Submission to the Parliamentary Select Committee reviewing the law on termination in Queensland

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This submission is prepared in response to an invitation from the Parliamentary Select Committee reviewing the law of termination. The views expressed in this submission are my own and not necessarily those of the Royal Brisbane & Women's Hospital (**RBWH**) or Metro North Hospital and Health Service.

Background information and work done at the Royal Brisbane and Women's Hospital:

The Maternal and Fetal Medicine Unit (**MFMU**) at the RBWH is a tertiary level service. Typically MFMU carries out approximately 100 terminations each year. Approximately 23% occur in the first trimester; 72% in the second and 6% in the third.

Generally, terminations can occur "chemically" up to 9 weeks by means of a pill and miscarriage; "surgically" by means of dilation and curettage; and then after 16 weeks "medically" by means of induction of labour.

The MFMU at RBWH carries out surgical terminations up to 16 weeks gestation whereas most other hospitals have a lower limit of 12 or 14 weeks gestation. Surgical terminations are considered to be less traumatic than medical terminations which involve the patient going through a birthing process.

The tertiary referrals to the Maternal and Fetal Medicine Unit (**MFMU**) at the RBWH are usually from the MNHSS area. These referrals are for abnormal first trimester screen, genetic abnormalities in previous pregnancies, family history of genetic abnormalities, abnormal morphology scan.

In addition to these the MFMU also sees women for routine first trimester screen where maternal age is above 37 years of age, complex multiple pregnancies and mothers with significant medical conditions and pre-pregnancy counselling.

The MFMU also receives referrals from other health service areas where termination of pregnancy is not provided (e.g. the Mater Hospital) or gestational age is over 22 weeks with a diagnosis fetal abnormalities and the patient is requesting termination of pregnancy.

Operating under the law in Queensland

The starting point for the law in Queensland is an unequivocal prohibition on carrying out, procuring or assisting with the abortion of a baby set out in sections 224-226 *Criminal Code 1899*.

The caveat to this set out in s282(1)(b) is less emphatic stating that

"... a person is not criminally responsible for providing in good faith and with reasonable care and skill, a surgical operation or medical treatment of a person or unborn child to protect the mother's life; if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."

On the face of it this would only allow terminations where it is reasonable course of action to "*preserve*" the mother's life. Also if a termination is carried out negligently then the clinician may be liable to criminal prosecution rather than just a civil claim as would apply with any other form of clinical negligence.

Current clinical practice relies on judicial interpretation of this clause in *R v Bayliss and Cullen* which permits terminations where there is a serious risk of physical or mental injury to the patient presumably greater than the risk of injury posed by the proposed termination.

The law is far from clear and as such poses a significant risk to clinicians. It is archaic and unlike other jurisdictions such as Victoria or the UK has no consideration of critical issues such as gestational age, fetal abnormalities and the circumstances of the conception such as rape. There is little understanding or appreciation of the difficult position of the women who are patients and invariably in a very stressful situation.

Procedures have necessarily been developed to provide support and guidance to both patients and clinicians within an uncertain legal framework.

Terminations before 22 weeks

At present when mothers request termination of pregnancy before 22 weeks' gestation, due to fetal abnormalities or significant maternal health the process is as follows:

Two specialists which can be either an Obstetrician, Physician or Psychiatrist document in the chart the reasons for supporting termination of pregnancy after discussing the options of continuing with the pregnancy and fetal outcomes and adoption. The patient chart is then taken to the Director of Obstetrics and Gynecology who reads through the chart and signs a support documentation of the mother's request for termination of pregnancy. Following this, the patient is booked in for the procedure either surgical or medical depending on the gestational age at when the procedure is performed.

The families are counselled prior to the procedure and full informed consent is obtained.

Post procedure follow up is arranged to check on the patient's well being physically and mentally. Advice is given regarding any future pregnancy and

contraception options. Autopsy findings are also discussed in order to provide more information for future pregnancies.

Terminations beyond 22 weeks

When termination takes place at or after 22 weeks of gestation, the RBWH policy requires the convening of an ethics committee to discuss the patient's request for termination of pregnancy. The purpose of the ethics committee is to provide support and protection to the MFMU clinicians and patients who run the risk of prosecution. The ethics committee's decision is final.

In order to arrange this ethics meeting, staff in the MFMU have to spend at least 1-2 hours scanning, counseling and arranging for the patient to see a psychiatrist who consults for another 1-2 hours. Following this, another Obstetrician or MFM specialist who agrees with the mothers' request sees the patient. The midwives who work in this area then request the office of the Executive Director of the hospital to convene an ethics committee meeting. Representatives are required from Obstetrics, Psychiatry, Legal, Ethics, Nursing and Midwifery.

Following this, the patient is contacted and an induced fetal demise procedure is performed so that the baby is not born alive following the procedure.

This ethics committee process is time consuming taking between 5 and 10 days which can be critical as the pregnancy progresses. It only adds to the stress of the patient who invariably just wants the whole procedure over as quickly as possible. Social workers are required to assist families through this process.

The process is also expensive and puts pressure on the delivery of frontline services because it requires several clinicians from various specialties to make time at short notice to attend the meetings. Such meetings occur approximately once a fortnight.

The clinicians in the MFMU are overstretched with their clinical duties. Preparing for and attending ethics committees is a significant imposition on valuable clinical time.

The RBWH takes referrals from hospitals from within Metro North and outside where termination of pregnancy is not performed or other secondary hospitals where the procedure for the induced fetal demise cannot be safely performed. Consequently, we see all patients referred to us after 22 weeks of gestation and take them through the ethics committee process (usually doubling of the process) and most patients return to the referral hospital to deliver following the procedure. The process of counseling, education, support and follow up are important for these mothers which helps in their healing in the grieving process.

Improvement in ultrasound imaging has resulted in the earlier detection of fetal abnormalities. When fetal abnormalities are identified early in pregnancy usually before 14-16 weeks of gestation, mothers usually request termination, as this is one of the main reasons why they would go through early screening. There is no recognition of this in the current law.

When abnormalities are detected at the routine 18-20 week morphology scan in the private sector and seen by tertiary units, there is a minimum 2-3 week turnover period taking the gestational age to beyond 22 weeks raising the possibility of live birth which is distressing for both patients and staff. Confusion sometimes also follows because the referring facility would likely not have considered the matter through an ethics committee necessitating approval through the RBWH ethics committee process leading to further delay and stress for the patient.

To give an example, when a significant heart abnormality is seen at 20 weeks ultrasound scan, by the time she has been seen and counselled by both the maternal and fetal medicine team and pediatric cardiologist, it is about 23 weeks of gestation. This then places the treating obstetricians and hospitals where they are not sure how to proceed with the termination process as this may lead to a live birth following termination of pregnancy; referral to a tertiary unit such as RBWH is made.

To assist secondary hospitals and other tertiary hospitals in the best management of termination of pregnancy, the statewide guidelines set out what is done at the RBWH.

Other specific problematic areas

Pregnancy in a minor
This poses significant problems under the current law, especially where the child is 14 years or less and assessing the risk of psychiatric injury to the mother let alone her capacity is often not a simple task. *Parens patriae* applications are far from straight forward particularly as the Supreme Court does not have any relevant practice directions. Secondary hospitals usually want to transfer these patients to RBWH, which is not helpful for the families. This again highlights the nebulous nature of the law surrounding termination of pregnancy and the resulting lack of no clear guidance for the patient or the doctors what needs to be done.

Refugees and immigrants from other ethnic backgrounds
Often women who are either refugees or immigrants from foreign ethnic backgrounds are usually in these situations where the pregnancy may not be consensual and may request termination of pregnancy. They are more frightened than most and are particularly fearful of authority. The law simply adds to their burdens and stresses by adding extra scrutiny and delay.

Higher order multiples and fetal reduction
In many parts of the developed world where advances in ultrasound technology and treatment of infertility, there are situations where there is diagnosis of higher order multiples such as quadruplets, quintuplets, and others. We need to counsel mothers and families that these pregnancies carry significant morbidity to both mother and babies especially prematurity and cerebral palsy. Following these discussions, some parents may request fetal reduction, to improve

outcome of the pregnancy. Again, the maternal and fetal medicine specialists seek approval from the ethics committee irrespective of gestational age. There is no clear guidance for the doctors who are faced with this situation. There is nothing in the *Criminal Code* providing for the selective reduction in a multiple pregnancy.

Selective reduction is usually discussed and provided as a form of treatment in higher order multiple pregnancies in many developed countries without having to go through the process of an ethics committee.

Discordant fetal abnormalities in multiple pregnancies

When ultrasound scans diagnose fetal abnormality in one twin of a twin or triplet pregnancy, they are faced with a very hard decision to terminate one baby of a twin or triplet pregnancy. Again, an ethics committee meeting to address this issue is arduous.

Diagnosis of poor prognostic findings in monochorionic twin pregnancies on ultrasound scan

There are situations in a twin pregnancy, where a single placenta is shared between the twins who have 2 separate sacs. When there is significant growth discordancy especially before 24 weeks of gestation, the demise of one twin can significantly damage the live twin (20% of neurological abnormality) and the couples may chose to make this a singleton pregnancy. Time is the essence in these situations and by the time we meet again for an ethics committee to discuss these situations, we may loose one twin and thus affect the surviving twin.

Proposals for change

The current law does not promote equity of health care across Queensland or indeed Australia. The law should be clearer and provide pregnancy specific and patient focused guidance for patients and clinicians alike. In Queensland the path for a woman seeking a termination is unnecessarily more stressful and fraught with legal risk than that faced by her counterpart in Victoria. The same can be said for the treating clinicians in each state.

Similarly in places like the UK, there are clear guidelines to both the person who is requesting termination of pregnancy and the person who provides the same. Time consuming, stress creating, protective administrative measures are not necessary. Two specialists agree on a gestational age for a patient and the rules stipulating when a termination should occur are clear.

The law should also provide clarity for situations where a health care provider may have a conscientious objection to a procedure but at the same time has a duty of care to the patient who needs acute and critical care during or following the procedure.

Reforming the law in accordance with modern medicine and society will facilitate better access to care for women across Queensland. Clarity in the law

will allow and empower local hospitals and obstetricians to assist and treat women requesting terminations.

Careful consideration should be given to the terminology used in any legislation and any ancillary regulations and guidelines. Expressions such as "social termination" are nebulous and unhelpful and should be avoided.

This also highlights that, as in many developed parts of the world, easy access and education to contraception reduces unwanted pregnancies. Clear guidelines, equitable and easy access to termination of pregnancy will in the long run dispel the taboo attached to this procedure and help women in places such as Queensland who may live a considerable distance from a tertiary health care facility. This in turn will provide equity of access to care for women right across Queensland.

Firmly held views prevail on both sides of the debate on abortion law and the topic is not without controversy particularly in Queensland. However amongst those opposing abortion there is a significant minority who are prepared to take action beyond reasoned debate and peaceful protest. Stressed and emotionally vulnerable patients do not need to be confronted by protesters when attending facilities offering family planning advice and terminations. Similarly, health care workers have a right to safe access to and from work and to work safely free from threat and intimidation. The law should seek to balance the right of peaceful protest with the safety of patients and health care workers and prohibit anti-abortion protest within a certain distance of relevant facilities.

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