Submission No. 757
Received 28 June 2016

28/6/2016

The Committee of Inquiry into Abortion Law Reform
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Dear Committee Members,

As a GP, I have supported many women through the trials and tribulations of their fertile years. I have shared their joy in the addition of a new family member, and held their hand after the loss of a dearly wanted pregnancy. I have counselled them on family planning methods, and have seen firsthand that no contraceptive method is 100% effective. For some women who have made the considered and difficult decision to terminate a pregnancy, I have helped them to navigate our complex and inequitable system. The possibility of a 7 year jail term is the last thing that a woman needs in an already distressing situation.

I am writing to express my **support for the decriminalisation of abortion in Queensland** and for Mr Pyne's *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016*. In relation to this complex ethical issue, I believe that women should be trusted to make moral decisions for their own circumstances. Termination of pregnancy is a women's health issue that should be regulated as a health issue, not a criminal one.

I will address the Committee's terms of reference below.

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

The Children by Choice website (Children by Choice, 2016) provides an excellent summary of the current provider options for terminations in Queensland. My understanding is that the vast majority of terminations are performed within the few private clinics in coastal cities. Women accessing these services can face financial and geographical/logistical barriers to care. The recent availability of mifepristone has also allowed women to access medication termination of pregnancy under nine weeks gestation via tele-health services and some general practitioners.

It is estimated that only 1% of abortions in Queensland are provided by public hospitals. While Queensland Health has developed guidelines on termination (Queensland Maternity and Neonatal Clinical Guidelines Program, 2013) that recommend all referred women should be assessed within 5 days, individual Hospital and Health Services seem to have varying interpretations of their responsibilities and scope of practice. I have only referred women with severe medical or social complications, as I am concerned that less "convincing" cases may have to endure weeks of delay before possibly ultimately ending up back in the private system regardless.

I am concerned that doctors and women are at risk of criminal prosecution despite acting with good intentions and within good medical practice. Practitioners are left to interpret for themselves what protection they may have under case law. What constitutes "serious danger to her life or physical or mental health" as per R v Bayliss and Cullen? A common indication for termination in the public system is severe foetal abnormality, but this is not adequate legal protection for women and their doctors unless it can be argued that this is a serious harm to the woman's mental health. The case is the same for pregnancies arising from sexual assault. Women choose abortion for a multitude of reasons, and once her decision is made, it could be argued that being forced to continue a pregnancy against her will constitutes a harm to her mental health. It is in this legal grey area that I believe a large proportion of terminations are performed.

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2. Existing legal principles that govern termination practices in Queensland

The Victorian Law Reform Commission was given a similar term of reference, and concluded that "those principles are not clear" (Victorian Law Reform Commission, 2008). Whether these laws were put in place to protect the life of the foetus or to protect women from dangerous abortion practices is contested.

I don't think that the 2010 case of R v Leach and Brennan did much to clarify the intent of section 225 of the criminal code, with the focus placed on the noxiousness of the medication rather than the fact that the couple intentionally procured a miscarriage. Judge Everson has been quoted as remarking that these old laws are difficult to interpret (Carlisle, 2010).

3. The need to modernise and clarify the law to reflect current community attitudes and expectations

Queensland laws that make abortion a criminal offence (sections 224,225 and 226 *Criminal Code 1899)* are archaic and need to change. Abortion is a reality for many Australian women, with at least 1 in 4 having chosen a termination in their lifetime (Scheil, et al., 2015). I don't believe that our society wants all of these women (and the doctors who help them) to be treated as criminals. I was appalled in 2009 when the couple in Cairns were charged under Section 225, and disturbed by the subsequent withdrawal of medically indicated terminations within Queensland Health hospitals.

The Victorian Law Reform Committee collated an excellent summary of policy objectives and legal principles relevant to abortion law reform.

Community attitudes

Our community is ready for law reform. The Victorian Law Reform Commission reviewed the data in 2008, and their conclusion was that a majority of Australians support a woman's right to choose. Anecdotally, most patients that I have discussed abortion with were shocked to learn that it is still a criminal offence in Queensland. This is borne out by the Auspoll commissioned by Children by Choice that found 65% of respondents were unaware of the legal status (Children by Choice, 2009).

Health Equity

The criminalisation of abortion in Queensland is a health equity issue. There are currently significant barriers in place that disproportionately affect vulnerable women. Women who live remotely, have limited financial means, are homeless, or victims of violence are facing significant challenges accessing safe and affordable terminations.

As the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, I'm sure members are aware of the link between unplanned pregnancy and intimate partner violence. ANROWS (Australia's National Research Organisation for Women's Safety, 2016) summarises the current evidence, which shows that women seeking terminations are more likely to have experienced domestic violence. Reproductive coercion can be part of the abuse, and access to termination may be vital to allow the women to distance herself from her abuser.

Decriminalisation may lead to GPs offering medication termination of pregnancy, which could improve access for rural and remote women.

Informed consent

I believe that voluntary and informed consent from the pregnant woman should be the principle factor in deciding if a termination is lawful. This is standard for any medical procedure and is an essential part of good medical practice. I believe that current health regulation in this respect is adequate, including in relation to women with reduced capacity and mature minors. Legislation for mandatory information provision as in some areas of the United States of America has the risk of being politically motivated rather than evidence-based. RANZCOG provides a summary of the accepted medical risks of termination, both short and long term (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2005).

Gestational periods

Legislation does not need to regulate abortion according to gestation period, although it may be found to be politically necessary. The Victorian Law Reform Commission put forward three possible models for decriminalisation, only one of which references gestation. I favour "Model C", which would regulate abortion in the same way as all other medical procedures (lawful with the woman's consent, if performed by a medical practitioner). This would place decision-making responsibility with the woman, and service availability with the medical profession. This model would not be strictly abortion "on demand", as the medical practitioner involved would still have to consider the procedure ethically appropriate, with later gestations carrying greater ethical weight.

While over 90% of terminations are performed before 14 weeks (Scheil, et al., 2015), there will always be a need to provide termination services at later gestations. RANZCOG has a college statement describing the most common reasons, which are principally diagnoses that are not known or confirmed until later in the pregnancy (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016). A routine and recommended part of antenatal care in Australia is the 18-20 week foetal morphology scan, yet if a severe abnormality is found services to provide termination are much less accessible.

There will never be a consensus between those who believe the foetus attains full rights at conception and those who believe the woman's autonomy is absolute throughout pregnancy. The fraught middle ground is found trying to decide when/how the foetus's right to consideration outweighs the woman's right to bodily integrity. Viability is often chosen as a point where decision making should change, but even this is a complex choice.

The Victorian Law Reform Commission's "Model B" and current legislation could be seen as a middle ground involving a two stage approach around 24 weeks gestation. After this stage, two medical practitioners must reasonably believe that abortion is appropriate in all the circumstances. The Victorian Law Reform Commission's report explored the issues around termination review panels (including lack of transparency, loss of autonomy) and I trust that this committee will consult with providers in tertiary hospitals around this issue.

Conscientious objection

The Australian Medical Association makes it clear in a position statement that doctors can refuse to provide medical care if that care is in conflict with their own sincerely held beliefs (Australian Medical Association, 2013). The AMA also holds that care should always be provided in an emergency situation and that doctors should ensure that there is minimal disruption to delivery of health care. I do not believe that this needs to be legislated. If a conscience clause is included in legislation, it should mirror the Victorian Act which requires the objecting doctor to refer the woman to another practitioner who does not object. This is of particular concern in rural and remote areas, where women's care may be unfairly delayed due to the actions of local practitioners. For some Queensland women, there is only one GP available.

4. Legislative and regulatory arrangements in other Australian jurisdictions

The legal status of abortion in the various states and territories is well summarised in the Committee's information paper and on the Children by Choice website. I favour the Victorian model, including the safe access zone amendment.

5. Provision of counselling and support services for women

Formalised counselling and support around abortion should be readily available but not compulsory. This was the conclusion reached by the Victorian Law Reform Commission (Victorian Law Reform Commission, 2008). They found on consultation with providers that the "majority of women who seek abortion are informed, have considered their decision thoughtfully and for some time, and are clear in their decision not to continue this particular pregnancy at this particular time in their life for a set of unique and individual reasons". Mandatory counselling or "cooling-off" periods would not only be a barrier to care and a waste of resources, but they suggest that women are not fully capable of making own decisions and require protection. **Coerced counselling is not counselling**. Children by Choice are currently providing an invaluable service to the women of Queensland in relation to all-options pregnancy counselling and support.

In summary, as a Queensland GP, I urge the Committee to facilitate the **decriminalisation of abortion in Queensland** and to trust women to make their own health decisions.

Yours sincerely,

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