The Research Director
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George St
Brisbane QLD 4000

By email: abortion.bill@parliament.qld.gov.au

14 October 2016

Dear Research Director,

Submission to the Health (Abortion Law Reform) Amendment Bill 2016

Executive summary

The authors of this submission support the decriminalisation of abortion in Queensland, and argue that the issue of termination of pregnancy should be dealt with as a health matter. Legalising abortion in Queensland would also achieve fundamental policy objectives including modernisation of the law to reflect community attitudes; provide clarity and certainty; protect and promote women's health and safety; facilitate equity of access to abortion services and enable health professionals to practice in a legally-certain environment. To achieve this, we recommend that:

1. Sections 224, 225 and 226 of the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed.

2. Queensland's abortion laws be governed by the legal principles of certainty; enforceability; justice and equity; autonomy; promotion of well-being and avoidance of harm; and should reflect contemporary community attitudes and medical practice.

We make the following recommendations in relation to the Health (Abortion Law Reform) Amendment Bill 2016:

3. That only an appropriately trained, registered medical practitioner (or registered nurse as indicated below) be able to lawfully perform an abortion. It should be a criminal offence to perform an abortion for persons other than a registered medical practitioner, or registered nurse administering a drug under the direction of a doctor.

4. The law should be clear that a woman does not commit an offence by performing, consenting to or assisting in performing an abortion on herself. This outcome would be best achieved by decriminalising abortion in Queensland by removing sections 224, 225 and 226 from the Criminal Code.

5. A two-tiered approach (similar to that in Victoria) be adopted to regulate termination of pregnancy by gestation periods, whereby:
   - Women may access an abortion on request up to 24 weeks gestation.
   - Abortions be available post-24 weeks gestation where one doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus.

6. The ability to make a conscientious objection to terminating a pregnancy be available to health practitioners in non-urgent situations, but incorporate an obligation to refer. We believe that a medical practitioner (and registered nurse) with a conscientious objection must be required by law to perform an abortion in an emergency where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health.

7. Access/buffer zones outside of facilities offering abortion services be implemented in Queensland, within a 150 metre radius of such facilities.

As a final point, we note that this submission represents the views of the authors, and is not made on behalf of all of the members of the Australian Centre for Health Law Research.

Background

We are the Directors and Co-ordinator of the Australian Centre for Health Law Research (ACHLR), a specialist research Centre within the Queensland University of Technology's Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

This submission draws heavily on our submission to the *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland* (dated 6 July 2016), and the evidence provided by Professors White and Willmott to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee at the Inquiry public hearing on 13 July 2016.

Decriminalisation of abortion in Queensland

Prior to addressing the specific issues raised by the Health (Abortion Law Reform) Amendment Bill 2016 ('the second Bill'), we reiterate our view that decriminalisation of abortion should occur in Queensland, and that that termination of pregnancy should be regulated by the law as fundamentally a women's health matter, rather than a criminal offence. Compelling evidence was provided at the first Inquiry as to why decriminalisation should occur, including that the current law is uncertain, fails to promote women's health, exposes women to harm and inequity, and does not reflect contemporary community standards.

Continuing to classify abortion in Queensland as a criminal offence warranting condemnation, punishment and penalties is problematic, harmful and counterproductive. Failure to determine this issue once and for all serves only to perpetuate uncertainty, delay and harm for women, their families, medical practitioners and the broader Queensland community. We strongly urge the Committee to recommend decriminalising abortion, and that sections 224, 225 and 226 of the *Criminal Code Act* 1899 (Qld) ('the Criminal Code') be repealed. This is needed to modernise existing laws, address the significant problems present in the current legal framework, and ensure greater access to treatment and certainty for women.

Legal principles that should inform the law governing termination of pregnancy

As noted in our previous submission and the evidence provided at the public hearing, we reiterate that the following legal principles should underpin the law governing abortion in Queensland.

a) Clarity and certainty

A fundamental problem with Queensland's current abortion law is its uncertainty, ambiguity and complexity, and the resulting confusion in its interpretation and application to women and doctors. This is primarily due to the unusual interaction between the Criminal Code offence provisions, and the common law. This, and other complexities of the existing Queensland laws on abortion, are explained more fully in our submission to the first Inquiry (refer to pages 5-7).

The current complexity of these laws has generated confusion and anxiety, both for women who are pregnant and wish to know their options about termination, and also for health professionals seeking to provide advice to women.

The case of *Medical Board of Queensland v Freeman* [2010] QCA 93 demonstrates the consequences and harm which can occur to both women seeking abortions and medical practitioners performing abortions if they are unclear about the law on abortion. In that case, a 19-week pregnant patient, who was suicidal, underwent an unsupervised outpatient termination from which serious complications arose. Freeman, her obstetrician, had prescribed her misoprostol to terminate the pregnancy as an outpatient as she mistakenly believed no hospital would assist a patient seeking a mid-trimester termination. Freeman was subsequently found to have behaved in way that constituted unsatisfactory professional conduct and was suspended.

Laws that are unclear cannot appropriately guide the community. Queensland's existing abortion laws need to be amended to provide clarity and certainty.

b) Enforceability of laws

Related to clarity and certainty is the issue of enforceability of laws. The rule of law provides that society should be governed by the law, obey it, and be able to be guided by it.[1] It is impossible to be appropriately guided by laws which are unclear and cause confusion.

A further fundamental proposition is that laws that are in force should be enforced. If laws are flouted and not enforced, our legal system is at risk of being brought into disrepute. In the context of laws that make an abortion illegal, this raises important points:

i) **Abortion offences are rarely enforced, and are difficult to enforce.** Prosecutions of women who procure an abortion, doctors who perform abortions, and other people who supply drugs or instruments to procure an abortion are extremely rare. The last Queensland prosecution of which the authors are aware occurred in 2010 in *R v Brennan and Leach*.[2] Prior to that, there had been no prosecutions of Queensland doctors since 1986 in *R v Bayliss and Cullen*.[3] Indeed prior to decriminalisation of abortion in other Australian jurisdictions, prosecutions were equally rare.[4] From a law enforcement perspective, it is incredibly difficult to obtain sufficient evidence that a termination has occurred, particularly given the existence of physician-patient privilege, which protects the privacy, confidentiality and dignity of the patient with respect to her health matters.

ii) **There is no public interest in pursuing abortions**. From the limited prosecutions which have occurred in Queensland, it appears (in addition to the difficulties in obtaining sufficient evidence to prosecute) there is very little interest from the Queensland Police Service or the Director of Public Prosecutions in prosecuting women or their doctors for these offences, even if it is known that a termination occurred. We do not consider it is in the public interest for prosecutions of women obtaining abortions or doctors to be prosecuted for performing what is, in essence, a women's medical procedure. Such prosecutions serve only to exacerbate the distress, harm and humiliation of the women concerned and their families, and have the potential to cause stress, anxiety and unwarranted damage to the reputation of their doctors.

c) Justice and equity

Queensland's laws should reflect the legal principles of fairness, justice and equity. In our view the current laws are inequitable, and disadvantage women seeking a termination. The fact that an abortion is unlawful necessarily affects the availability of the procedure. Women should have access

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[1] Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and law for the health professions* (4th ed, 2013) (Federation Press: Sydney) 56.
[2] *R v Brennan and Leach* (unrep, District Ct, Qld, Criminal Jurisdiction, 12-14 October).
[3] Victorian Law Reform Commission, *Law of Abortion Final Report*, Final report No 15, (March 2008) 21.
[4] For a full analysis of Australia's history of abortion-related prosecutions, see the Victorian Law Reform Commission's Final Report, ibid, ch 2.

to termination of pregnancies regardless of their economic circumstances, place of residence or other personal circumstances.

The practical application of the laws can cause economic disadvantage for women in Queensland seeking an abortion. It is understood that the majority of terminations are performed in private, not public facilities.[5] This means that women with greater access to financial resources are more likely to be able to afford the procedure. Making the procedure lawful is likely to increase its availability in public health services therefore increasing access to more women. This current inequity is further exacerbated for women residing in regional or remote Queensland who must travel long distances to access an abortion where services are not available locally. Increasing accessibility should reduce these costs. In our view, there should be equitable access to abortion for all women, regardless of location or economic status.

d) Autonomy

A fundamental principle that underpins laws in a liberal democracy and contemporary medical ethics is that of autonomy. This principle provides that women should be allowed to exercise autonomy and self-determination when making decisions about their bodies and health, including whether to continue with or terminate a pregnancy. Queensland's current abortion laws do not promote the value of autonomy, rather they significantly undermine women's autonomy by placing the decision about the lawfulness of termination in the hands of the woman's doctor and, therefore, the medical profession.[6] Women are responsible decision makers and should be afforded the right to decide what should be able to be done to their bodies. Except in limited circumstances (considered further below), their autonomy should not be constrained or subject to external decision-making by the medical profession or courts, as is currently the case in Queensland.

e) Promotion of well-being and avoidance of harm to the community

Queensland's laws should promote the wellbeing of its citizens and, to the extent that is possible, ensure its citizens are not harmed. In our view, the current law on abortion does not achieve these values as it does not allow women to make the decision that is in their best interests. It is an offence for a woman to procure an abortion and an offence for an abortion to be performed. Such an action is only excused if the doctor falls within the provisions of the section 282 defence. For that defence to be successful, the criteria of the section 282 provision requires something more than 'in the woman's best interests' to be proved. The law, therefore, does not currently allow a woman to make a decision about her body that is in her best interests, and fails the value of promoting her health.

If the Queensland law remains unchanged, unnecessary harms will continue to be inflicted on women and health professionals performing termination procedures. Examples of such harm include:

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[5] Dr Carol Portman, 'Therapeutic Abortion Provision' in Abortion in *Queensland conference report* (17 October 2008) <http://www.childrenbychoice.org.au/images/downloads/AbortionInQldConfReport2008.pdf>.
[6] Kerry Petersen, 'Classifying abortion as a health matter' in Sheila McLean, *First do no harm: Law, ethics and healthcare* (2006) (Ashgate: England) 355.

- Women and health professionals being exposed to potential criminal prosecution and penalties for procuring abortions.
- Continued barriers to access to abortions for women in rural and remote areas.
- The potential for women to seek 'backyard' abortions, or illegal abortions through importation of drugs from overseas (as occurred in *R v Brennan and Leach*).
- Women obtaining an abortion in unsafe circumstances, as occurred, for example in *Medical Board of Queensland v Freeman*.
- Harm, distress, humiliation and unnecessary delays for non-*Gillick* competent young women receiving a termination because of the need for court authorisation for an abortion, as well as confusion and anxiety for health practitioners.
- The impact of all of the above on a woman's physical and mental health (and the resulting effect on others i.e. existing children, partners, family members).

Unless and until abortion is treated by the law as a health issue rather than a criminal issue, the law will be unable to promote the value of health and avoidance of harm. Decriminalisation of abortion would in many cases eliminate or mitigate these harms.

f) Law should reflect community attitudes and medical practice

Queensland's laws should reflect contemporary community attitudes and standards as well as modern medical practice. Queensland's current abortion laws date from 1899 when the Criminal Code was first enacted. While the defence to abortion (section 282) has been amended in recent years, the offence provisions have not been revisited in more than a century. The three abortion offences (sections 224 – 226) are still contained within chapter 22 of the Code, entitled 'offences against morality', alongside bestiality and indecent dealings with children.

In the past 117 years there has been a fundamental shift in community views and attitudes towards abortion. There is evidence, including in peer-reviewed literature, of widespread support for reform of the law by the community, medical practitioners (including obstetricians and gynaecologists) and politicians. In our view, the fact that abortion and acts relating to it constitute offences under the Criminal Code and are regulated by the criminal law demonstrates that the laws are archaic and do not reflect community standards.

Response to the second Bill

In the following section we address the provisions contained in the second Bill:

1) Who may perform an abortion

We support the introduction of a provision in Queensland law which provides that only a doctor or a registered nurse administering a drug under the direction of a medical practitioner should be able to lawfully perform an abortion. We further agree that it should be a criminal offence for any other person to do so.

The Committee may wish to explore whether the legislation should refer to any potential role played by pharmacists. Pharmacists may also be involved in termination of pregnancies due to their role in prescribing medication which causes terminations.

2) Offence provisions relating to women and abortions

In principle, we agree that the law should be clear that a woman does not commit an offence by performing, consenting to or assisting in performing an abortion on herself. However, if abortion was decriminalised in Queensland, by removing sections 224, 225 and 226 from the Criminal Code, in our view the proposed provision would not be necessary. We reiterate our view that removal of these provisions should occur, thereby legalising abortion in Queensland.

3) Abortions for women more than 24 weeks pregnant

We consider that regulating termination of pregnancy by gestation periods should be incorporated into relevant legislation, and recommend the 'two-tiered' approach of the Victorian law, whereby a woman may access an abortion on request up to 24 weeks gestation, and in certain circumstances following 24 weeks gestation. However, in contrast to the Victorian law, we submit that following 24 weeks gestation, there should be no requirement for a second doctor to agree to the abortion, and that one doctor is sufficient for this purpose.

a) *Abortions prior to 24 weeks*

There is evidence that at 24 weeks a foetus is potentially viable, that is, capable of being born alive and surviving independently from its mother, albeit with medical intervention.[7] Accordingly, we consider it justifiable to treat termination up to 24 weeks gestation differently from a termination after this time. Up until 24 weeks gestation, we believe termination should be available to a woman who requests that procedure, and provides consent.

b) *Circumstances in which an abortion post-24 weeks can occur*

It is our submission that an abortion should be available post-24 weeks if the termination is requested by the woman and the following can be established:

> "a doctor reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the foetus."

[7] See for example the discussion in the VLRC report about relevance of viability, above n3, 40 – 41.

Number of practitioners involved

Where a woman is requesting a termination post 24 weeks, we consider that the agreement of only one doctor who is satisfied that the relevant criterion has been met, is needed, rather than two doctors. The decision to terminate a pregnancy is a serious and important one, and a woman would not come to a decision about termination without having carefully considered all relevant issues. We also believe that doctors who participate in the process would be aware of the interests involved. Unless there is reliable evidence that there is inappropriate conduct in the context of late-term terminations, we believe that law should interfere with the decision to terminate a pregnancy to the least extent possible. In our view, the gatekeeping role of one doctor is sufficient.

Grounds for termination

As articulated above, we believe that termination post 24 weeks should be possible if one of two grounds are satisfied. These are set out below.

(i) ***The woman's physical or mental health***

We consider that the woman's physical or mental health is an appropriate criterion for a woman to be able to obtain an abortion post-24 weeks. This criterion would promote the woman's health and safety, and would reduce risk and harm, whether physical or psychological, that may result if the pregnancy were to continue.

(ii) ***Serious medical condition of the foetus***

We note that termination on the grounds of a child's medical condition is a highly contentious issue. We consider that for an abortion on this ground to be lawful the condition of the foetus must be sufficiently grave. Western Australia is the only Australian jurisdiction which makes a similar provision for abortions post-20 weeks, on the grounds that the 'unborn child has a severe medical condition'. We note that this terminology is undefined in the legislation.[8] The United Kingdom also has not defined its analogous provision within the *Abortion Act 1967* (UK). Australian law academics Karpin and Savell note this is because the 'majority (in those Parliaments) understood that contextual matters would be significant in determining the meaning of 'severe medical condition' or 'serious handicap'....'.[9]

[8] Other jurisdictions make similar provisions, for example the United Kingdom. For a discussion of the position in that jurisdiction see the VLRC report, above n 29, and also Emily Jackson, *Medical law texts, cases and materials* (2006), 609-613.

[9] Isabel Karpin and Kristin Savell, *Perfecting Pregnancy: Law, Disability and the Future of Reproduction* (2012) (Cambridge University Press) 147. Comprehensive analysis of the relevant domestic and international debates concerning this issue are contained in this book.

4) Conscientious objection by health practitioners to termination of pregnancy

a) Legal duty to perform abortions in emergency situations

We believe that if a conscientious objection provision is introduced into Queensland law, specific provision must be made requiring a doctor to perform an abortion in emergency situations, and a registered nurse to assist, where it is necessary to save the life of the woman, or prevent serious injury to her physical or mental health. Care must be taken to uphold the safety and health interests of the woman at all times, and to avoid any situation where a woman loses her life, or sustains severe, permanent injury through a doctor's reluctance to terminate her pregnancy.[10]

b) Obligation to refer to another practitioner who does not have an objection

We further submit the proposed conscientious objection clause should include a legal obligation of referral, whereby a health practitioner exercising a conscientious objection is required by law to refer the woman to a practitioner who does not have an objection. Referral in those circumstances is critical to ensure the patient is able to receive appropriate advice and information about termination, and to reduce delay in securing a termination.[11]

An obligation to refer exists in Tasmania,[12] and in Victoria.[13] The Victorian provision requires the doctor with the conscientious obejction to refer the patient to a registered health practitioner in the same regulated health profession who the objecting doctor knows does not have a conscientious objection. The Tasmanian provision requires the objecting doctor to provide the woman with a list of prescribed health services from which she may seek advice, information or counselling on the full range of pregnancy options. We consider the Victorian provision a better model to ensure more timely and direct access to a qualified health practitioner who is known not to have a conscientious objection.

5) Access and safe zones around abortion facilities

We support the introduction of protected or safe zones outside of abortion facilities, and support implementation of these in Queensland. We note and agree with the principles underpinning the Victorian safe access zone laws which are that:

- the public are entitled to access health services, including abortions;

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[10] See for example the case of 31-year-old Irish woman Savita Halappanavar, who died of septicaemia in 2013 after hospital staff refused to perform an abortion of her 17 week old foetus. She subsequently died: Associated Press, 'Irish Jury finds poor care in death of woman denied abortion', *The New York Times* (online, 19 April 2013 <http://www.nytimes.com/2013/04/20/world/europe/jury-cites-poor-medical-care-in-death-of-indian-woman-in-ireland.html?_r=0>.

[11] VLRC report, above n3, 47.

[12] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s6.

[13] *Abortion Law Reform Act 2008* (Vic) s8.

- the public, employees and others who need to access abortion facilities should be able to enter and leave those premises without interference and in a manner which
    - protects the person's safety and wellbeing; and
    - respects the person's privacy and dignity.[14]

Women considering or receiving an abortion should not be subjected to harassment, bullying, intimidation or harm through protests, communications, distribution of offensive materials or other acts of aggressive behaviour, and are entitled to sufficient protection of their personal safety and privacy, by the law, in such situations. Staff and other persons entering or leaving abortion facilities are also entitled to protection from such behaviour. We also believe that such laws should prohibit publication of images of persons entering, leaving or trying to enter of leave abortion facilities. Sufficient penalties should be introduced to deter persons from engaging in such acts.

Currently the Victorian, ACT and Tasmanian laws make provision for these zones.[15] We note that in Victoria and Tasmania the laws establish safe access zones of a radius of 150 metres around abortion facilities. The proposed distance in the second Bill is 'at least 50 metres' only. We submit that safe access zones in Queensland should also be a radius of 150 metres, to ensure the utmost safety and protection of women and other people, including staff, entering those premises.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Committee further if additional information is required.

Yours sincerely

[redacted]

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Director

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[14] *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.
[15] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s9; *Health (Patient Privacy) Amendment Act 2015* (ACT) Div 6.2 and *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s185C.

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