Committee Secretary
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: health@parliament.qld.gov.au

4 September 2018

Dear Committee Secretary

Submission on the review of the Termination of Pregnancy Bill 2018

The authors of this submission support decriminalisation of abortion in Queensland, and argue that the issue of termination of pregnancy should be dealt with as a health matter.

There are some critical policy considerations that, in our view, demonstrate the need for reform to legalise abortion in Queensland so that it is treated as a health matter. These are:

- modernisation of laws to reflect community attitudes;
- clear and certain laws;
- promoting and protecting women's health and safety;
- recognition and treatment of abortion as a women's health issue;
- promoting greater equity in access to abortion services; and
- ensuring health professionals practice in a legally-certain environment

We also consider that there are important legal principles that should inform the design of the law governing termination of pregnancy, such as:

- clarity and certainty;
- enforceability of laws;
- justice and equity;
- autonomy;
- promotion of well-being and avoidance of harm to the community

For elaboration of these points, we refer you to our previous submissions in relation to the review of termination of pregnancy laws in Queensland. The following have been attached for your convenience:

- Willmott, White and Neller, Submission to the Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws,* 13 February 2018
- McGee, Jansen and Sheldon, Submission to the Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws,* 13 February 2018

- Willmott, White and Neller, Submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Health (Abortion Law Reform) Amendment Bill 2016*, 14 October 2016
- Willmott, White and Neller, Submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Inquiry into the Abortion Law Reform Bills and laws governing termination of pregnancy in Queensland*, 6 July 2016

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Committee further if additional information is required.

Professor Lindy Willmott
Australian Centre for Health Law Research
[redacted]

Professor Ben White
Australian Centre for Health Law Research
[redacted]

Penny Neller
Australian Centre for Health Law Research
[redacted]

Dr Andrew McGee
Australian Centre for Health Law Research
[redacted]

The Secretary
Queensland Law Reform Commission
PO Box 13312
GEORGE STREET POST SHOP QLD 4003

By email: lawreform.commission@justice.qld.gov.au

13 February 2018

Dear Secretary

Submission to the Review of termination of pregnancy laws

Executive summary

The authors of this submission support the decriminalisation of abortion in Queensland, and argue that the issue of termination of pregnancy should be dealt with as a health matter. Legalising abortion in Queensland would also achieve fundamental policy objectives including modernisation of the law to reflect community attitudes; provide clarity and certainty; protect and promote women's health and safety; ensure equity of access to abortion services; and enable health professionals to practise in a legally-certain environment.

We make the following recommendations:

1. Sections 224, 225 and 226 from the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed.
2. Section 226 be deleted from schedule 2 of the *Transport Operations (Road Use Management) Act 1995* (Qld).
3. That Queensland's abortion laws be governed by the legal principles of certainty; enforceability; justice; equity; autonomy; and avoidance of harm. These legal principles are discussed more fully in our previous submissions to the Inquiry into the Abortion Law Reform Bill and laws governing termination of pregnancy in Queensland, and on the Health (Abortion Law Reform) Amendment Bill 2016, which we attach.
4. In determining whether termination of a pregnancy up to 24 weeks is lawful, the relevant principles should be those that govern other medical procedures.
5. A two-tiered approach (similar to that in Victoria) be adopted to regulate termination of pregnancy by gestation periods, whereby:
    - Women may access an abortion on request up to 24 weeks gestation.
    - Abortions be available post-24 weeks gestation where a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus.

6. Legislation be introduced which provides that parental consent is sufficient authorisation for the termination of a non-*Gillick* competent minor's pregnancy, with the child's best interests being the relevant criterion. Court approval should not be required. For abortions after 24 weeks gestation, abortion should be available where a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the minor's physical or mental health and/or the serious medical condition of the foetus.
7. The ability to make a conscientious objection to terminating a pregnancy be available to health professionals in non-urgent situations, but must incorporate an obligation to refer. We further recommend that a doctor with a conscientious objection must be required by law to perform an abortion where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health.
8. Accessing an abortion in Queensland should not be subject to a mandatory requirement for the woman seeking a termination to be referred to, or access, counselling and support services.
9. Access/buffer zones outside of facilities offering abortion services be implemented in Queensland.
10. Residency requirements to access an abortion should not be introduced in Queensland.

Background

We are the Directors and former Centre Coordinator of the Australian Centre for Health Law Research (ACHLR), a specialist research Centre within the Queensland University of Technology's Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

We hope this review will result in the reform of termination of pregnancy from a criminal law to health law framework, thereby promoting women's health and reproductive rights, and providing clarification and modernisation of the Queensland law in relation to this challenging and sensitive issue. We provide this submission in response to the Review terms of reference and the questions for consideration noted in the Consultation Paper.

Who should be permitted to perform or assist in performing terminations? (Question 1)

We support the introduction of a provision in Queensland law which provides that only a doctor or a registered nurse administering a drug under the direction of a medical practitioner should be able to lawfully perform an abortion. It should be a criminal offence for persons other than a registered medical practitioner, or registered nurse administering a drug under the direction of a doctor to perform an abortion.

The Commission may wish to explore whether the legislation should refer to any potential role played by pharmacists. Pharmacists may also be involved in termination of pregnancies due to their role in prescribing medication which causes terminations.

Should a woman be criminally responsible for the termination of her own pregnancy? (Question 2)

We reiterate our view that decriminalisation of abortion should occur in Queensland, and that termination of pregnancy should be regulated by the law as fundamentally a women's health matter, rather than a criminal offence. Compelling evidence was provided at the first Inquiry to the Parliamentary Committee as to why decriminalisation should occur, including that the current law is uncertain, fails to promote women's health, exposes women to harm and inequity, and does not reflect contemporary community standards.

Continuing to classify abortion in Queensland as a criminal offence warranting condemnation, punishment and penalties is problematic, harmful and counterproductive. Failure to determine this issue once and for all serves only to perpetuate uncertainty, delay and harm for women, their families, medication practitioners and the broader Queensland community. We strongly urge the Commission to recommend decriminalising abortion, and that sections 224, 225 and 226 of the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed. This is needed to modernise existing laws, address the significant problems present in the current legal framework, and ensure greater, more equitable access to treatment and certainty for women.

Gestational limits and grounds (Questions 3-7)

We consider that regulating termination of pregnancy by gestation periods should be incorporated into relevant legislation, and recommend the 'two-tiered' approach of the Victorian law, whereby a woman may access an abortion on request up to 24 weeks gestation, and in certain circumstances following 24 weeks gestation. However, in contrast to the Victorian law, we submit that following 24 weeks gestation, there should be no requirement for a second doctor to agree to the abortion, and that one doctor is sufficient for this purpose.

a) Abortions prior to 24 weeks

There is evidence that at 24 weeks a foetus is potentially viable, that is, capable of being born alive and surviving independently from its mother, albeit with medical intervention.[1] Accordingly, we consider it justifiable to treat termination up to 24 weeks gestation differently from a termination after this time. Up until 24 weeks gestation, we believe termination should be available to a woman who requests that procedure, and provides consent.

b) Circumstances in which an abortion post-24 weeks can occur

It is our submission abortions should be available post-24 weeks if the termination is requested by the woman and the following can be established:

[1] See for example the discussion in Victorian Law Reform Commission, *Law of Abortion Final Report*, Final report No 15, (March 2008), 40 – 41.

a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus.

(i) Number of practitioners involved

When a woman is requesting a termination post 24 weeks, we consider that the agreement of a doctor who is satisfied that the relevant criterion proposed above has been met is needed. The decision to terminate a pregnancy is a serious and important one. Where the foetus is viable up until the time of birth, we believe that the competing interests of the woman and foetus exist. We also are of the view that a woman would not come to a decision about termination without having carefully considered all relevant issues, and that doctors who participate in the process would be aware of the interests involved and are unlikely to perform a termination post-24 weeks other than in the circumstances noted in the criterion proposed above. Unless there is evidence that there is inappropriate conduct in the context of late-term terminations, we believe that law should interfere with the decision to terminate a pregnancy to the least extent possible. In our view, the gatekeeping role of one doctor is sufficient.

We also oppose any requirement for a clinical ethics or panel approach to decision-making. Such an approach is unnecessarily onerous and burdensome, and would constitute unwarranted intrusion and delay.

(ii) The woman's physical or mental health

We consider that the woman's physical or mental health is an appropriate criterion for a woman to be able to obtain an abortion post-24 weeks. This criterion would promote the woman's health and safety, and would reduce risk and harm, whether physical or physiological, that may result if the pregnancy were to continue.

(iii) Serious medical condition of the foetus

We note that termination on the grounds of a child's medical condition is a highly contentious issue. We consider that for an abortion on this ground to be lawful the condition of the foetus must be sufficiently grave. What constitutes a 'serious medical condition' is more appropriately a matter to be determined by Parliament, in consultation with the medical profession. Western Australia is the only Australian jurisdiction which makes a similar provision for abortions post-20 weeks, on the grounds that the 'unborn child has a severe medical condition', yet that terminology is undefined.[2] The United Kingdom also has not defined its analogous provision within the *Abortion Act 1967* (UK). Australian law academics Karpin and Savell note this is because the 'majority (in those Parliaments) understood

[2] Other jurisdictions make similar provisions, for example the United Kingdom. For a discussion of the position in that jurisdiction see the VLRC report, above n 29, and also Emily Jackson, *Medical law texts, cases and materials* (2006), 609-613.

that contextual matters would be significant in determining the meaning of 'severe medical condition' or 'serious handicap'….'.[3]

Consultation by the medical practitioner (Questions 8-10)

Please see our comments above under the heading 'Number of practitioners involved'.

Conscientious objection (Questions 11-12)

We believe that if a conscientious objection provision is introduced into Queensland law, specific provision must be made requiring a doctor to perform an abortion in emergency situations, and a registered nurse to assist, where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health. Care must be taken to uphold the safety and health interests of the woman at all times, and to avoid any situation where a woman loses her life, or sustains severe, permanent injury or harm, whether physical or psychological, through a doctor's reluctance to terminate her pregnancy.[4]

We further submit the proposed conscientious objection clause should include a legal obligation of referral, whereby a health practitioner exercising a conscientious objection is required by law to refer the woman to a practitioner who does not have an objection. Referral in those circumstances is critical to ensure the patient is able to receive appropriate advice and information about termination, and to reduce delay in securing a termination.[5]

An obligation to refer exists in Tasmania,[6] and in Victoria.[7] The Victorian provision requires the doctor with the conscientious objection to refer the patient to a registered health practitioner in the same regulated health profession who the objecting doctor knows does not have a conscientious objection. The Tasmanian provision requires the objecting doctor to provide the woman with a list of prescribed health services from which she may seek advice, information or counselling on the full range of pregnancy options. We consider the Victorian provision a better model to ensure more timely and direct access to a qualified health practitioner who is known not to have a conscientious objection.

Counselling (Question 13)

We submit that counselling and support services for women considering terminating a pregnancy, and who have terminated a pregnancy, can be an important source of support, information and resources

---

[3] Isabel Karpin and Kristin Savell, *Perfecting Pregnancy: Law, Disability and the Future of Reproduction* (2012) (Cambridge University Press) 147. Comprehensive analysis of the relevant domestic and international debates concerning this issue are contained in this book.

[4] See for example the case of 31-year-old Irish woman Savita Halappanavar, who died of septicaemia in 2013 after hospital staff refused to perform an abortion of her 17 week old foetus. She subsequently died: Associated Press, 'Irish Jury finds poor care in death of woman denied abortion', *The New York Times* (online, 19 April 2013 <http://www.nytimes.com/2013/04/20/world/europe/jury-cites-poor-medical-care-in-death-of-indian-woman-in-ireland.html?_r=0>.

[5] VLRC report, above n 1, 47.

[6] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s6.

[7] *Abortion Law Reform Act 2008* (Vic) s8.

for them and their families. However, we do not consider that the ability to receive an abortion should be contingent on accessing such services. A requirement for counselling presumes that women are incapable of making decisions without external guidance, and would further undermine their autonomy. Decisions to access such assistance prior to or following an abortion, as with any other medical procedure, should be a matter of personal choice for women, and should not be mandated. We also believe any counselling offered should be through impartial, independent, appropriately qualified sexual health and reproduction counsellors and organisations.

Protection of women and service providers and safe access zones (Questions 14-19)

We support the introduction of protected or safe zones outside of abortion facilities, and support implementation of these in Queensland. We note and agree with the principles underpinning the Victorian safe access zone laws which are that:

- the public are entitled to access health services, including abortions;
- the public, employees and others who need to access abortion facilities should be able to enter and leave those premises without interference and in a manner which
    - protects the person's safety and wellbeing; and
    - respects the person's privacy and dignity.[8]

Women considering or receiving an abortion should not be subjected to harassment, bullying, intimidation or harm through protests, communications, distribution of offensive materials or other acts of aggressive behaviour, and are entitled to sufficient protection of their personal safety and privacy, by the law, in such situations. Staff and other persons entering or leaving abortion facilities are also entitled to protection from such behaviour. We also believe that such laws should prohibit publication of images of persons entering, leaving or trying to enter of leave abortion facilities. Sufficient penalties should be introduced to deter persons from engaging in such acts.

Currently the Victorian, ACT and Tasmanian laws make provision for these zones.[9] We note that in Victoria and Tasmania the laws establish safe access zones of a radius of 150 metres around abortion facilities. We submit that safe access zones in Queensland should also be a radius of 150 metres, to ensure the utmost safety and protection of women and other people, including staff, entering those premises.

Collection of data about terminations of pregnancy (Question 20)

The authors believe that it would be useful to gather data about the prevalence of termination of pregnancies and the circumstances surrounding the procedure. This would facilitate better allocation

[8] *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.
[9] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s9; *Health (Patient Privacy) Amendment Act 2015* (ACT) Div 6.2 and *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.

of healthcare resources to ensure needs of women are met. However, we defer to others regarding the most appropriate method to collect potentially sensitive healthcare data.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Commission further if additional information is required.

Yours sincerely

Professor Lindy Willmott
Director
Australian Centre for Health Law Research
[redacted]

Professor Ben White
Director
Australian Centre for Health Law Research
[redacted]

Penny Neller
Australian Centre for Health Law Research
[redacted]

To: The Secretary

Queensland Law Reform Commission PO Box 13312

It is with pleasure that I and my colleagues enclose our submission to the Law Reform Commission's Review of termination of pregnancy laws in Queensland.

Dr Andrew McGee
Senior Lecturer in Law and Medical Ethics
Australian Centre for Health Law Research
Faculty of Law
Queensland University of Technology

Submission to Review of termination of pregnancy laws in Queensland

Dr Andrew McGee is a lawyer and medical ethicist who has published papers in leading international peer reviewed philosophy journals on the moral status of the embryo, fetus, and newborn baby.

Dr Melanie Jansen is a medical doctor and senior registrar in general paediatrics and intensive care medicine. She is also the Clinical Ethics Fellow at the Centre for Children's Health Ethics and Law at the Lady Cilento Children's Hospital.

Dr Sally Sheldon is a lawyer and philosopher who has worked in a number of academic and social justice roles.

THE FOLLOWING SUBMISSION ANSWERS QUESTIONS Q2-Q5, BASED ON OUR ACADEMIC RESEARCH. BUT THE MATERIAL IS ALSO RELEVANT TO THE OTHER QUESTIONS.

1. SUMMARY OF SUBMISSION:

A woman should not be criminally responsible for the termination of her own pregnancy in any circumstances. The reasons are:

1. The only possible justification for keeping abortion a crime is where it has clearly been shown to be morally unacceptable.
2. No philosophical or ethics literature has been able to show this. Instead, there is ongoing debate about it, which has proven to be intractable.
3. Since the moral acceptability or unacceptability of abortion is uncertain, the law should take a minimalist position by not imposing criminal sanctions for abortion.
4. Most laws recognise that, should her life be endangered by her pregnancy, a woman's right to life shall prevail.
5. However, the impacts of carrying a fetus to term and delivery on a woman are not restricted to the risks to her life (mortality), but extend to significant permanent changes to her body, and include risks of injury that are not negligible (morbidity).
6. These risks have largely been ignored in the debate on abortion, but provide further compelling grounds for decriminalisation.

2. SUBMISSION IN ANSWER TO QUESTIONS Q2-Q5:

A: Intractability of debate about abortion's acceptability or unacceptability is ground for full decriminalisation

1. We support the full decriminalisation of abortion, with some regulation being retained to reflect current practice in respect of late-term abortions.
2. Debate about the acceptability or unacceptability of abortion typically focuses on the moral status of the fetus (we use 'fetus' to include the embryo). Many religious and some secular views believe that the fetus should be afforded the same moral protection, from conception

onwards, as an adult.[1] Others believe that moral status is only enlivened later, either when the fetus has developed a brain, or when the fetus has acquired the capacity for consciousness and the capacity to feel pain – normally at or after 24 weeks gestation.[2] Others claim that moral status is acquired at extrauterine viability.

3. However, long-standing ethical debate concerning which of these possible views is the correct view has to date proven intractable. The matter remains at a stalemate in terms of rational debate, contributing to the ongoing absence of political and popular consensus about the issue in our society.
4. This means that the moral status of the fetus is uncertain. The only possible justification for keeping abortion a crime is acceptance of the view that abortion is immoral. Since no philosophical or ethical literature has demonstrated this to be so, criminalisation of abortion is untenable. Where there is uncertainty about the true moral status of the fetus, the law should instead adopt a minimalist position by not imposing criminal sanctions for abortion. Abortion should therefore be decriminalised in Queensland.
5. We emphasise that the claim that abortion should be decriminalised for this reason is not equivalent to the claim that abortion is morally acceptable. It is instead the different claim that there is no basis for the law to criminalise abortion as an act which has not conclusively been demonstrated to be morally *un*acceptable.

B: Further grounds for decriminalisation: maternal morbidity and mortality

6. The effects of carrying a fetus to term and of delivery are always substantial for a woman. The current law recognises that, should her life be in danger, the woman's right to life shall prevail. However it is not always possible to predict which pregnancies and deliveries will present life-threatening complications. Although the risk of death occurring is small in first-world jurisdictions, the risk is not zero. The so-called 'normal' risks of pregnancy also include risks associated with interventions such as induced labour, spinal and/or epidural anaesthetic and caesarean section.
7. Further, the impacts of pregnancy and delivery on a woman are not restricted to the risks to her life (mortality), but extend to significant permanent changes to her body, and include risks of injury that are not negligible (morbidity). The president of the Royal College of Obstetricians and Gynaecologists in the United Kingdom reports that approximately 90% of women have some kind of perineal tear at birth, with up to almost 6% of first time mothers in the UK experiencing a third or fourth degree tear.[3] Long term complications of third and fourth degree tears include urinary and faecal incontinence, fistula formation, dyspareunia and prolapse. About 50% of women, following a vaginal birth, will have significant changes to the functional anatomy of a key pelvic floor muscle implicated in the development of prolapse.[4] If caesarean section is required, there is well-known morbidity associated with

---

[1] Robert P George and Christopher Tollefsen. *Embryo: A Defense of Human Life* (Doubleday, 2008).

[2] Royal College of Obstetricians and Gynaecologists, 'Fetal Awareness: A Review of Research and Recommendations for Practice', March 2010.

[3] Richmond D. Perineal tearing is a national issue we must address. Royal College of Obstetricians and Gynaecologists, July 2014 https://www.rcog.org.uk/en/blog/perineal-tearing-is-a-national-issue-we-must-address/

[4] Dietz H. Pelvic floor trauma in childbirth. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2013; 53: 220–230.

this, including that subsequent pregnancies and deliveries are more risky.[5] While for most women the complications of pregnancy and birth are well managed, and women have good functional outcomes, there is still significant risk associated with the process; research shows only 27.4 per cent of births in Queensland are 'normal'.[6]

8. The psychological impact of pregnancy and birth is also significant. Many women report body image dissatisfaction post partum and this can affect multiple aspects of their health and wellbeing.[7] In addition, prenatal anxiety and depression affects up to 1 in 10 women and postnatal depression up to 1 in 7 women.[8]
9. These risks to a woman are greater than those risks attending a termination of pregnancy.[9] Specifically, there is no evidence that women who have an unintended pregnancy ending in termination have any higher incidence of psychological sequelae compared with those who decide to continue with an unintended pregnancy.[10]
10. A woman should therefore not be compelled to take these risks by laws prohibiting abortion when there is no decisive argument that the embryo or fetus has the same moral status as an adult human being. Some protection for late-term fetuses should, however, remain to reflect current medical practice and community standards.

Attached in the Appendix is our published peer-reviewed research which goes through these issues in more detail.

---

[5] Queensland Maternity and Neonatal Clinical Guideline: Vaginal birth after caesarean section (VBAC), June 2015 https://www.health.qld.gov.au/qcg/documents/g-vbac.pdf

[6] Queensland Maternity and Neonatal Clinical Guideline: Normal Birth, April 2012 https://www.health.qld.gov.au/__data/assets/pdf_file/0014/142007/g-normalbirth.pdf

[7] Gjerdingen D, et al. Predictors of Mothers' Postpartum Body Dissatisfaction. *Women Health* 2009; 49(6):491-504 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796197/

[8] Perinatal Anxiety and Depression Australia (PANDA) Factsheet: Anxiety and Depression in Pregnancy and Early Parenthood. http://www.panda.org.au/images/FINAL_PDF_Anxiety_and_Depression_in_Early_Parenthood.pdf

[9] Royal College of Obstetricians and Gynaecologists. *Best Practice in Comprehensive Abortion Care* Paper No. 2. June 2015 https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf page 1.

[10] Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion*. November 2011 (https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf page 10).

Authors' published peer-reviewed research

ANZJOG

DOI: 10.1111/ajo.12817

OPINION

Abortion law reform: Why ethical intractability and maternal morbidity are grounds for decriminalisation

Andrew McGee[1], Melanie Jansen[2,3] and Sally Sheldon[4]

[1]Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia

[2]Intensive Care, Centre for Children's Health Ethics and Law, Children's Health Queensland, Brisbane, Queensland, Australia

[3]Faculty of Medicine, University of Queensland, Brisbane, Queensland, Australia

[4]The Myuma Group, Mount Isa, Queensland, Australia

Correspondence: Dr Andrew McGee, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, 2 George St Brisbane Qld 4001, Australia.
Email: a.mcgee@qut.edu.au

Conflict of Interest: The authors report no conflicts of interest.

Received: 8 November 2017;
Accepted: 22 March 2018

In this paper, we present two grounds for arguing that abortion should be decriminalised. First, we consider the implications of the fact that the long-standing ethical debate concerning the morality of abortion has to date proven intractable. We maintain that because the philosophical literature has failed to demonstrate conclusively that views either for or against abortion's moral acceptability are false, the matter remains at a stalemate in terms of rational debate, contributing to the ongoing absence of political and popular consensus about the issue in our society. In these circumstances, we argue, the law should adopt a minimalist position by not imposing criminal sanctions for abortion. Second, we present evidence, often neglected in the moral debates about abortion, that the risks of carrying a fetus to term and of delivery are substantial for a woman. Most laws recognise that, should her life be endangered by her pregnancy, a woman's right to life shall prevail. However, the impacts of carrying a fetus to term and delivery on a woman are not restricted to the risks to her life, but extend to significant permanent changes to her body, and include risks of injury that are not negligible. We argue that a woman should not be compelled to take these risks by laws prohibiting abortion, when no conclusive argument exists against the morality of abortion. We also address, albeit briefly, the issue of late-term abortion.

KEYWORDS

termination of pregnancy, physical and psychological risks of pregnancy and delivery, maternal morbidity and mortality, abortion law reform

INTRODUCTION

Should abortion be fully decriminalised? The debate about abortion continues to make headlines in many places throughout the world. In Queensland, abortion is prohibited except in a very narrow range of circumstances (where there is serious danger to the mother's life or to her physical or mental health),[1] but in 2016 two bills were introduced into Parliament for the decriminalisation of abortion in that state.[2] The issue in Queensland has now been referred to the Queensland Law Reform Commission for further consideration and the Commission must provide its final report by 30 June, 2018. In New South Wales, where the law is similar to the Queensland law,[3] a bill to legalise abortion was introduced in 2016 on the ground that the current regime technically means that women seeking abortions and doctors providing them are both criminals.[4] The narrow range of circumstances in which abortion is permitted in Ireland, Northern Ireland and in the Isle of Man has also been well publicised in the last two years, and attempts to introduce Bills to reform the law have been made in these countries as well.[5] In Ireland, a referendum on the issue was announced on 30 January, 2018, to be held in May, 2018.[5]

In this paper we argue that, in the absence of philosophical and popular consensus surrounding the morality of abortion, abortion should be decriminalised. We maintain that, despite decades-long debate about the issue, the philosophical literature

has not yielded a conclusive demonstration that abortion is either moral or immoral and has, accordingly, failed to intervene decisively in the popular and political debates about the issue. The matter remains intractable when approached in philosophical terms, as neither side of the debate can establish the irrationality of its opposing position. We claim that, in these circumstances, the law should adopt a minimalist position by not imposing criminal sanctions for abortion, and that to decriminalise abortion for this reason is not, of itself, to endorse abortion's moral acceptability. We also present evidence that is often neglected in the moral debates about abortion: that the risks of carrying a fetus to term and of delivery are always substantial for a woman, and are higher than those associated with termination of pregnancy. This, we argue, further supports abortion being decriminalised in a context where no conclusive argument exists to demonstrate its immorality. For reasons of space, we do not address in detail in this paper the issue of late-term abortions, access to which is currently restricted to reflect current medical practice and community standards. We restrict ourselves to one point.

WHY IS THE ISSUE STILL SO CONTROVERSIAL? THE INTRACTABILITY OF THE MORAL DEBATE CONCERNING THE VALUE OF LIFE OF THE EMBRYO AND FETUS

The moral debate about whether abortion should be decriminalised typically centres on the value of the life of the fetus (for ease of exposition we use 'fetus' to refer both to the embryo and the fetus in this paper). Many religious and some secular views believe that the fetus should be afforded the same moral protection, from conception onwards, as an adult.[6] Others believe that full moral status is only enlivened later, with arguments made for various times at which this occurs throughout gestation – for example, when the fetus has developed a brain, or when it has acquired the capacity for consciousness (normally at or after 24 weeks gestation[7]), or for extrauterine viability. Still others have claimed that none of these times represent the time at which the fetus attains moral status. Instead, only beings who are *persons*, and so capable of self-awareness, acquire full moral status.[8] On this view, that status is acquired only much later after birth. Others retort that potentiality for personhood suffices, which takes us back to conception.[6]

We believe that no argument has yet been proposed which decisively demonstrates the truth or falsity of any one of these positions. Such a demonstration would have to establish that one particular view of the fetus's moral status is rational, and that all other views cannot rationally be maintained. We are not aware of any contribution to the debate which has produced such an argument. In particular, we note that the belief that full moral status is acquired at conception has not been clearly demonstrated to be an *irrational* view, although it is not a view that we ourselves endorse. As Judith Jarvis Thomson states[9] (in an essay written decades after her famous 'pro-abortion' contribution to the philosophical debate), although it makes no sense to claim, for example, that a famous painting has an interest in being protected from destruction (and so has the correlative right to be so protected), it does at least appear to make sense to assert that a newly fertilised egg has an interest in not being destroyed, and so a correlative right not to be destroyed – this makes sense because the fertilised egg has the potential to develop into a being that can possess hopes and desires, and have an interest in obtaining the things it hopes for and desires. However, equally, it *makes sense* – even if one does not agree with the position – to deny that the newly fertilised egg has interests and rights, on the basis that only a being that can currently possess hopes and desires can have a right to obtain the things it hopes for and desires. There is no 'knock-down' argument available to either side. A knock-down argument would be one that shows that it is as irrational to hold that a newly fertilised egg has an interest in continuing to live as it is to say that a painting has an interest in continuing to exist. The debate has not become intractable for no reason: the reason is that no such rationally compelling grounds can be given, at least at this point in time, to demonstrate the untenability of all but one of the opposing views in the debate about the fetus's moral status.

WHAT DO WE DO, IN THE FACE OF THIS INTRACTABILITY?

Because there is an ongoing absence of political and popular consensus about the issue in our society, we believe the law should adopt a minimalist, morally neutral position by not imposing criminal sanctions for abortion.

The only possible justification for the current criminal status of abortion in jurisdictions such as Queensland is acceptance of the view that abortion is immoral, based upon an acceptance of the view that the fetus possesses the same moral status as an adult human being from the time of conception. We agree with the point made by Thomson in her 1995 essay: because it has not been shown conclusively that the only rational view possible is that a newly fertilised egg has the same moral status as an adult human being, no adequate basis exists to criminalise abortion. As Thomson explains:

> *What is in question here is not which of two values we should promote, the deniers' or the supporters'. What the supporters [of full moral status from conception] want is a license to impose force; what the deniers want is a license to be free of it. It is the former that needs the justification.*[9]

We emphasise that to accept that abortion should be decriminalised for this reason is *not* to adopt the view that abortion is

morally acceptable, but rather to recognise that there is no basis for the law to criminalise abortion as an act which has not conclusively been demonstrated to be morally *un*acceptable. Our claim in this paper is that there is real uncertainty as to the moral status of the fetus and, by extension, as to the moral acceptability of abortion. Currently, in the face of this uncertainty, the law restricts the autonomy of some people, by criminalising abortion. We argue that the presence of such intractable moral uncertainty undermines the legitimacy of the law's criminalisation of abortion and its consequent restriction of autonomy.

FURTHER ARGUMENTS IN SUPPORT OF A WOMAN'S CHOICE: MATERNAL MORBIDITY AND MORTALITY

There is another important reason why abortion should be decriminalised, so that the decision about whether to have an abortion is one that can be taken by the woman who will otherwise carry the fetus to term. It is very common in debates about abortion, including in parliamentary debates,[10] for women to be invisible. A woman is not reducible to a vessel for delivery of a baby – 'a fetal container'.[11] The actual physical delivery of a baby in childbirth is not a simple process by which the child seamlessly slides into existence outside the womb. On the contrary, childbirth is dramatic, risky and sometimes, traumatic, both physically and mentally, for the mother. The so-called 'normal' risks of pregnancy are not akin to the normal risks of crossing a road. In addition to these risks, are others such as the risks associated with induced labour, spinal and/or epidural anaesthetic and caesarean section. We believe that there is a meaningful sense in which a woman is putting her life and health at risk in delivering a baby.

Although the risk of death occurring is small in first-world jurisdictions, the risk is not zero, and it is reasonable for a woman to say that, given the magnitude of what she may lose if she carries a child to term, a small risk is not a risk she desires to take. If a woman does not want to proceed with a pregnancy, it is reasonable for the woman to cite risks such as these even if, statistically, the risk is low. No one can know, in advance, whether they will fall into the small percentage of those experiencing the outcome for which they are at risk.

In addition to maternal mortality, morbidity associated with childbirth can be significant. While rates of perineal injury vary depending on the setting, with new imaging techniques and greater awareness, there is growing recognition that significant perineal injury is more common than once realised.[12] The president of the Royal College of Obstetricians and Gynaecologists in the United Kingdom reports that approximately 90% of women have some kind of perineal tear at birth, with up to almost 6% of first-time mothers in the UK experiencing a third or fourth degree tear.[13] Long-term complications of third and fourth degree tears include urinary and faecal incontinence, fistula formation, dyspareunia and prolapse. About 50% of women, following a vaginal birth, will have significant changes to the functional anatomy of a key pelvic floor muscle implicated in the development of prolapse.[12] If caesarean section is required, there is well-known morbidity associated with this, including that subsequent pregnancies and deliveries are more risky.[14] While for most women the complications of pregnancy and birth are well managed, and women have good functional outcomes, there is still significant risk associated with the process.

The psychological impact of pregnancy and birth is also significant. Many women report body image dissatisfaction postpartum and this can affect multiple aspects of their health and wellbeing.[15] In addition, prenatal anxiety and depression affects up to one in ten women and postnatal depression up to one in seven women.[16]

Some may argue that termination of pregnancy also carries risk of mortality and morbidity, including potential long-term psychological and emotional sequelae. This is true, as it is with any medical or surgical intervention. However, the risks associated with termination of pregnancy are much lower than the risks of carrying a pregnancy to full term and giving birth.[17] Specifically, there is no evidence that women who have an unintended pregnancy ending in termination have any higher incidence of psychological sequelae compared with those who decide to continue with an unintended pregnancy.[18] Examining the facts around termination of pregnancy makes the case for decriminalising abortion stronger, given the robust evidence that decriminalisation markedly decreases harm associated with termination of pregnancy.[17]

We believe that an additional argument for decriminalising abortion, then, is this: a fetus cannot become an independent being without the woman taking the above-stated risks and accepting these impacts of carrying a fetus to term and childbirth. Given (1) that the moral status of the fetus is still intractably disputed, and (2) there are very real impacts of carrying and delivering a child, we should not require of a woman that she put her own life, health and bodily integrity at risk, when she does not want to bring a child to term. It is not reasonable to require this of a woman when there is no decisive argument for the claim that the fetus has the same moral status as an adult human being, and when it is therefore at least not irrational to believe – as many people do – that they do not have equal moral status.

ABORTION ON DEMAND?

In our view, there is no single point from conception onward that the fetus gains full moral status. Rather, moral status increases with gestation, with full moral status (at least according to the law) being accorded at birth. We accept that, accordingly, many people wish to see some regulation of abortion after 24 weeks. Such regulation would reflect current practice.[19] We note that, when this issue was debated in Victoria, it was found by the Victorian Law Commission that 94.6% of abortions in Australia occurred before 13 weeks gestation, with only 4.7% occurring after 13 weeks and

before 20 weeks, and 0.7% occurring after 20 weeks.[19] Research following the change in the law in Victoria showed that, even among the 48% of people who thought abortion should remain unlawful for the third trimester, there was little support for sanctions against doctors providing terminations after 24 weeks gestation.[20] In this respect, we believe that the *Abortion Law Reform Act 2008* (Vic.), which was enacted in Victoria in 2008 to decriminalise abortion and bring the law up to date with community expectations (and current clinical practice),[19] has the balance right. In this jurisdiction, a practitioner may only perform an abortion if they reasonably believe it is appropriate in all the circumstances and if they have consulted another independent practitioner who has formed the same view. Other Australian states should follow suit.

REFERENCES

1. *R v Bayliss and Cullen* (1986) 6 QLR 8; Sections 224-226 and section 282 *Criminal Code 1899* (Qld).
2. Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (Qld); Health (Abortion Law Reform) Amendment Bill 2016 (Qld);[Accessed 22 February 2018.] Available from URL: http://www.independent.co.uk/news/uk/home-news/the-island-that-feminism-forgot-campaign-grows-to-change-the-isle-of-man-s-medieval-abortion-laws-a7231851.html; http://www.abc.net.au/news/2016-05-10/queensland-abortion-bill-to-be-introduced-by-rob-pyne/7399368.
3. Sections 82-84 *Crimes Act 1900* (NSW); *CES and Anor v Superclinics* (1995) 38 NSWLR 47.
4. Jabour B. Bill to legalise abortion introduced to NSW Parliament. [Accessed 22 February 2018.] Available from URL: https://www.theguardian.com/world/2016/aug/11/law-academics-nsw-government-abortion-criminal-code.
5. Isle of Man 'must update abortion law'. [Accessed 22 February 2018.] Available from URL: http://www.bbc.co.uk/news/world-europe-isle-of-man-38668044; Why can't women on the Isle of Man get an abortion where they live?, https://www.theguardian.co/uk-news/commentisfree/2016/jun/21/isle-of-man-women-cant-get-abortion-where-they-live; Bill to reform Isle of Man abortion laws backed by politicians, http://www.bbc.co.uk/news/world-europe-isle-of-man-38731111; Irish abortion referendum: Debate rages after vote announced, http://www.bbc.com/news/world-europe-42870299.
6. George RP, Tollefsen C. *Embryo: A Defense of Human Life*. New York, NY: Knopf Doubleday Publishing Group, 2008.
7. Royal College of Obstetricians and Gynaecologists. *Fetal Awareness: A Review of Research and Recommendations for Practice*, 2010. [Accessed 22 February 2018.] Available from URL: https //www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf.
8. Singer P. *Practical Ethics*, 3rd edn. New York: Cambridge University Press, 2011.
9. Thomson J. Abortion. *Boston Review*; 1995.
10. Victoria, Legislative Assembly (2008) *Parliamentary Hansard*, Tuesday, 9 September (The Hon. J Merlino MLA, Minister Assisting the Premier on Multicultural Affairs and Minister for Sport, Recreation and Youth Affairs), p 3313.
11. Herring J. The loneliness of status: the legal and moral significance of birth. In: Ebtehaj F, Herring J, Johnson M, eds. *Birth Rites and Rights*. Portland, OR: Hart Publishing, 2011; 103.
12. Dietz H. Pelvic floor trauma in childbirth. *Aust N Z J Obstet Gynaecol* 2013; **53**: 220–230.
13. Richmond D. Perineal tearing is a national issue we must address. Royal College of Obstetricians and Gynaecologists, 2014. [Accessed 22 February 2018.] Available from URL: https://www.rcog.org.uk/en/blog/perineal-tearing-is-a-national-issue-we-must-address/
14. Queensland Maternity and Neonatal Clinical Guideline: Vaginal birth after caesarean section (VBAC), 2015. [Accessed 22 February 2018.] Available from URL: https://www.health.qld.gov.au/qcg/documents/g-vbac.pdf
15. Gjerdingen D, Fontaine P, Crow S *et al.* Predictors of mothers' postpartum body dissatisfaction. *Women Health* 2009; **49**(6): 491–504. [Accessed 22 February 2018]. Available from URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796197/
16. Perinatal Anxiety and Depression Australia (PANDA) Fact sheet: Anxiety and Depression in Pregnancy and Early Parenthood. [Accessed 22 February 2018.] Available from URL: https://www.panda.org.au/images/resources/Resources-Factsheets/Anxiety-And-Depression-In-Early-Parenthood-And-Pregnancy.pdf
17. Royal College of Obstetricians and Gynaecologists. *Best Practice in Comprehensive Abortion Care* Paper No. 2. 2015. [Accessed 22 February 2018.] Available from URL: https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf p 1.
18. Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion*. 2011. [Accessed 22 February 2018.] Available from URL: (https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf p 10)
19. Victorian Law Reform Commission (2008) *Law of Abortion: Final Report*, Melbourne. [Accessed 22 February 2018]. Available from URL: http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf
20. De Crespigny LJ, Wilkinson DJ, Douglas T *et al.* Australian attitudes to early and late abortion. *Med J Aust* 2010; **193**(1): 9–12.

The Research Director
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George St
Brisbane QLD 4000

By email: abortion.bill@parliament.qld.gov.au

14 October 2016

Dear Research Director,

Submission to the Health (Abortion Law Reform) Amendment Bill 2016

Executive summary

The authors of this submission support the decriminalisation of abortion in Queensland, and argue that the issue of termination of pregnancy should be dealt with as a health matter. Legalising abortion in Queensland would also achieve fundamental policy objectives including modernisation of the law to reflect community attitudes; provide clarity and certainty; protect and promote women's health and safety; facilitate equity of access to abortion services and enable health professionals to practice in a legally-certain environment. To achieve this, we recommend that:

1. Sections 224, 225 and 226 of the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed.

2. Queensland's abortion laws be governed by the legal principles of certainty; enforceability; justice and equity; autonomy; promotion of well-being and avoidance of harm; and should reflect contemporary community attitudes and medical practice.

We make the following recommendations in relation to the Health (Abortion Law Reform) Amendment Bill 2016:

3. That only an appropriately trained, registered medical practitioner (or registered nurse as indicated below) be able to lawfully perform an abortion. It should be a criminal offence to perform an abortion for persons other than a registered medical practitioner, or registered nurse administering a drug under the direction of a doctor.

4. The law should be clear that a woman does not commit an offence by performing, consenting to or assisting in performing an abortion on herself. This outcome would be best achieved by decriminalising abortion in Queensland by removing sections 224, 225 and 226 from the Criminal Code.

5. A two-tiered approach (similar to that in Victoria) be adopted to regulate termination of pregnancy by gestation periods, whereby:
   - Women may access an abortion on request up to 24 weeks gestation.
   - Abortions be available post-24 weeks gestation where one doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus.

6. The ability to make a conscientious objection to terminating a pregnancy be available to health practitioners in non-urgent situations, but incorporate an obligation to refer. We believe that a medical practitioner (and registered nurse) with a conscientious objection must be required by law to perform an abortion in an emergency where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health.

7. Access/buffer zones outside of facilities offering abortion services be implemented in Queensland, within a 150 metre radius of such facilities.

As a final point, we note that this submission represents the views of the authors, and is not made on behalf of all of the members of the Australian Centre for Health Law Research.

Background

We are the Directors and Co-ordinator of the Australian Centre for Health Law Research (ACHLR), a specialist research Centre within the Queensland University of Technology's Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

This submission draws heavily on our submission to the A*bortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland* (dated 6 July 2016), and the evidence provided by Professors White and Willmott to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee at the Inquiry public hearing on 13 July 2016.

Decriminalisation of abortion in Queensland

Prior to addressing the specific issues raised by the Health (Abortion Law Reform) Amendment Bill 2016 ('the second Bill'), we reiterate our view that decriminalisation of abortion should occur in Queensland, and that that termination of pregnancy should be regulated by the law as fundamentally a women's health matter, rather than a criminal offence. Compelling evidence was provided at the first Inquiry as to why decriminalisation should occur, including that the current law is uncertain, fails to promote women's health, exposes women to harm and inequity, and does not reflect contemporary community standards.

Continuing to classify abortion in Queensland as a criminal offence warranting condemnation, punishment and penalties is problematic, harmful and counterproductive. Failure to determine this issue once and for all serves only to perpetuate uncertainty, delay and harm for women, their families, medical practitioners and the broader Queensland community. We strongly urge the Committee to recommend decriminalising abortion, and that sections 224, 225 and 226 of the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed. This is needed to modernise existing laws, address the significant problems present in the current legal framework, and ensure greater access to treatment and certainty for women.

Legal principles that should inform the law governing termination of pregnancy

As noted in our previous submission and the evidence provided at the public hearing, we reiterate that the following legal principles should underpin the law governing abortion in Queensland.

a) Clarity and certainty

A fundamental problem with Queensland's current abortion law is its uncertainty, ambiguity and complexity, and the resulting confusion in its interpretation and application to women and doctors. This is primarily due to the unusual interaction between the Criminal Code offence provisions, and the common law. This, and other complexities of the existing Queensland laws on abortion, are explained more fully in our submission to the first Inquiry (refer to pages 5-7).

The current complexity of these laws has generated confusion and anxiety, both for women who are pregnant and wish to know their options about termination, and also for health professionals seeking to provide advice to women.

The case of *Medical Board of Queensland v Freeman* [2010] QCA 93 demonstrates the consequences and harm which can occur to both women seeking abortions and medical practitioners performing abortions if they are unclear about the law on abortion. In that case, a 19-week pregnant patient, who was suicidal, underwent an unsupervised outpatient termination from which serious complications arose. Freeman, her obstetrician, had prescribed her misoprostol to terminate the pregnancy as an outpatient as she mistakenly believed no hospital would assist a patient seeking a mid-trimester termination. Freeman was subsequently found to have behaved in way that constituted unsatisfactory professional conduct and was suspended.

Laws that are unclear cannot appropriately guide the community. Queensland's existing abortion laws need to be amended to provide clarity and certainty.

b) Enforceability of laws

Related to clarity and certainty is the issue of enforceability of laws. The rule of law provides that society should be governed by the law, obey it, and be able to be guided by it.[1] It is impossible to be appropriately guided by laws which are unclear and cause confusion.

A further fundamental proposition is that laws that are in force should be enforced. If laws are flouted and not enforced, our legal system is at risk of being brought into disrepute. In the context of laws that make an abortion illegal, this raises important points:

i) **Abortion offences are rarely enforced, and are difficult to enforce.** Prosecutions of women who procure an abortion, doctors who perform abortions, and other people who supply drugs or instruments to procure an abortion are extremely rare. The last Queensland prosecution of which the authors are aware occurred in 2010 in *R v Brennan and Leach*.[2] Prior to that, there had been no prosecutions of Queensland doctors since 1986 in *R v Bayliss and Cullen*.[3] Indeed prior to decriminalisation of abortion in other Australian jurisdictions, prosecutions were equally rare.[4] From a law enforcement perspective, it is incredibly difficult to obtain sufficient evidence that a termination has occurred, particularly given the existence of physician-patient privilege, which protects the privacy, confidentiality and dignity of the patient with respect to her health matters.

ii) **There is no public interest in pursuing abortions**. From the limited prosecutions which have occurred in Queensland, it appears (in addition to the difficulties in obtaining sufficient evidence to prosecute) there is very little interest from the Queensland Police Service or the Director of Public Prosecutions in prosecuting women or their doctors for these offences, even if it is known that a termination occurred. We do not consider it is in the public interest for prosecutions of women obtaining abortions or doctors to be prosecuted for performing what is, in essence, a women's medical procedure. Such prosecutions serve only to exacerbate the distress, harm and humiliation of the women concerned and their families, and have the potential to cause stress, anxiety and unwarranted damage to the reputation of their doctors.

c) Justice and equity

Queensland's laws should reflect the legal principles of fairness, justice and equity. In our view the current laws are inequitable, and disadvantage women seeking a termination. The fact that an abortion is unlawful necessarily affects the availability of the procedure. Women should have access

---

[1] Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and law for the health professions* (4th ed, 2013) (Federation Press: Sydney) 56.

[2] *R v Brennan and Leach* (unrep, District Ct, Qld, Criminal Jurisdiction, 12-14 October).

[3] Victorian Law Reform Commission, *Law of Abortion Final Report*, Final report No 15, (March 2008) 21.

[4] For a full analysis of Australia's history of abortion-related prosecutions, see the Victorian Law Reform Commission's Final Report, ibid, ch 2.

to termination of pregnancies regardless of their economic circumstances, place of residence or other personal circumstances.

The practical application of the laws can cause economic disadvantage for women in Queensland seeking an abortion. It is understood that the majority of terminations are performed in private, not public facilities.[5] This means that women with greater access to financial resources are more likely to be able to afford the procedure. Making the procedure lawful is likely to increase its availability in public health services therefore increasing access to more women. This current inequity is further exacerbated for women residing in regional or remote Queensland who must travel long distances to access an abortion where services are not available locally. Increasing accessibility should reduce these costs. In our view, there should be equitable access to abortion for all women, regardless of location or economic status.

d) Autonomy

A fundamental principle that underpins laws in a liberal democracy and contemporary medical ethics is that of autonomy. This principle provides that women should be allowed to exercise autonomy and self-determination when making decisions about their bodies and health, including whether to continue with or terminate a pregnancy. Queensland's current abortion laws do not promote the value of autonomy, rather they significantly undermine women's autonomy by placing the decision about the lawfulness of termination in the hands of the woman's doctor and, therefore, the medical profession.[6] Women are responsible decision makers and should be afforded the right to decide what should be able to be done to their bodies. Except in limited circumstances (considered further below), their autonomy should not be constrained or subject to external decision-making by the medical profession or courts, as is currently the case in Queensland.

e) Promotion of well-being and avoidance of harm to the community

Queensland's laws should promote the wellbeing of its citizens and, to the extent that is possible, ensure its citizens are not harmed. In our view, the current law on abortion does not achieve these values as it does not allow women to make the decision that is in their best interests. It is an offence for a woman to procure an abortion and an offence for an abortion to be performed. Such an action is only excused if the doctor falls within the provisions of the section 282 defence. For that defence to be successful, the criteria of the section 282 provision requires something more than 'in the woman's best interests' to be proved. The law, therefore, does not currently allow a woman to make a decision about her body that is in her best interests, and fails the value of promoting her health.

If the Queensland law remains unchanged, unnecessary harms will continue to be inflicted on women and health professionals performing termination procedures. Examples of such harm include:

---

[5] Dr Carol Portman, 'Therapeutic Abortion Provision' in Abortion in *Queensland conference report* (17 October 2008) <http://www.childrenbychoice.org.au/images/downloads/AbortionInQldConfReport2008.pdf>.

[6] Kerry Petersen, 'Classifying abortion as a health matter' in Sheila McLean, *First do no harm: Law, ethics and healthcare* (2006) (Ashgate: England) 355.

- Women and health professionals being exposed to potential criminal prosecution and penalties for procuring abortions.
- Continued barriers to access to abortions for women in rural and remote areas.
- The potential for women to seek 'backyard' abortions, or illegal abortions through importation of drugs from overseas (as occurred in *R v Brennan and Leach*).
- Women obtaining an abortion in unsafe circumstances, as occurred, for example in *Medical Board of Queensland v Freeman*.
- Harm, distress, humiliation and unnecessary delays for non-*Gillick* competent young women receiving a termination because of the need for court authorisation for an abortion, as well as confusion and anxiety for health practitioners.
- The impact of all of the above on a woman's physical and mental health (and the resulting effect on others i.e. existing children, partners, family members).

Unless and until abortion is treated by the law as a health issue rather than a criminal issue, the law will be unable to promote the value of health and avoidance of harm. Decriminalisation of abortion would in many cases eliminate or mitigate these harms.

f) Law should reflect community attitudes and medical practice

Queensland's laws should reflect contemporary community attitudes and standards as well as modern medical practice. Queensland's current abortion laws date from 1899 when the Criminal Code was first enacted. While the defence to abortion (section 282) has been amended in recent years, the offence provisions have not been revisited in more than a century. The three abortion offences (sections 224 – 226) are still contained within chapter 22 of the Code, entitled 'offences against morality', alongside bestiality and indecent dealings with children.

In the past 117 years there has been a fundamental shift in community views and attitudes towards abortion. There is evidence, including in peer-reviewed literature, of widespread support for reform of the law by the community, medical practitioners (including obstetricians and gynaecologists) and politicians. In our view, the fact that abortion and acts relating to it constitute offences under the Criminal Code and are regulated by the criminal law demonstrates that the laws are archaic and do not reflect community standards.

Response to the second Bill

In the following section we address the provisions contained in the second Bill:

1) Who may perform an abortion

We support the introduction of a provision in Queensland law which provides that only a doctor or a registered nurse administering a drug under the direction of a medical practitioner should be able to lawfully perform an abortion. We further agree that it should be a criminal offence for any other person to do so.

The Committee may wish to explore whether the legislation should refer to any potential role played by pharmacists. Pharmacists may also be involved in termination of pregnancies due to their role in prescribing medication which causes terminations.

2) Offence provisions relating to women and abortions

In principle, we agree that the law should be clear that a woman does not commit an offence by performing, consenting to or assisting in performing an abortion on herself. However, if abortion was decriminalised in Queensland, by removing sections 224, 225 and 226 from the Criminal Code, in our view the proposed provision would not be necessary. We reiterate our view that removal of these provisions should occur, thereby legalising abortion in Queensland.

3) Abortions for women more than 24 weeks pregnant

We consider that regulating termination of pregnancy by gestation periods should be incorporated into relevant legislation, and recommend the 'two-tiered' approach of the Victorian law, whereby a woman may access an abortion on request up to 24 weeks gestation, and in certain circumstances following 24 weeks gestation. However, in contrast to the Victorian law, we submit that following 24 weeks gestation, there should be no requirement for a second doctor to agree to the abortion, and that one doctor is sufficient for this purpose.

a) *Abortions prior to 24 weeks*

There is evidence that at 24 weeks a foetus is potentially viable, that is, capable of being born alive and surviving independently from its mother, albeit with medical intervention.[7] Accordingly, we consider it justifiable to treat termination up to 24 weeks gestation differently from a termination after this time. Up until 24 weeks gestation, we believe termination should be available to a woman who requests that procedure, and provides consent.

b) *Circumstances in which an abortion post-24 weeks can occur*

It is our submission that an abortion should be available post-24 weeks if the termination is requested by the woman and the following can be established:

> "a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus."

[7] See for example the discussion in the VLRC report about relevance of viability, above n3, 40 – 41.

Number of practitioners involved

Where a woman is requesting a termination post 24 weeks, we consider that the agreement of only one doctor who is satisfied that the relevant criterion has been met, is needed, rather than two doctors. The decision to terminate a pregnancy is a serious and important one, and a woman would not come to a decision about termination without having carefully considered all relevant issues. We also believe that doctors who participate in the process would be aware of the interests involved. Unless there is reliable evidence that there is inappropriate conduct in the context of late-term terminations, we believe that law should interfere with the decision to terminate a pregnancy to the least extent possible. In our view, the gatekeeping role of one doctor is sufficient.

Grounds for termination

As articulated above, we believe that termination post 24 weeks should be possible if one of two grounds are satisfied. These are set out below.

(i) ***The woman's physical or mental health***

We consider that the woman's physical or mental health is an appropriate criterion for a woman to be able to obtain an abortion post-24 weeks. This criterion would promote the woman's health and safety, and would reduce risk and harm, whether physical or psychological, that may result if the pregnancy were to continue.

(ii) ***Serious medical condition of the foetus***

We note that termination on the grounds of a child's medical condition is a highly contentious issue. We consider that for an abortion on this ground to be lawful the condition of the foetus must be sufficiently grave. Western Australia is the only Australian jurisdiction which makes a similar provision for abortions post-20 weeks, on the grounds that the 'unborn child has a severe medical condition'. We note that this terminology is undefined in the legislation.[8] The United Kingdom also has not defined its analogous provision within the *Abortion Act 1967* (UK). Australian law academics Karpin and Savell note this is because the 'majority (in those Parliaments) understood that contextual matters would be significant in determining the meaning of 'severe medical condition' or 'serious handicap'....'.[9]

[8] Other jurisdictions make similar provisions, for example the United Kingdom. For a discussion of the position in that jurisdiction see the VLRC report, above n 29, and also Emily Jackson, *Medical law texts, cases and materials* (2006), 609-613.

[9] Isabel Karpin and Kristin Savell, *Perfecting Pregnancy: Law, Disability and the Future of Reproduction* (2012) (Cambridge University Press) 147. Comprehensive analysis of the relevant domestic and international debates concerning this issue are contained in this book.

4) Conscientious objection by health practitioners to termination of pregnancy

a) Legal duty to perform abortions in emergency situations

We believe that if a conscientious objection provision is introduced into Queensland law, specific provision must be made requiring a doctor to perform an abortion in emergency situations, and a registered nurse to assist, where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health. Care must be taken to uphold the safety and health interests of the woman at all times, and to avoid any situation where a woman loses her life, or sustains severe, permanent injury through a doctor's reluctance to terminate her pregnancy.[10]

b) Obligation to refer to another practitioner who does not have an objection

We further submit the proposed conscientious objection clause should include a legal obligation of referral, whereby a health practitioner exercising a conscientious objection is required by law to refer the woman to a practitioner who does not have an objection. Referral in those circumstances is critical to ensure the patient is able to receive appropriate advice and information about termination, and to reduce delay in securing a termination.[11]

An obligation to refer exists in Tasmania,[12] and in Victoria.[13] The Victorian provision requires the doctor with the conscientious obejction to refer the patient to a registered health practitioner in the same regulated health profession who the objecting doctor knows does not have a conscientious objection. The Tasmanian provision requires the objecting doctor to provide the woman with a list of prescribed health services from which she may seek advice, information or counselling on the full range of pregnancy options. We consider the Victorian provision a better model to ensure more timely and direct access to a qualified health practitioner who is known not to have a conscientious objection.

5) Access and safe zones around abortion facilities

We support the introduction of protected or safe zones outside of abortion facilities, and support implementation of these in Queensland. We note and agree with the principles underpinning the Victorian safe access zone laws which are that:

- the public are entitled to access health services, including abortions;

---

[10] See for example the case of 31-year-old Irish woman Savita Halappanavar, who died of septicaemia in 2013 after hospital staff refused to perform an abortion of her 17 week old foetus. She subsequently died: Associated Press, 'Irish Jury finds poor care in death of woman denied abortion', *The New York Times* (online, 19 April 2013 <http://www.nytimes.com/2013/04/20/world/europe/jury-cites-poor-medical-care-in-death-of-indian-woman-in-ireland.html?_r=0>.

[11] VLRC report, above n3, 47.

[12] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s6.

[13] *Abortion Law Reform Act 2008* (Vic) s8.

- the public, employees and others who need to access abortion facilities should be able to enter and leave those premises without interference and in a manner which
    - protects the person's safety and wellbeing; and
    - respects the person's privacy and dignity.[14]

Women considering or receiving an abortion should not be subjected to harassment, bullying, intimidation or harm through protests, communications, distribution of offensive materials or other acts of aggressive behaviour, and are entitled to sufficient protection of their personal safety and privacy, by the law, in such situations. Staff and other persons entering or leaving abortion facilities are also entitled to protection from such behaviour. We also believe that such laws should prohibit publication of images of persons entering, leaving or trying to enter of leave abortion facilities. Sufficient penalties should be introduced to deter persons from engaging in such acts.

Currently the Victorian, ACT and Tasmanian laws make provision for these zones.[15] We note that in Victoria and Tasmania the laws establish safe access zones of a radius of 150 metres around abortion facilities. The proposed distance in the second Bill is 'at least 50 metres' only. We submit that safe access zones in Queensland should also be a radius of 150 metres, to ensure the utmost safety and protection of women and other people, including staff, entering those premises.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Committee further if additional information is required.

Yours sincerely

Professor Lindy Willmott
Director
Australian Centre for Health Law Research
[redacted]

Professor Ben White
Director
Australian Centre for Health Law Research
[redacted]

Penny Neller
Centre Coordinator

[14] *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.
[15] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s9; *Health (Patient Privacy) Amendment Act 2015* (ACT) Div 6.2 and *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.

Australian Centre for Health Law Research
[redacted]

This submission is also supported by the following academic staff from the QUT Faculty of Law:

Stephanie Jowett

Kylie Pappalardo

Assoc Prof Molly Dragiewicz

Rachel Hews

Dr Fiona McDonald

Adjunct Prof Sara Davies

Erin O"Brien

Alice Witt

Dr Kelly Purser

Nick Suzor

Brodie Evans

This submission is also supported by the following academic staff from the QUT Faculty of Law:

Dr Anna Huggins

Prof Bill Duncan

Catherine Campbell

Dr Andy McGee

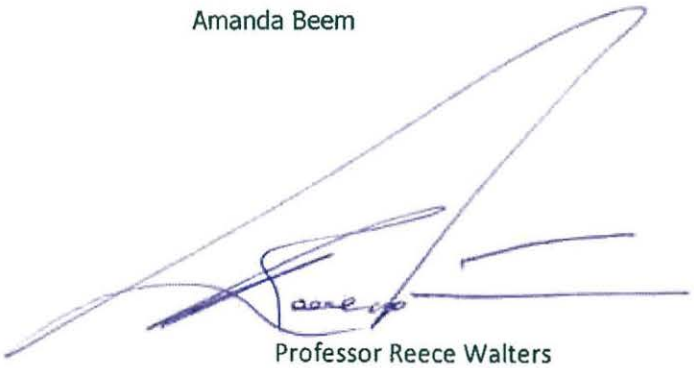
Dr Shih-Ning Then

Prof Belinda Carpenter

Assoc Professor Tina Cockburn

Amanda Beem

Professor Kerry Carrington



Professor Reece Walters

Professor Terry Hutchinson