied freedom of political communication is infringed. I agree with Professor Nicholas Aroney on this point.[6] Similar provisions in Victoria are currently being challenged on this basis in the High Court. I can provide a more detailed analysis going through the elements if the Committee wishes.

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[4] QLRC Recommendations at 4.149.

[5] See e.g Nicholas Aroney, 'Freedom of Religion as an Associational Right' (2014) 33(1) *University of Queensland Law Journal* 153.

[6] [redacted] . This article relates to the previous Pyne bills but the conclusion is the same as this bill does not differ substantively in regard to safe access zones.