Reproductive Choice Australia

6 October 2016

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

In June of this year we provided a submission to your inquiry into abortion law reform. We now write to broadly support the supplementary bill, the *Health (Abortion Law Reform) Amendment Bill 2016* and to urge that the two bills be debated together in parliament rather than separately.

Specific comments on components of this new amendment bill:

Division 2

Section 20, "Only qualified health practitioner may perform abortion"
We recommend against limiting the type of health professional who can provide abortion care services. The scope of practice for health professionals, particularly nurse practitioners, changes over time and this law may not be appropriate in years to come. In our original submission, we provided detailed discussion of this, which is copied in the appendix to this letter.

Section 21, "Abortion on woman more than 24 weeks pregnant"
As in our original submission, we do not think that conditions placed at particular gestations are wise, as clinical management and medical technology change over time and it is the role of medical, not political organisations, to provide advice on medical management of pregnancy.

If, however, conditions related to gestation are to be included in legislation, the amendments here are consistent with the recommendations in our original submission. Detailed discussion of this is copied in the appendix to this letter.

Section 22, "Duty to perform or assist in abortion"
This section should include a duty to refer on to a health professional or service without a conscientious objection, so that the patient may receive unbiased information about all her options. More detail is provided in our original submission and copied in the appendix to this letter.

Division 3
Section 23, "Declarations for abortion facility"
We recommend against giving the Minister of the day the power to declare, or not declare, a protected area around a particular facility. This has the potential to lead to inconsistency across premises and over time, based on the particular viewpoint of the minister of the day, and create an

unnecessary administrative burden for both abortion care providers and government departments. Instead, we recommend that all facilities providing abortion care services automatically have an access zone created by law of a particular radius or diameter, consistent with law in Tasmania and Victoria.

Section 24, “Prohibited behaviour in relation to abortion facility”
As with section 23, we recommend against decisions being made by ministers, and instead have the ‘protected period’ defined in the legislation. We recommend that protected areas are deemed so 24 hours a day, to avoid confusion. People with a genuine interest in protest can do so elsewhere.

Section 25, “Publishing images of person entering or leaving abortion facility”
In addition to publishing images, we recommend that the taking of images, through photographic or electronic means also be prohibited, with the exception of police, staff of the service and neighbouring premises with a legitimate interest in taking images, where people entering or leaving the clinic is inconsequential to the purpose of taking of the image.

Thank you for the opportunity to comment on this additional bill, and we reiterate that the two bills need to be debated in the parliament as one.

Yours sincerely

Jenny Ejlak
President
Reproductive Choice Australia

APPENDIX – Extracts from Reproductive Choice Australia June 2016 submission.

Conscientious objection & referral

The Australian Medical Association (AMA) code of ethics[1] 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[2] 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[3] 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.

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.

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[1] 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

[2] 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

[3] 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

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[4] 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.

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.

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

[4] 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

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[5]. Changes in scope of practice for health professionals may see this happening in Australia before long.

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.

[5] 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/