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Ethical Considerations

The Bill before the Parliament seeks to remove termination of pregnancy (ToP) from the Criminal Code.

The fundamental ethical question for the committee is whether decriminalising termination of pregnancy in Queensland is likely to result in increased harm to the key stakeholders[1] affected by the legislation.

ToP is an ethically complex health issue. Queenslanders hold a range of divergent beliefs on the ethical acceptability of ToP based upon their individual moral frameworks and life experiences. Hence, the task of law reform in this complex medical and social environment requires careful consideration. Law reform cannot impose moral consensus across these widely diverging standpoints. When grounded objectively in evidence based medical and public health practices, law reform can promote the reduction of harm associated with ToP and reduce its occurrence. Well-formed legislation could contribute to reducing the risks associated with unwanted pregnancy through enhancing transparency in medical practice. This in turn, could inform and improve future reproductive and sexual health practices in Queensland. Unfortunately in Australia as a consequence of inconsistent laws and poor data collection, little can be confidently known about ToP (Chan and Sage 2005, Chan et al 2008). International medical research confirms that it is through public health and social policy measures that termination rates are reduced (Fletcher et al 2008;Cleland 2012;Sedgh et al 2007, 2012; Shusheela et al 2010) and hence, the harms (real and potential) associated with ToP are best reduced using this framework.

The international medical literature confirms that criminalisation of ToP is not associated with reducing termination of pregnancy rates. Similarly, decriminalisation is not predictive of increased ToP rates (Sedgh et al 2007, 2012). Throughout the world, rates of ToP are decreasing in general due to more effective public health (sexual and reproductive health) interventions (Sedgh et al 2007). Therefore criminalisation of ToP is not protective of the rights of the foetus or the mother[2]. Preventing unwanted pregnancy through known effective public health measures (such as increased access to healthcare, education, support) is the most effective means respecting the rights of stakeholders.

If the ethical aim of legislation is to reduce overall harm, reducing the numbers of ToP is best achieved in a context of decriminalised abortion with supportive public health and access to medical care. Criminalisation acts as a barrier to the ultimate ethical goal, which is a collective reduction of harm.

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

In Queensland there is no reliable data regarding the actual practice and frequency of ToP. This is due largely in part to how the current Qld legislation is drafted. The prospect of criminal prosecution creates a clinical culture in which 'work arounds' - around the law ensure best clinical outcomes for patients. Practitioner anxiety and uncertainty about the Queensland law can create access barriers for Queenslanders seeking advice and support with unwanted pregnancy. Such obfuscation inhibits genuine understanding of how and why ToP is used, and prevents practice improvement. The lack of honest and transparent collation of information on this medical procedure in Queensland undermines our ability to

[1] Pregnant women seeking ToP, Medical practitioners, the foetus, the community at large.
[2] In Queensland law the foetus has no recognised legal rights until birth.

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understand, inform and develop practice improvements which further reduces the harm of ToP.

The existence of, and access to federally funded Medicare rebates for ToP in Australia (including Queensland) signals broad communal and government endorsement that legitimises this intervention as a relevant clinical service.

TOR 2. Existing legal principles that govern termination practices in Queensland.

Legislation should be drafted to minimise individual and public harm. If we accept the premise that termination of pregnancy is harmful to women, to the medical profession, to the unborn foetus and erodes community values that respects the sanctity of life, we may consider how legislation can best ameliorate these harms.

Public health research from around the globe supports the view that criminalisation does not reduce termination rates (Sedgh et al 2007, 2012). International research confirms that the promotion of transparency in practice which informs research and progresses evidence based practice, by ensuring best medical and public health measures are in place to prevent unwanted pregnancy and to support informed decision making (Cleland 2012;Sedgh et al 2007, 2012; Shusheela et al 2010).

As a consequence of Australia's inconstant state and territory ToP laws there is scant reliable data on the demographic characteristics of women who undergo ToP. However, international research confirms that women seeking ToP are more likely to be young, poor, lacking in education, have experienced poor access to appropriate medical care to prevent unwanted pregnancy, and be women of colour (Sedgh et al 2007). The incidence of ToP among women who have experienced domestic violence is also higher (Hall et al 2014). Criminalisation may create additional access barriers unjustly creating a disproportionate burden on this identifiable group of disadvantaged, potentially vulnerable and predominantly young women. Decriminalisation could reduce these barriers.

TOR 3. The need to modernise and clarify the law (without altering current clinical practice), to -reflect current community attitudes and expectations.

We cannot state with any certainty what "current community attitudes" in Queensland are, except to say that there are a range of divergent and entrenched views that the law cannot mediate.

Legislation is dynamic and adjusts to reflect changing community attitudes and expectations. Importantly, when legislation is reviewed it must accommodate the reality of advances in medical practice and improved public health knowledge[3]. In 2016 the interests of the foetus are better served through decriminalisation and the implementation of appropriate clinical care within a culture of transparency and reflective practice.

A number of Queensland and Australian laws consistently confirm that a foetus has no legal status before birth. The current criminalisation of ToP is arguably out of alignment with the vast body of Australian legislation.

TOR 4. Legislative and regulatory arrangements in other Australian jurisdictions including regulating terminations based on gestational periods.

[3] Current clinical examples where legislatie reform has been undertaken to accommodate medical advances include organ transplantation, assisted reproductive technologies, Withdrawal and Withholding of life Sustaining Measures (WWLSM) legislation.

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Advances in medical practice have resulted in foetal survival at earlier gestational ages. Currently, the survival of infants born at >24weeks gestation is high with Pignotti and Benzelli (2008) concluding that 'with *current standards, intensive care is generally considered justifiable at ≥25 weeks, compassionate care at ≤22 weeks, and an individual approach at 23 to 24 weeks, consistent with the parents' wishes and the infant's clinical conditions at birth'.* A range of gestational limits (from 14 in NT to 24 weeks in Victoria) for access to ToP are in place throughout Australia. Currently under Queensland's Criminal Code, no gestational limit to ToP access exists. Hence, decriminalising and placing a gestational limit after which heightened review and oversight to manage the increased risk is applied. This is more protective of the mother and the foetus and is more likely to satisfy community concerns and expectations.

TOR 5. Provision of counselling and support services for women.

The provision of independent counselling and support services for women is essential in ensuring appropriate understanding and gaining informed consent. Promoting informed consent through patient education and counselling is protective of patients' future psychological wellbeing and engagement with health professionals (Braddock 2002). A systematic review of the risk of psychological harm following ToP concluded that psychological harms were "mostly neutral, suggesting few, if any, differences between women who had abortions and their respective comparison groups in terms of mental health sequelae"(Charlesa et al 2008). Contradicting this finding, Coleman (2009) concluded there was '*a moderate to highly increased risk of mental health problems after abortion. Consistent with the tenets of evidence-based medicine, this information should inform the delivery of abortion services'*. Even if the sole purpose of pre termination counselling was to ensure better informed consent, this would be a welcome outcome.

Summary

Law reform cannot resolve the moral disagreements that exist concerning ToP, nor can it impose a moral consensus on those holding diametrically opposed views on the moral acceptability of abortion. It is therefore important that this reform bill does not become bogged in intractable moral arguments about personhood, sanctity of life or maternal vs foetal autonomy and rights. If we approach this question with the ultimate objective of reducing the harms associated with ToP in mind, it seems that decriminalisation which will facilitate transparency, form an appropriate basis of reflective practice and improve access to medical care/social support is the most effective way to reduce rates of ToP, and its associated harms.

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