Submission No. 835
Received 30 June 2016

A SUBMISSION TO:

The Chair,
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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

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Affiliation for purposes of this Submission: Individual Medical Practitioner with expertise in the field. All views expressed are those of the author, and are not to be construed as representing those of any group or organisation with which the author is affiliated.

Intent of Submission: Rather than provide copious statistics or references, but it is the intent of this submission to relate this debate to practical experience, and in so doing give a voice to the numerous women under my care in the past 15 years.

Author's Background:
Queensland medical graduate. Postgraduate training based in Queensland supplemented by short periods in NSW and London UK.
Qualifications:
MBBS (University of Qld); Masters of Applied Science (Prenatal Genetics and Fetal Medicine) (University College London).
Fellow Royal Australian College of Obstetricians and Gynaecologists
Subspecialist training and recognition in Maternal Fetal Medicine.

Employment History

Previously:
Queensland public health system as a specialist from 2001 to 2015, providing care to women with high risk pregnancies including pregnancy options.
Current:
private sector consultant in tertiary obstetric ultrasound;
contraception and abortion provider for Dr Marie Australia (Marie Stopes).

Author's Credentials Relevant to Termination of Pregnancy: significantly involved in the provision of pregnancy options in the public sector since commencing employment at Royal Brisbane and Women's Hospital in 2001. . This includes involvement in updating protocols, guidelines and consent forms

for termination of pregnancy; introducing late termination of pregnancy protocols; introducing misoprostol and subsequently mifepristone for medical termination of pregnancy. Provider of pregnancy termination services in the private sector for the past three years.
The combination has provided extensive insight into how termination of pregnancy is managed in Queensland in both the public and private sectors.

Author's personal background and disclosures:
In the interest of full disclosure, the author

- Is a Christian, an Elder in the Church
- Has professional relationship with Children by Choice.
- Currently works for a private provider of abortion services.

Summary:

Abortion is currently in the criminal code in Queensland. Abortion is seen as essentially illegal, and women and their caregivers are therefore guilty of a criminal act until proven otherwise ie proving lawfulness. This has resulted in serious ambiguity in interpretation of 'lawful termination of pregnancy' across the various health areas/hospitals in the State. As a consequence, care for women requesting termination of pregnancy is fragmented, geographically variable and subject to the personal opinions and biases of the care providers. Both referring health care providers and their patients do not know if they can access care in the public system as it varies according to provider.

The doctors and care workers potentially rendering these services are uncertain of their legal standing and fearful of criminal action. This impacts on their ability to provide appropriate care. When care can be provided, it can be subject to prolonged approval and ethics processes which are both intimidating to women and result in delays to care – not for the benefit of their wellbeing, but to prove lawfulness.. Women from at risk groups, including those with no fixed abode, financially destitute, resident in remote regions, non residents of Australia, suffering mental health issues, or subject to domestic violence) suffer further discrimination by having to undergo multiple assessments resulting in unduly delayed or denial of care. Those women at greatest risk and need are paradoxically those most likely to be failed by the system due to concerns regarding lawfulness of abortion.

In Queensland, pregnancies ending in termination represent 15% of pregnancies. It therefore constitutes not a small minority but a significant proportion of women. In Queensland, the number being cared for in the public system is less than 10% of all women presenting for termination of pregnancy. The private sector is unable to provide the counseling and social supports these women need, though these are often the women with significant social and psychological needs and represent our most marginalized and at vulnerable groups.

Removing termination of pregnancy from the criminal code will place abortion where it should be: in the hands of women, their health care providers and

support services. The responsibility for their wellbeing is, and should be, a medical and social care issue, not a legal one.
Decriminalising abortion is the first step in acknowledging the medical and psychosocial welfare needs of a significant proportion of pregnant women in Queensland, and destigmatising a relevant pregnancy option..

Women requesting and undergoing termination of pregnancy are not criminals needing to prove their innocence, they are women in need.

SUBMISSION

TERMINOLOGY – see appendix for summary of terms relating to termination of pregnancy.

EXISTING PRACTICES REGARDING TERMINATION OF PREGNANCY IN QLD.

Termination of pregnancy is provided by public and private practitioners, and by private clinics. Public and private hospital practitioners provide indicated termination of pregnancy and a very small number of serious psychosocial indicated terminations of pregnancy. The majority of women undergoing termination of pregnancy do so at fee-for-service private clinics (90-95%).

Hospital Care:

Public hospitals use the "Queensland Clinical Guideline for Therapeutic Termination of Pregnancy" as a guide to manage requests for termination of pregnancy, which includes assessment of lawful termination of pregnancy. [Queensland Health document https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf].
Conscientious objection is also respected. Public hospitals may perform early medical termination of pregnancy, surgical termination of pregnancy up to 14 weeks (up to 16/17 weeks in some cases), and late medical termination of pregnancy up to 20-22 weeks gestation. Terminations of pregnancy after 22 weeks can usually only be considered for significant fetal or medical indications and is usually performed at a tertiary obstetric hospital and requires medical and psychiatric assessment and ethics consideration.

Less than 15% of terminations are performed for maternal indications, of which one fifth are for psychiatric or psychosocial conditions. The majority of these terminations are first trimester. (Barrett, H. L et al. (2011), Termination of pregnancy for maternal medical indications. ANZJOG 51: 532–535. Data from tertiary Brisbane hospital).

Hospital care can provide good support services for women including counseling, social work, drug and alcohol services, psychiatric care, and any required additional medical care.. Unfortunately this is often only offered to women with indications for termination of pregnancy deemed acceptable. Women denied termination, or denied even the possibility of assessment, are

also denied access to these services. This group are my greatest concern. They are usually in significant financial distress, have drug or alcohol issues, may be victims of domestic violence and often have underlying psychiatric issues. Unfortunately if there is no fetal anomaly they are unable to access care as no hospital is willing to assess their circumstance. In so doing there is no opportunity to provide the support services and care these vulnerable and marginalized women desperately need.

Private Clinics – Private day surgical units provide fee for service assessment and termination of pregnancy services ranging from early medical termination of pregnancy, to surgical procedures. Most clinics provide surgical services up to 12 weeks, some to 14 or 16 weeks, and two clinics up to 20 weeks gestation. Most of these clinics are situated in South East Queensland, one in Rockhampton and one in Townsville. There are no inland private services. Cost varies by facility, and the gestation, and ranges from $400 to $3000. The clinics provide sexual health screening and information, and contraception. There is some counseling available, but no capacity for psychiatric after care, social work or drug and alcohol services or referral for these.

These clinics provide the majority of terminations in Queensland. Approx 10% of procedures would be for fetal conditions or medical risk factors. The remaining are for psychosocial indications with approximately a third of these women having a significant social risk factor (domestic violence, young age, drug or alcohol abuse, unstable social circumstances, psychiatric illness). A small number of women are financially supported by some groups such as Children by Choice, or the private clinic managers. These clinics do not marginalize or disempower women, but they operate as businesses and there is therefore a limit to the services and support that they can offer these women. The are also subject to protestors, threats and vandalism which can affect the women..

GP Medical termination of pregnancy – a small number of GPs are providing medical termination of pregnancy up to 9 weeks gestation. This has not been widely adopted by GPs in Queensland as yet, particularly not by those in rural or remote areas.

ACCESS TO TERMINATION OF PREGNANCY

Public - Women access termination of pregnancy a number of ways. They may already be a “booked” patient at the time the fetal or medical diagnosis is made. They may be referred by a GP if they are in the referral district of that hospital. Inter-hospital transfer may occur if the maternal condition is too complex, or the pregnancy too advanced or otherwise complex. In most circumstances, they must have a medical referral and live in an hospital district prepared to accept the referral, or be able to otherwise access a ‘sympathetic’ hospital. For women in remote areas with only one available GP who is a conscientious objector, even the first step of referral may be difficult.

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In actuality, each hospital provides termination of pregnancy based on the combined belief system of the obstetricians providing care and the hospital administration. For example:

- Some obstetricians will not consider termination for any non-fetal or non life threatening condition, while other hospitals will base it on psychiatric or legal opinion.
- Some obstetricians would not provide termination for Down Syndrome or spina bifida, but would for more severe chromosomal or physical abnormalities (though the fetal condition is not an aspect of consideration for lawfulness).
- Some hospitals may consider psychosocial issues (serious risk of self harm, serious domestic violence, unremitting psychiatric disorders, sexual assault) while others would not even consider assessing the circumstances in the absence of a fetal or medical condition.

Whether a termination of pregnancy would be considered or not is often up to the obstetrician on call, the departmental head or the administrator. If there is a change in staff, there may be a change in policy. In some cases, a referral may be received by a receptionist, junior doctor or nurse and these referrals may be refused with no regard or further enquiry because "we don't do that here". In contrast, for example Cairns Sexual Health Service provide assessments and pregnancy options on a case-by-case basis and without referrals. The process may be internally consistent, but is not clear to external referrers.

If or once - the patient is able to access a hospital, the delay until assessment and the time to a decision can vary from days to a couple of weeks. The requirements for a decision can vary greatly, with some hospitals requiring psychiatric assessment in all cases (sometimes at another hospital or a private psychiatrist) followed by ethics approval regardless of indication or gestation. Other hospitals require two medical opinions only (up to 22 weeks). In practical application the required psychiatric evaluation is used as a tool for proving lawful termination rather than for specific concerns about mental health.

A number of private and public obstetric hospitals in Queensland are affiliated with religious organisations which oppose termination of pregnancy. This creates issues with provision of care for women of these hospitals, especially if they are not in a referral district that also can access a public hospital. In some cases, there is also no assistance given to the woman or their GP on where and how they can go about accessing a termination of pregnancy.

Access is thus unpredictable, and for subgroups in rural/remote areas or with psychosocial issues, inequitable.

Private Day Surgery Clinics– Women do not need a referral and can simply present for assessment. However, there is a fee-for-service which is generally high and at most clinics must be paid prospectively . Unless women live in the South East region or Rockhampton or Townsville, they must travel significant distances and arrange accommodation at their own expense.

It has been suggested that anyone wanting an abortion can get one in Queensland, so why change the law? That belief/statement is uninformed as it does not acknowledge a number of critical factors:
- the geographical and financial pressures some women face in trying to access termination of pregnancy.
- the varied practices in the public hospitals across the state and how this affects the ability to access service and support for women with medical and fetal complications.
- the impact of the law on health care providers' attitudes, and the follow on impact this has on how women seeking termination of pregnancy are treated and responded to, and the effect this has on women already in a vulnerable position.

ABORTION IN THE CRIMINAL CODE AND IMPACT ON CURRENT PRACTICE

The law as it currently is written has no regard for the circumstances of a woman's involvement in procuring an abortion other than capacity to give consent. A woman cannot procure an abortion, but a medical practitioner can decide if it is reasonable to perform an abortion. Both the wording and the manner in which they are applied completely disempowers women. They are required to subject themselves to investigation/interrogation by complete strangers who then decide if their circumstances fulfill "lawfulness" according to the individual medical practitioner's interpretation of s282 and case law and with no regard to how the woman sees her own circumstances.

Indeed there are doctors who do apply loose interpretations of "risk to maternal wellbeing" and are respectful of women, their situations and needs. But the number of these is far outweighed by the care providers/institutions that are rigid in their approach to requests for termination, subject women to unnecessary psychiatric evaluation and multiple interrogations, or just outright deny assessment as the request is likely to be unlawful.

Fear of criminal action is a reason many doctors/medical administration and other staff are not involved in termination of pregnancy. Unfortunately this extends to all care and has resulted in a culture of discrimination and condemnation. Many care givers use the law and their personal feelings to deny care in a passive manner. By denying the need to assess a woman's request for termination of pregnancy, they are ignoring the fact that many women (especially those unable to pay for a private procedure) are at serious social risk for things such as domestic violence, mental illness, drug and alcohol use, lack of antenatal care, other medical problems. Blocking access to abortion care also blocks access to other care services. Subjecting women to multiple appointments with different doctors and then telling them that they don't know their own needs – effectively treating their actions as criminal - usually results in the woman feeling victimized and marginalized and unlikely to attend for care services even if they are offered. The opportunity to actively support and intervene in the person's life in a positive manner is lost.

The current law doesn't prevent termination of pregnancy occurring in Queensland, but it certainly contributes to both preventing some women with

significant needs from being cared for appropriately, and shifting care to the private sector where allied health and social services are simply not available.

Suicide is a significant cause of death during and in the first year after pregnancy in Queensland both for women giving birth to a live baby, and for women undergoing termination of pregnancy. (This information is available in the Maternal and Perinatal Mortality and Morbidity in Qld 2013 and 2015 reports.) Pre existing mental health issues and social vulnerability are indications for termination of pregnancy, but may also affect a woman's ability to cope in the period after termination of pregnancy. The vast majority of women with these issues attend a private clinic (with no capacity for mental health/social support or follow up), and know they are not welcome at a public service. It is difficult to know whether termination of pregnancy precipitated suicide or was a symptom of the woman's personal, mental and social circumstances, . But it is clear that a significant number of vulnerable women are not receiving best care. This is not due to the medical care of the private clinics, but rather the whole interplay of factors surrounding abortion in Queensland.

THE LAW GOVERNING TERMINATION OF PREGNANCY – WHAT SHOULD INFORM IT OR BE GOVERNED BY IT?

The author supports the proposed private member's bill to remove all reference to abortion from the criminal code, but maintain s313 (killing of an unborn child). It is my hope and belief that this will remove the obstacle to vulnerable women accessing the care they need (and this may include termination of pregnancy). It will reduce unnecessary assessments and protocol in the care for women with fetal abnormalities, and allow psychiatrists to be involved in mental health care and not legal psych evaluations.

Evidence from other states and internationally would indicate that the absolute number of abortions is unlikely to increase, but rather there may be a shift in service provision. This is unlikely to happen quickly as there is a significant cultural shift that must occur in Queensland.

Removal of abortion from the criminal code is unlikely to result in an increase in late termination of pregnancy (and may reduce the number of late psychosocial terminations as they will be able to access local care quicker). Private clinics will still be restricted by the maximum gestational age they are credentialed to perform terminations, and the skills of the proceduralists. Public hospitals are still very unlikely to provide psychosocial termination over 20 weeks (perhaps in very exceptional circumstances of unremitting mental illness) and will certainly only perform terminations over 24 weeks for fetal abnormalities. It is likely that the Qld Maternity and Neonatal Therapeutic Termination of Pregnancy Clinical Guidelines will still be the process adhered to for assessment and management, but with reference to the indication for termination meeting ethical rather than legal requirements.

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Queensland Maternity and Neonatal Guidelines working parties are multidisciplinary and capable of creating sound, ethical and safe guidelines for abortion care if abortion is removed from the criminal code. Removal of abortion from the criminal code is unlikely to have any impact on the manner in which private clinics provide their service, but will impact on the way women are treated, and may also allow for a network of referral to be established between the private clinics and counseling/after care services.

Obstetricians are well able to self regulate in this area. This is demonstrated in the Guideline, where the law was only one aspect of the assessment and provision of care. Obstetricians will certainly not provide late termination of pregnancy for no reason, nor will they provide this in the very late gestations.

THE LAW AND GESTATION.

It is the author's opinion that stratifying indications for termination of pregnancy and lawfulness according to gestation is unhelpful, confusing and in some cases may force women to make premature decisions without full counseling just in case they miss out on the option due to gestational age. It also does not allow for the fact that gestational age is not absolute – it is a range of +/-5-7 days depending on the type of ultrasound and when it was performed and which parameter of measurement is going to be used.

As stated above, the medical profession is able to self regulate and does not need rigid and complex legal gestational age limits to further complicate rather than demystify abortion care..

Concerns that the amendment will encourage regarding social terminations up to 9 months are unfounded and nonsensical.. There is simply no medical practitioner who could or would offer this under current ethical and regulatory guidelines

Conscientious Objectors

Another consideration for the removal of abortion from the criminal code rather than creating a complex series of laws around what can and can't be provided is that there is nothing in the absence of a law that forces doctors to provide abortions. There would be no need for a law to protect conscientious objectors, as there is no legal obligation to provide a non emergency medical care option.

Obviously there would be recommendations regarding duty of care in Statewide Guidelines, but this would not be a criminal issue.

Personally, the author feels there is no place for a conscientious objector who refuses to even talk to or refer a patient. There is personal knowledge of a number of religious obstetricians, whose strong beliefs do not prevent them from referring women requesting termination of pregnancy for fetal anomalies, nor continuing their care afterwards.

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Most obstetricians and GPs routinely send their patients for screening ultrasounds and many of them refer for Down Syndrome screening as well. Abnormalities will be detected and some women will request termination of pregnancy as a result of this. Can it be considered ethical to suddenly withdraw a patient's care and refuse to refer them to another doctor?

Pre existing prejudice disguised as conscientious objection, may also impact on the holistic care of the woman. Refusal to see a patient or discuss abortion with them is a lost opportunity to assess their wellbeing. Up to 30% or more of women have either significant underlying social/psychiatric or substance abuse issues, were given poor contraceptive advice, were given erroneous information about the danger of pregnancy or of a medical condition or drug on pregnancy. Refusal to engage in a discussion of why they wish to have a termination means that the opportunity to assist that woman is lost.

The author does not believe the law has a role in protecting these individuals, but neither does it have a role in forcing them to be involved in abortion care. Duty and responsibility of care are issues for the respective colleges and perhaps medical/hospital boards to oversee.

The author hopes that this commentary provides some relevant information and a balanced background to abortion in Queensland, as well as expressing both concerns for the manner in which it is currently legislated and support for decriminalisation of abortion – the simplest solution.

Yours Sincerely

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APPENDIX A

TERMINOLOGY

Indicated termination of pregnancy – where women have serious medical problems that could result in serious, permanent medical consequences or death; where the woman has serious and/or life threatening psychiatric issues; where the fetus has a diagnosis of moderate to severe or lethal outcomes. Obviously in Queensland, the latter is not a lawful indication unless the mother's mental or psychosocial circumstances are significantly adversely affected by the fetal diagnosis.

Psychosocial termination of pregnancy – indications within this group vary but include domestic violence, drug use, sexual assault, psychological issues, serious social deprivation, financial problems, lack of social supports, maternal age.

Gestational age: Pregnancy is measured from the first day of the last menstrual period (historical). Conception actually occurs around ovulation, which on average is 14 days after the last menstrual period. This means there is a two week difference between gestational age and embryonic development, the latter beginning which begins at conceptiion. For example, a pregnancy of 6 weeks gestational age by 'dates' or ultrasound represents in fact 4 weeks of embryonic development. This is relevant as many anti-abortion groups will quote embryonic developmental stages rather than gestational age. For instance, the heart may begin to develop and beat between 3-4 weeks of embryonic development, which is 5-6 weeks gestational age. Medical and ultrasound measurements are all based around this concept of gestational age, not embryonic development.

Early Medical Termination of Pregnancy: Medication is used to induce miscarriage. This is a method that may be used up to 9 weeks of gestation. Mifepristone and misoprostol are used, and the use of these medications is approved by Therapeutic Goods Administration and the procedures associated with their use covered by Medicare.

Late Medical Termination of Pregnancy: Medication is used to induce miscarriage/labour in pregnancies over 12-14 weeks. This may be a combination of mifespristone and misoprostol, misoprostol alone, or intravenous syntocinon in some cases. This only occurs in a hospital setting (public or private). The use of mifepristone in this setting is approved by TGA but does not attract a Medicare benefit. Surgery is not involved unless there is retained products of conception/placenta, or the medication has failed to induce miscarriage/labour.

Surgical Termination of Pregnancy: A surgical procedure is performed to remove the pregnancy from the uterus, usually via the cervix/vagina. This is the preferred method between 9-14 weeks of gestation, and possible in some circumstances between 14 and 20 weeks gestation. No surgical terminations of pregnancy via the cervix are performed over 20 weeks gestation in Queensland. Medication or other methods are used to prepare the cervix before the

procedure in cases over 12 weeks gestation. In the majority of circumstances in cases over 16 weeks gestation medication is given to the fetus to ensure it has passed away prior to the procedure.

Hysterotomy/Caesarean Section: The fetus is delivered by a surgical incision in the uterus. This is a rare occurrence and occurs in situations where it is a serious risk to the mother to deliver that baby vaginally eg placenta praevia (placenta covers the cervix which means significant risk of bleeding) or cervical fibroid (a mass obstructing the cervix and preventing vaginal delivery). This is only an option for late termination of pregnancy (generally over 20 weeks gestation), and in the setting of severe/lethal fetal abnormalities or life threatening maternal medical complications.

Feticide: The process where a fetus is injected with medication to ensure it passes away before delivery. This method is used prior to surgical termination over 16 weeks, or before medical termination over 22 weeks (in most circumstances).

Live Birth: A live birth is any baby born with a visible/palpable heart beat after delivery regardless of gestation. Live births can occur as a result of miscarriage, preterm labour or medical termination of pregnancy. Survival is not possible under 22 weeks gestation, unlikely at 23 weeks gestation, and possible at 24 weeks gestation, but usually only if aggressive methods of care are used and deemed appropriate.