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5 September 2018

Committee Secretary
Health, Communities, Disability Services and Domestic
and Family Violence Prevention Committee
Via email: ***health@parliament.qld.gov.au***

To the Committee Secretary

Thank you for providing AMA Queensland with the opportunity to give feedback to the Health, Communities, Disability Services and Family Violence Prevention Committee's inquiry into the *Termination of Pregnancy Bill 2018*.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. We have previously advocated publicly on issues of public health, vaccination and medical regulation. Our members take a very strong interest in medico-legal issues given their importance the health system in Queensland.

AMA Queensland supports many of the intentions of this legislation. Queensland's current laws, which criminalise terminations of pregnancy are a barrier to a doctor's first duty – best patient care. This bill, should it become law, would provide legal certainty to Queensland doctors when it comes to performing terminations of pregnancy and patients who seek termination from doctors.

Our organisation provided a submission to the Queensland Law Reform Commission (QLRC) as part of the consultation process it undertook for the creation of this bill. This submission was discussed and supported by our member elected council. I **attach** a copy of our submission to the QLRC, and I commend it to all committee members.

We note that the recommendations in the QRLC report largely aligns with the position our council undertook in its submission and we also note that these have largely transferred to the bill. However, AMA Queensland would like to highlight some notable exceptions.

In this submission to the *Termination of Pregnancy Bill 2018*, AMA Queensland will restrict feedback to these exceptions and where we feel the bill could go further in protecting patients and medical practitioners.

For other topics, such as AMA Queensland's view on gestational limits and the establishment of safe access zones, I would refer you to our submission to the QLRC.

Section 6: Termination by medical practitioner after 22 weeks

In our submission to the QLRC, our position was that a second medical practitioner, not necessarily an obstetrician, must be asked to consider the appropriateness of a termination of pregnancy post 22 weeks and must have had the opportunity consult and examine the woman before making their determination. Both medical practitioners need to consider all the circumstances and must have regard to all relevant medical circumstances ***and*** the woman's current and future physical, psychological and social circumstances. By way of example, the second practitioner could be a Geneticist if a late diagnosis of a congenital abnormality is made or by a psychiatrist in the event of the mother developing an acute psychosis.

We note in the QLRC's report they had determined that the legislation "should not require that the second medical practitioner must examine the woman, or that the consultation must occur in person." We do not agree with this determination and strongly encourage you to mandate the consultation with a second medical practitioner in the legislation. We consider that for rural and remote patients who may incur costs of travel, inconvenience and additional delay that this second consultation can be facilitated via telehealth videoconferencing facilities.

Ensuring that the second medical practitioner has had the chance to consult with a patient is critically important for the following reasons;

- It provides a safety net for both the doctor and the patient as this will demonstrate consistency in decision-making process and independent peer-review. Applied to other fields of Medicine other than O&G, this clause is also consistent with use of seeking second opinions in medico legal cases
- It also provides an inbuilt system of checks and balances to ensure that the reasons for the termination are applicable to the criteria laid out in the legislation
- It provides both the mother and the specialist an opportunity for further review of the pregnancy and the circumstances of the termination

We would therefore recommend that a provision be incorporated into the bill which requires a consulting medical practitioner to have consulted with the woman prior to making a determination on the appropriateness of the termination and that this can occur in person or through other means such as telehealth.

Section 8: Registered health practitioner with conscientious objection

As per our submission to the QLRC, the AMA Queensland position is that a doctor should "always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with the doctor's personal beliefs and values." However, we added a very important caveat to that position.

> *"… it is important for the QLRC to understand that not every medical practitioner will have the skills and training to provide an abortion, even in an emergency. The wording of Clause 8(3) in the Abortion Law Reform Act 2008 (Victoria) states that despite any conscientious objection to terminations of pregnancy, "a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman." This means that in an emergency, general practitioners or even ophthalmologists could technically be criminally liable for not doing something which they may not be trained for or is well outside their normal scope of practice.*
>
> *For this reason, AMA Queensland would recommend that any potential legislation should reflect that despite any conscientious objection to abortion, only a registered medical practitioner who has the necessary skills and training to safely perform a termination of pregnancy is under a duty to do so. If they do not have these skills or training, in an emergency they should be obligated to urgently refer or otherwise assist the patient to a registered medical practitioner who has these skills and training, where the termination is necessary to preserve the life of the pregnant woman."*

The QLRC Report noted this advice in paragraph 4.109. However Clause 8(4) of the *Termination of Pregnancy Bill 2018* does not seem to take this into account, stating that the section of the bill relating to conscientious objection "does not limit any duty owed by a registered health practitioner to provide a service in an emergency." This would mean that any registered medical practitioner would be under

a duty to perform a termination in an emergency, regardless of whether they have the skill and training to safely provide one.

We therefore suggest the following amendment to Clause 8(4).

> *(4) This section does not limit any duty owed by a registered health practitioner who is qualified to provide a termination of pregnancy to provide a service in an emergency.*

Whilst AMA Queensland agrees that holding a conscientious objection should not limit any duty of a registered health practitioner to provide or assist in providing a termination of pregnancy, requiring a medical practitioner to perform a procedure outside of their regular scope is dangerous for the patient and is likely to have serious legal ramifications for the practitioner.

AMA Queensland thanks the committee for the opportunity to provide feedback on this bill. If you require further information or assistance in this matter, please contact Mr Leif Bremermann, Senior Policy Advisor, on 3872 2222.

Yours sincerely

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President
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6 March 2018

The Secretary
Queensland Law Reform Commission
Via email: lawreform.commission@justice.qld.gov.au

To the Secretary

Thank you for providing AMA Queensland with the opportunity to give feedback to the Queensland Law Reform Commission (QLRC) on its consultation paper regarding abortion law reform.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. We have previously advocated publicly on issues of public health, vaccination and medical regulation. Our members take a very strong interest in medico-legal issues given their importance the health system in Queensland.

AMA Queensland has considered the questions posed in your consultation paper and offers the following responses.

Q1. Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

As we stated in our submissions to the *Abortion Law Reform Bill 2016* and the *Health (Abortion Law Reform) Amendment Bill 2016,* AMA Queensland is of the view that where surgical termination of pregnancy is performed, the procedure and the associated anaesthesia should, as with any other medical intervention, be performed by appropriately trained doctors in premises approved by a recognised health standards authority. This is consistent with the AMA position statement on *Ethical Issues in Reproductive Medicine* and with legislation in every other state and territory (except NSW) which exempts medical practitioners from criminal offences for performing terminations of pregnancy.

As the Commission states in the consultation paper for this review, 'as a matter of clinical practice, other health practitioners, such as nurses and midwives, Aboriginal and Torres Strait Islander health practitioners, and pharmacists, may also assist in performing terminations of pregnancy' as long as this occurs under the direction of a medical practitioner.

Non-surgical forms of termination (such as RU486/mifepristone) should also be made available as an alternative to surgical abortion in cases where they are medically deemed to be the safest and most appropriate option based on an appropriate clinical assessment by a medical practitioner.[1]

Q2. Should a woman be criminally responsible for the termination of her own pregnancy?

No.

[1] AMA Position Statement on *Reproductive Health And Reproductive Technology (2008)*

Q3. Should there be a gestational limit or limits for a lawful termination of pregnancy?

AMA Queensland supports a position which mirrors Clause 4 of the *Abortion Law Reform Act 2008 (Victoria)*.

In relation to Clause 5, we make two comments:

- **Clause 5(1)(b):** We would recommend that a similar clause be included in any potential Queensland legislation, with an amendment as follows.

  "has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances ***and that the other medical practitioner has seen the patient prior to making that determination.***"

- We note that Clause 5 specifically requires the medical practitioner to consider whether the abortion is appropriate in all the circumstances and must have regard to;
  a) all relevant medical circumstances; and
  b) the woman's current and future physical, psychological and social circumstances

  We consider this very important to avoid one circumstance being considered in isolation of the other circumstances.

Q4. If yes to Q-3, what should the gestational limit or limits be?

We believe the gestational limit should be 22 weeks.

Q5. Should there be a specific ground or grounds for a lawful termination of pregnancy?

Please refer to our response regarding Clause 5 in Question 3.

Q7. If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

Please refer to our response regarding Clause 5 in Question 3.

Q8. Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

AMA Queensland supports a position similar to that which is set out in Clause 5(1)(b) of the *Abortion Law Reform Act 2008 (Victoria)*, with the recommendation we made in response to Question 3.

Q9. If yes to Question 8, what should the requirement be?

Queensland Health uses a clinical guidelines document to help guide clinicians performing therapeutic terminations of pregnancy. Section 3.2.1 of the current clinical guidelines indicates that two medical specialists, one of whom must be a specialist obstetrician, must consider the circumstances of each individual case and we would be supportive of this continuing.

Depending on the clinical complexity of the pregnancy, further consultation with a medical practitioner whose specialty is relevant to the circumstances of the case may also be appropriate. For example, if the termination is due to be performed on mental health grounds, the medical opinion of a psychiatrist should be sought to determine if the termination is appropriate on mental health grounds or if another form of treatment could be considered.

Ideally, as set out in our response to Question 3, AMA Queensland would also like to ensure that any other registered medical practitioner involved in the consultation and who also reasonably believes that the abortion is appropriate in all the circumstances has seen the patient prior to making that determination.

Despite our willingness to consider further consultation, AMA Queensland is not supportive of a committee being formed to consider the case. We are in agreement with the RANZCOG submission to one of the two abortion bills which says that a panel being formed is not only a gross infringement of privacy in a highly sensitive health matter, but that as the numbers of clinicians empowered to make decisions these decisions expand, there is an increasing likelihood that individuals with varying degrees of prejudice against termination of pregnancy come to influence the decision making around the needs of individual women.

Q10. When should the requirement apply? For example: (a) for all terminations, except in an emergency; (b) for terminations to be performed after a relevant gestational limit or on specific grounds?

The requirement to consult should apply for a termination of pregnancy by a registered medical practitioner after 22 weeks. The wording should be similar to that set out in Clause 5 the *Abortion Law Reform Act 2008 (Victoria)*, with the recommendation we made in response to Question 3.

Q11. Should there be provision for conscientious objection?

Yes.

Q12. If yes to Q.11, are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?

The AMA position statement on *Conscientious Objection* states that a doctor should "always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with the doctor's personal beliefs and values." AMA Queensland upholds this position.

However, it is important for the QLRC to understand that not every medical practitioner will have the skills and training to provide an abortion, even in an emergency. The wording of Clause 8(3) in the *Abortion Law Reform Act 2008 (Victoria)* states that despite any conscientious objection to terminations of pregnancy, "a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman." This means that in an emergency, general practitioners or even ophthalmologists could technically be criminally liable for not doing something which they may not be trained for or is well outside their normal scope of practice.

For this reason, AMA Queensland would recommend that any potential legislation should reflect that despite any conscientious objection to abortion, only a registered medical practitioner who has the necessary skills and training to safely perform a termination of pregnancy is under a duty to do so. If they do not have these skills or training, in an emergency they should be obligated to urgently refer or otherwise assist the patient to a registered medical practitioner who has these skills and training, where the termination is necessary to preserve the life of the pregnant woman.

If the situation is not an emergency, conscientious objectors should not use their objection to impede access to treatments that are legal or which would impede the patient's access to care and AMA Queensland therefore supports an obligation to refer to a doctor who does not have a conscientious objection. Although this may not always be easy, especially in rural or remote areas, AMA Queensland upholds the view stated in our position statement which says that when exercising a conscientious objection, the doctor must "take whatever steps are necessary to ensure the patient's access to care is not impeded."

Q13. Should there be any requirements in relation to offering counselling for the woman?

AMA Queensland believes counselling both prior to a termination and after can be useful however this should be optional rather than compulsory or a requirement. Any counselling that is provided should be delivered by an objective organisation or individual as to do otherwise would undermine the principle of informed consent.

Q14. Should it be unlawful to harass, intimidate or obstruct:

> **(a) a woman who is considering, or who has undergone, a termination of pregnancy; or**
>
> **(b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?**

Yes to both (a) and (b).

Q15. Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

AMA Queensland is supportive of any measures which protect patients and staff from harm, intimidation or harassment. We would support any sensible measures which achieves this.

Q16. If yes to Q15, should the provision:

> **(a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or**
>
> **(b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?**

As stated in our response to Q15, we would support any sensible measures which achieves the aim of protecting patients and staff. In regards to the particulars of how this is achieved in practice, we believe this question is best answered through a combination of police, legal experts and facility operators.

Q17. What behaviours should be prohibited in a safe access zone?

Any kind of protest or action which is likely to make staff or patients feel fearful or intimidated when entering or leaving the premises.

Q18. Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

Restrictions should be imposed 24 hours a day, seven days a week, so as to ensure staff and patients can safely enter and leave the premises at all times.

Q19. Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Yes.

Q20. Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

Yes. More data is always valuable and helps promote public health. However, even if this data is anonymised it must be limited to collecting basic incidence and demographic data for legitimate public health purposes. If this data goes beyond this limited scope, for example by including information on whether or not the patient undertook counselling or what their reason for seeking a termination was, it could have the unintended effect of stigmatising women who obtain terminations.

In closing, AMA Queensland thanks you for providing us with the opportunity to provide the Queensland Law Reform Commission with a submission on this issue. If you require further information or assistance in this matter, please contact Mr Leif Bremermann, Senior Policy Advisor, on

Yours sincerely

Dr Shaun Rudd
Chair
AMA Queensland Board and Council