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Inquiry Secretary
Inquiry into Abortion Law Reform
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Queensland Parliament
abortionlawreform@parliament.qld.gov.au

Dear Committee Secretary

Reproductive Choice Australia is a coalition of organisations and individuals who are committed to ensuring women's reproductive rights are protected and enhanced in Australia. It is Australia's only dedicated pro-choice advocacy organisation, a non-partisan, not-for-profit organisation run by volunteers.

The association's purpose is to:

Promote women's reproductive rights, engage stakeholders, educate and inform the community and reduce stigma.

Advocate for the promotion, maintenance, extension and improvement of access to the full range of reproductive health care services, including but not limited to:

- *all forms of contraception including emergency contraception*
- *medical and surgical abortions*
- *evidence based, unbiased information and counselling in relation to pregnancy options*
- *respect for women's bodily autonomy*
- *unhindered medical decision-making*
- *appropriate legal frameworks governing abortion.*

We welcome this opportunity to make a submission to Committee's Inquiry into Abortion Law Reform and congratulate Rob Pyne, MP for drafting and tabling the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016. The passing of this bill would result in a significantly improved legal environment for Queensland women and health professionals.

Our submission has been endorsed by Family Planning NSW and both organisations would be happy to provide any further information if required by the committee.

Yours sincerely

Jenny Ejlak
President
Reproductive Choice Australia

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Guiding principles and context

Key issues for the Queensland Government to address are; prevention, service delivery and equity of access.

A key policy objective for the Queensland Government should be a comprehensive, statewide sexual and reproductive health strategy with a focus on promoting healthy sexuality and fertility, safe sex practices, respectful relationships and the prevention of unintended pregnancy and sexually transmissible infections.

There is a strong link between domestic violence and reproductive coercion which can lead to repeat unwanted pregnancies and abortions. Including the provision of reliable contraception within violence prevention and response services is crucial.

In addition to a prevention and health promotion focus, there needs to be adequate service planning for abortion care services both in the public and private health sectors to ensure affordable and appropriate services are available to women at the earliest possible stage of their pregnancy. As a large state with a dispersed population, consideration also needs to be given to rural and remote access to abortion services within health service planning.

Medico-legal context

Termination of pregnancy is one of the safest and most common procedures undertaken globally, when it is performed by qualified health professionals, with proper equipment, appropriate technique and training and in sanitary conditions, in an environment where the procedure is legal and accessible.

In their 2012 publication, *Safe Abortion: Technical and Policy Guidance for Health Systems 2nd edn*[1], the World Health Organisation (WHO) states: *"Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed."*

In the same publication the WHO also states: *"Additional barriers, that may or may not be codified in law, often impede women from reaching the services for which they are eligible and contribute to unsafe abortion."* Some of the barriers listed include:

- requiring third-party authorisation from one or more medical professionals
- restricting available methods of abortion, including surgical and medical methods
- restricting the type of health-care providers and facilities that can lawfully provide services
- failing to assure referral in case of conscientious objection
- requiring mandatory waiting periods
- failing to guarantee access to affordable services.

[1] World Health Organization. (2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed.). Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/index.html

Reproductive Choice Australia endorses these WHO principles and statements. We believe that termination of pregnancy is a health issue not a criminal one and as such should be governed by the existing health laws, professional registration criteria, standards and clinical and professional guidelines which cover all other medical and surgical procedures. No additional laws are required.

Ideal law reform outcomes would result in all references to abortion in criminal law being removed, and abortion being regulated like all other medical procedures through existing healthcare law and policy. This would enable a more comprehensive consultation in which health professionals can consider the unique circumstances for their individual patients, rather than deciding whether each patient fits a narrow set of criteria as is currently the case.

If passed unamended, the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 would make Queensland the only state in Australia fully compliant with World Health Organisation guidelines for legal frameworks for abortion.

Conscientious objection & referral

The Australian Medical Association (AMA) code of ethics[2] says: *"When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere."*

While this is responsible and professional advice, membership of the AMA is optional and the code of conduct is voluntary. Failure to refer to an unbiased medical practitioner, or worse, referral to an anti-choice group, can delay access to abortion as well as add to cost and distress. We recommend the inclusion of a legal requirement for referral in the case of conscientious objection so that the woman can access unbiased, all-options counselling and advice. Victorian and Tasmanian legislation both contain good models.

The Victorian Law Reform Commission (VLRC) Final Report on the Law of Abortion[3] states (p. 112-115): *"It is important to balance the rights of individuals to operate within their own moral and religious beliefs with the equally important ethical consideration doctors have to act in the best interest of patients. It is also important to minimise unintended consequences, for example exacerbating inequities in access, or increasing the risk of delay."* (p. 114)

Access zones

Evidence gathered in Victoria[4] as well as many jurisdictions overseas, shows significant distress caused to women and ongoing harassment of health professionals by anti-choice protesters outside abortion clinics. Access zones have been successfully introduced in three Australian jurisdictions; Tasmania, Victoria and the Australian Capital Territory. Access zones are recommended for Queensland, based on existing Australian models, to minimise intimidation and harassment of women and clinic staff.

Other issues

Drawing on our experience of law reform processes in other jurisdictions, we have prepared statements relating to common proposals by those opposed to, or unclear about, abortion related healthcare or access. Unless otherwise stated, references including page numbers are from the Victorian Law Reform Commission's *Law of Abortion: Final Report 2008.*

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[2] Australian Medical Association. (2004; editorially revised 2006). *AMA Code of Ethics.* Retrieved from https://ama.com.au/ position-statement/ama-code-ethics-2004-editorially-revised-2006

[3] Victorian Law Reform Commission. (2008). *Law of Abortion: Final Report 2008.* Retrieved from http://www.lawreform.vic.gov.au/all-projects/abortion; http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf

[4] Dean, R. E., & Allanson, S. J. (2004). Abortion in Australia: Access versus protest*, Law and Medicine, 11*(4), 510-515. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15214135

Restrictions related to gestation

There are many reasons a woman may not recognise or acknowledge a pregnancy until the second trimester, and of the small percentage of terminations after 20 weeks each represents a personal tragedy: a sick or substance addicted woman, a woman who is a victim of violence, a woman with a wanted pregnancy affected by a catastrophic fetal abnormality.

The need for specialised and multi-disciplinary medical care to obtain a termination at this stage of pregnancy means that extensive scrutiny of the woman's circumstances already takes place.

It is the role of professional medical colleges to continually refine clinical and practice guidelines for such complex cases. It is not the role of members of parliament to determine clinical practice or to put legal impediments in place. Legal obstacles achieve nothing but increasing the stigma surrounding the procedures, and potentially increasing delays in finding a safe service.

According to research in the VLRC report, later termination of pregnancy accounts for a very small percentage of all terminations – in 2005 in Australia only 0.7% occurred after 20 weeks (p.36 – 3.36). They found that later abortions are very rare, very difficult to obtain and are often sought for reasons that are particularly distressing for the woman (p.39 – 3.52).

Severe fetal abnormality can make later termination the most medically advisable option. Diagnosis of many fetal abnormalities is not possible until later gestation (p.43 – 3.78). Free screening for chromosomal abnormality does not happen until 18 weeks gestation or later, and the results may then take two weeks or more, delaying diagnosis until 22 weeks or later. Women living in regional and remote areas and those who can't afford to pay for early tests can be disadvantaged by this (p.42 – 3.71).

There is often uncertainty around diagnosis of fetal abnormality, which becomes clearer by waiting until a later stage of pregnancy. Setting gestational limits may lead to the abortion of healthy, wanted fetuses because women with these uncertain diagnoses are afraid of having the option of late termination closed to them (p.44 – 3.86).

We advise against restrictions or cut-off points at any gestation, as this can lead to women feeling pressured to make important decisions without sufficient time to gather and review adequate medical information.

If the parliament decides to impose some restrictions for second trimester pregnancy, this should not occur before 24 weeks. We refer to a study published in the British Medical Journal[5] in 2008 concerning fetal viability.

Following a review of abortion law in the United Kingdom in 2007, a team of neonatal specialists reviewed hospital records for the periods 1994 – 2005 to determine whether the survival of premature infants had improved due to medical and technological advances in neonatal intensive care.

They found that neonates less than 23 weeks gestation were unable to survive regardless of how much medical intervention they received. This was consistent over time despite advances in neonatal intensive care.

[5] Field, D. J., Dorling, J. S., Manktelow, B. N., & Draper, E. S. (2008). Survival of extremely premature babies in a geographically defined population: Prospective cohort study of 1994-9 compared with 2000-5. *British Medical Journal*, *336*(7655), 1221-1223. Retrieved from http://www.bmj.com/content/336/7655/1221.full

Those born at 24 and 25 weeks gestation had slight improvement in survival rates (to discharge) with improvements in medical care, however these were still in the minority and invariably suffered high rates of morbidity and disability.

The authors noted that for infants born less than 26 weeks gestation, resuscitation was not always attempted in the delivery room. They also noted that some jurisdictions had a blanket rule of no resuscitation prior to 26 weeks gestation due to the low survival rates and inevitably high morbidity for those neonates which do survive to discharge.

Panel of doctors to decide whether abortion goes ahead
A mandatory panel at law is not reflective of current clinical practice.

Termination review panels are sometimes constructed by public hospitals. In the main they serve to mitigate legal risk and legal uncertainty that emanate from abortion remaining in criminal law. There is no better example of this than the fact that the Termination Review Panel at the Royal Women's Hospital in Victoria (until decriminalisation in 2008) was chaired not by a clinician but by an administrator.

The VLRC Report states: "*The panel system leads to a loss of autonomy for the woman. Anecdotal information from Western Australia (where a panel exists for later term abortions) suggests 'women resent the ultimate decision of late pregnancy termination being removed from their direct control'*." (p. 38).

Restrictions related to the age of the pregnant woman
"The existing law governing consent and confidentiality for young people is adequate. No further legislative reform is required." (p. 8).

Current law relating to informed consent in healthcare provides that provided a young person can fully understand the nature of the treatment and its effect, they are able to give consent. There are well-adopted and longstanding tests that a clinician must satisfy him or herself of in order to deem that a patient has provided informed consent. That is not a function of age. That is a function of the person's ability to grasp both the outcome of proceeding and the outcome of not proceeding.

To involve the parents can often mean young women are ostracised from their families, face issues of violence, or may hide or be in denial of a pregnancy to avoid being forced to reveal it to their families.

In the case of a child who has been sexually abused by a parent or legal guardian, parental notification laws could compel health professionals to involve the abuser, who would then get to influence the decision about what would happen to the pregnancy resulting from that abuse. Government has an obligation to protect all young people who are victims of abuse, not exacerbate their abuse by involving the abuser in their healthcare decisions.

Restrictions on who can administer abortions or where they can take place

Hospital-only abortions or unnecessary clinic requirements
In the Northern Territory, South Australia and the Australian Capital Territory, abortions must be carried out in a hospital or 'prescribed facility'. This has led to numerous problems and barriers in each of these jurisdictions including travel time and costs for women, insufficient or irregular staffing within hospitals and an inability for medical terminations to be carried out in community health centres or general practice. This creates access barriers, inequities, long wait lists and prohibits many primary care practitioners from providing care to their long-term patients.

Restricting the performance of abortion to certain medical professionals

Limiting the provision of termination services to medical practitioners, particularly medical specialists, is problematic in many ways. Access to medical practitioners can be limited, particularly to specialists and requiring hospital based specialists (as in the Northern Territory and South Australia) can be very limiting for both patients and health services. Currently rural and regional women take on significant costs associated with travelling for surgical termination. Any changes to law should promote equity of access to services, not create further barriers.

Since the advent of medical, as opposed to surgical abortion, midwives, sexual and reproductive health nurses, nurse practitioners, pharmacists, and in some countries paramedics and non-clinician peer health workers are able to competently administer medication abortions, supported by a World Health Organisation framework[6]. Changes in scope of practice for health professionals may see this happening in Australia before long.

'Partial Birth' abortion

This is terminology used by anti-choice groups in the USA, however this type of technique is not used in Australia. In any case, it is not the role of the parliament to dictate in law what procedural techniques doctors can and can't use. Medical technology will always outpace law and to outlaw any particular surgical technique would set a dangerous precedent. Determining appropriate medical procedures is the role of medical colleges and health professionals, not parliamentarians.

Compulsory Information

The general standard of disclosure by a medical practitioner (informed consent) embodies the principle that doctors must provide all relevant information that a patient should consider before deciding whether to have a particular medical procedure. This includes the nature, risks, and benefits of any medical procedure and availability of alternatives.

Current law requires practitioners to inform women of the nature, risks, and benefits of medical procedures, including abortion. There is a plethora of information available to anyone on the internet including reputable sites such as medical college clinical guidelines and the Better Health Channel.

Every patient is different. Legally required information risks both under and over inclusiveness. The (VLRC) commission believes that appropriately qualified medical practitioners, rather than legislators, can best determine the relevant information to be given to a patient after bearing in mind the questions asked and concerns raised by each individual (p65). The VLRC report recommended*: "Any new abortion law should not contain mandated information provisions"* (p. 8),

Compulsory counselling

The Victorian Law Reform Commission report states:
"Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling" (p.8). *"Abortion counselling is a clinical, service delivery issue rather than one to be directed by law"* (p.124 - 8.122).

The VLRC found that non-directive counselling was current practice in clinics. *"As well as providing details of the procedure and medical risk information, a counsellor discusses the abortion decision with the woman to ensure she is clear in her decision and is giving free and informed consent"* (p.35 - 3.30).

[6] World Health Organization. (2015). *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception.* Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/

Forcing counselling can do more harm than good. There is consensus among providers that:
"…the majority of women who seek an 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" (p.120 - 8.80).
"Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm" (p.125 - 8.125).

Women's Health West, noting personal experience of counselling in a mandatory setting stated: "*Compulsory counselling not only reinforced a lack of control, it sparked anger among women that they were assumed to be incapable of making a considered decision*" (p.123 - 8.106).

"Mandating counselling may result in women having to travel long distances for multiple medical assessments and counselling sessions before they can proceed. This would exacerbate existing inequities" (p.125 - 8.127).

Marie Stopes International[7] commissioned survey of women who experienced unplanned pregnancy. This 2006 survey found that 75% of women did not wish to speak to a counsellor before deciding how to proceed. Among survey participants, the most common place to obtain counselling was an abortion clinic (45%). Of those women who obtained counselling, 46% said the most helpful thing was that counselling was nonjudgmental; 80% expressed satisfaction with the service provided.

There is no need for counselling to counter mental health concerns. The world's largest, most comprehensive and systematic review into the mental health outcomes of induced abortion was published by the Academy of Medical Royal Colleges at the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists. Their review[8] of 44 published studies spanning over 20 years found that it's unplanned pregnancy, not abortion, that is stressful for women.

Unbiased pregnancy options counselling, such as that already provided by Queensland based organisation Children by Choice, should be adequately funded so as to be available to all women with a problem pregnancy, but counselling should not be mandated.

Cooling off periods
The concept of 'cooling off' periods is ignorant and patronising given the reality of women's lives, the urgency of a problem pregnancy and the barriers and time delays already experienced by women.

Imposed cooling-off periods may delay access to safe first trimester abortion. This is of particular concern for rural and regional women who could face additional travel and accommodation costs.

VLRC Recommendation: *"6. Any new abortion law should <u>not</u> contain a compulsory delay or cooling-off period before an abortion may be lawfully performed."*

The need for advance bookings in private clinics and waiting lists in public facilities, travel issues for women living outside the cities, and costs associated with private abortions already create significant time delays between a woman deciding to seek an abortion and actually receiving one.

[7] Marie Stopes International. (2006). *What Women Want: When Faced with an Unplanned Pregnancy.* Retrieved from http://www.mariestopes.org.au/wp-content/uploads/2014/07/KeyFindings.pdf
[8] National Collaborating Centre for Mental Health. (2011). *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors.* London: Academy of Medical Royal Colleges. Retrieved from http://www.aomrc.org.uk/wp-content/uploads/2016 /05/Induced_Abortion_Mental_Health_1211.pdf

Fetal Pain arguments

A systematic review of the literature on fetal pain in the Journal of the American Medical Association, 2005 (Vol 294, No. 8)[9] reported: *"Neither withdrawal reflexes not hormonal stress responses prove the existence of fetal pain, because they can be elicited by nonpainful stimuli and occur without conscious cortical processing. Fetal awareness of noxious stimuli requires functioning thalamocortical connections. Thalamocortical fibers begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks."*

The report concluded: *"Fetal anesthesia or analgesia should not be recommended or routinely offered for abortion because current experimental techniques provide unknown fetal benefit and may increase risks for the woman."*

Compulsory viewing of ultrasounds

Ultrasounds are routinely done to ensure the pregnancy is not ectopic and to confirm gestation. There is no reason for the woman to be forced to view this. Such measures are designed only to distress and punish women and to coerce them to continue a pregnancy.

Imagine compulsory viewing of ultrasound in a scenario where a woman who has been informed her planned, wanted pregnancy has resulted in catastrophic fetal abnormality, or that her own life is at stake if the pregnancy is not terminated. This is an already extremely distressing situation – tor force a woman already distressed at losing a wanted pregnancy to view an ultrasound would be cruel in the extreme.

Summary

In summary, Reproductive Choice Australia recommends that the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 be passed, with the addition of referral in the case of conscientious objection and access zones around clinics, based on models in other Australian jurisdictions. No other amendments, restrictions or conditions should be applied.

We also recommend that Queensland reviews and improves services aimed at comprehensive, evidence based sexuality and relationships education embedded in the education system, affordable access to the most effective forms of contraception and improving access and affordability of both public and private abortion care services.

This submission has been prepared by Reproductive Choice Australia and has been endorsed by Family Planning New South Wales. Both organisations are happy to provide further information to the inquiry on request.

30 June 2016.

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[redacted] Lee, S. J., Ralston, H. J. P., Drey, E. A., Partridge, J. C., & Rosen, M. A. (2005). Fetal pain: A systematic multidisciplinary review of the evidence. *Journal of American Medical Association, 294*(8), 947-954. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=201429