Submission No. 840
Received 30 June 2016

To: **Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee**

Re: **Abortion Law Reform Amendment Bill 2016**

A. My Background

I make this submission as a leading academic in maternal-fetal medicine and a practicing fetal medicine sub-specialist for over 25 years, including for the last eight at Queensland's major public tertiary referral service for fetal abnormality. My interest lies in the management of pregnancy affected by fetal disease and fetal anomalies, and the counseling of pregnant women and their partners in this situation. I appeared as the expert witness for the Crown in the 2010 Cairns abortion trial, with my factual evidence pivotal in the acquittal. I have previously practiced in 4 other jurisdictions, including in the UK where I was Professor of Obstetrics & Fetal Medicine at Imperial College London and Chair of the Royal College of Obstetrician's and Gynaecologists' Scientific Advisory Committee. I am a former President of the International Fetal Medicine and Surgery Society, and have contributed over 400 publications in the field.

B. Current context

There is a disconnect between Queensland's 19th century Criminal Code (ss224-226) outlawing termination of pregnancy on the one hand, and current 21st century practice and community standards on the other. Around 14,000 terminations have been done annually in Queensland over the last decade[1], while nearly 90% of the Australian public supports legalised access to termination services[2]. An allowable defence under s282 and Judge Maguire's 1986 precedent ruling is in exceptional cases "to preserve the mother's life" (as reaffirmed by Parliament in 2009), interpreted as preventing serious danger to the mother's life or her physical or mental health, but excluding social and economic considerations. As maternal mortality in Australia is one of the lowest in the world (6/100,000 births), the fact that around one in five pregnancies is terminated in Queensland indicates that the vast majority are done outside the

[1] http://www.johnstonsarchive.net/policy/abortion/australia/ab-aust-qld.html
[2] Med J Aust 2010; 193 : 9-12.

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legal framework. Abortion law has been reformed in every other Australian jurisdiction except NSW, where it is currently under review and there is less restrictive precedent ruling.

C. Consequences in relation to Termination for Fetal Abnormality

1. There is currently no provision for fetal abnormality as an indication for termination of pregnancy[3]. This is despite widespread provision of prenatal genetic and ultrasound screening services in Queensland Health, and current practice where the majority of parents confronted with major handicapping fetal abnormality elect to undergo termination of pregnancy if offered.
2. The above results in hospital staff "manufacturing" mental illness and potential suicide risk in the mother as an allowable indication for legal termination. For fetal abnormality diagnosed in the mid trimester, this often involves psychiatric and social work consultations, and medical certification that continuing the pregnancy exposes serious risk to maternal mental health. In the presence of genuine mental illness, there can be concern re capacity to consent, whereas currently a rational sane women after appropriate counseling and in full possession of the facts is not permitted to make a balanced decision regarding the future of her own family.
3. One consequence of the above is a paternalistic attitude to the management of women, which is out of keeping with modern standards of patient respect, autonomy, participatory decision-making, and arguably gender equity. Another under the current legal uncertainty reflected in the guideline is there is no obligation for medical staff to counsel a woman with a fetal abnormality as to the availability of termination of pregnancy, only to respond to a woman who "requests" termination.
4. Women in such situations are often surprised to learn that fetal abnormality is not an allowable indication for termination of pregnancy,

[3] https://www.health.**qld**.gov.au/qcg/documents/g-ttop.pdf

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and that they too can be prosecuted under s225, especially at such a difficult emotional time.

5. Medical practitioners providing such services within Queensland Health are only indemnified within the current legal framework, which remains uncertain. This results in risk aversion in many public hospitals, which choose instead to refer simple cases to referral centres or private providers.

D. Format of proposed legislation

1. This seeks to drop s224-6, essentially removing abortion as a criminal offence. This is in line with the situation in Canada, where earlier restrictive laws were deemed unconstitutional in 1988. Interestingly, Canada's abortion rate (% of pregnancies terminated) is slightly lower than Queensland's[4], consistent with international data by region indicating that termination rates are statistically higher the more restrictive the legal framework.[5]
2. The proposal is similar to ACT legislation, and places termination of pregnancy on the same footing as other medical procedures. It would allow responsible decision making, in particular in relation to fetal abnormality across a range of severities and gestations, with practice determined by evidence based standards and guidelines as with other medical procedures.
3. The alternative of legislatively-stipulated indications and gestational ranges can work, as it has for decades in some jurisdictions such as the UK, but is critically dependent on the wording. Current legislation in Victoria and Tasmania provides an acceptable framework for fetal abnormality management without the undue imposition of panel reviews, which in my experience have been cumbersome and constrained by inappropriate non-expert and religious membership. Legislative wording in other Australian jurisdictions restrains fetal medicine practice and

[4] http://www.johnstonsarchive.net/policy/abortion/
[5] Lancet: 2012, 379: 625-632

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responsible parental decision making, is subject to interpretation, and the track record of Queensland practice respecting laws in this regard is fraught.

4. The proposed withdrawal of s224-6 is supported without further legislation. If further legislation is indicated, then the ACT model is recommended.

E. Late gestation termination

1. These account for ca. 1% of terminations, and are largely done for major fetal abnormality. The availability of late termination (> 20-24 weeks) for fetal abnormality paradoxically results in fewer terminations, as parents instead await the evolution of the particular abnormality with fetal growth and development, and with more advanced imaging such as fetal brain MRI. Other circumstances where later termination is appropriate include cases with late-emerging diagnosis, and in multiple pregnancy where selective termination of an abnormal fetus poses less risk to the healthy fetus than in earlier gestation.
2. I am surprised by the numbers mentioned in parliament recently of late terminations resulting in live births. This does not happen in countries such as the UK and France with long standing frameworks for late termination for fetal abnormality, and indeed the Queensland Health guideline contains similar recommendations to pre-empt this avoidable situation. Although the reported occurrence, which I have not observed anywhere, may relate to awkward state definitions of live birth at early gestations, I suspect it is more to do with such terminations being currently illegal in Queensland, and thus the cautiously optional advice in the extant guideline. This issue should be dealt with by robust preventative guidelines framed around legal procedures as happens elsewhere.
3. I fully endorse the Royal Australasian College of Obstetricians and Gynaecologists' 2016 Statement "strongly support(ing) the availability of a legal late termination of pregnancy for those women in the rare

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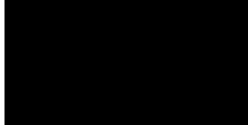
circumstances where it is clinically unreasonable to compel decisions around termination of pregnancy at an earlier gestation". It is thus important that the availability of late termination for fetal abnormality be encompassed within the proposed legislative reform.



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