

**Abortion Law Reform  
(Woman's Right to Choose)  
Amendment Bill 2016**

**and**

**Inquiry into laws governing  
termination of pregnancy in  
Queensland**

**Report No. 24, 55<sup>th</sup> Parliament  
Health, Communities, Disability Services and  
Domestic Family Violence Prevention  
Committee  
August 2016**



## Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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## Definitions

### ***Abortifacient***

An agent (e.g. a pharmaceutical drug) that induces abortion.

### ***Conscientious objection***

Conscientious objection is when a health practitioner refuses to provide, or participate in, a recognised treatment or procedure because it conflicts with his or her own personal beliefs and values.

### ***Foetal abnormality***

A term used by medical practitioners to describe a positive test or indication for certain genetic or other conditions in the foetus during pregnancy.

### ***Gestation***

Gestation is referred to in this report as a measure of the progress of a pregnancy, in terms of weeks, from the first day of a woman's last menstrual period.

### ***Gestational limits***

'Gestational limits' are sometimes referred to, in relation to termination of pregnancy, to set a fixed point in the pregnancy after which termination is either prohibited or subject to specific rules or conditions.

### ***Gillick-competence***

Refers to the legal concept of when a minor is competent to make decisions about their own medical treatment (see page 63).

### ***Late gestation termination***

'Late gestation termination' or 'late termination' generally refers to termination after gestation of between 20 and 24 weeks.

### ***Medical termination of pregnancy***

'Medical termination' or 'medical abortion' is the use of pharmaceutical drugs, most commonly Mifepristone followed by Misoprostol, to induce a termination. This method is considered suitable for pregnancies up to nine weeks gestation in an outpatient setting.

### ***Mifepristone***

Also known as RU 486, Mifepristone is a pharmaceutical that is administered to induce an early termination. It interferes with the body's use of progesterone — a key hormone for maintaining a pregnancy. When it is taken as the first step in a sequence of two medicines, followed by Misoprostol, Mifepristone starts the medical termination by relaxing and opening the cervix, and making the uterus sensitive to hormones called prostaglandins, which are responsible for starting contractions.

### ***Misoprostol***

This pharmaceutical mimics the natural prostaglandins produced by the body, which are responsible for starting contractions. When it is taken as the second step in a sequence of two medicines, Misoprostol continues the process of medical termination by further relaxing and opening the cervix, and causing contractions of the uterus so that its contents are expelled through the vagina.

### ***Miscarriage***

'Miscarriage' means loss of an embryo or foetus and is often referred to in medical literature as a 'spontaneous abortion'.

### ***Morning after pill***

A 'morning after pill' is a hormone treatment used for emergency contraception. It is considered most effective if taken up to 72 hours after having unprotected sex to prevent pregnancy.

### ***Surgical termination of pregnancy***

'Surgical termination' or 'surgical abortion' is where the contents of the uterus are removed surgically, most commonly by suction or curettage. Surgical termination may involve the prior use of medication or other techniques to dilate the cervix. This method may be used to terminate pregnancies from around five to six weeks gestation.

### ***Termination of pregnancy***

'Termination of pregnancy', as used in this report, means deliberately ending a pregnancy so it does not progress to birth. The report also uses the terms 'abortion', 'pregnancy termination' or simply 'termination', depending on the context.

### ***Trimester***

Pregnancy may be broken into three periods, or trimesters, each of approximately 14 weeks, for a total duration of 42 weeks. A pregnancy is considered full-term at 40 weeks.

## Abbreviations

ACHLR	Australian Centre for Health Law Research
ACL	Australian Christian Lobby
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
AUSSA	Australian Survey of Social Attitudes
BPAS	British Pregnancy Advisory Service
CEDAW	<i>Convention on the Elimination of all Forms of Discrimination Against Women</i>
Clinical Guideline	Queensland Health Clinical Guideline: <i>Therapeutic termination of pregnancy</i>
CRC	<i>Convention on the Rights of the Child</i>
CSCF	<i>Clinical Services Capability Framework for Public and Licensed Private Health Facilities</i> (Queensland Health)
GP	general practitioner
HHS	Health and Hospital Service - the statutory bodies established under the <i>Hospital and Health Boards Act 2011</i> , responsible for public hospitals and health services
ICCPR	<i>International Covenant on Civil and Political Rights</i>
ICESCR	<i>International Convention on Economic, Social and Cultural Rights</i>
IUD	intra-uterine device
NAAPOC	National Alliance of Abortion and Pregnancy Options Counsellors
NSW	New South Wales
OHCHR	Office of the High Commissioner for Human Rights
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia Inc.
POQA	<i>Parliament of Queensland Act 2001</i> (Qld)
private health facilities	private hospitals and day hospitals, licensed under the <i>Private Health Facilities Act 1999</i>

QNU	Queensland Nurses Union
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCOG	Royal College of Obstetricians and Gynaecologists (United Kingdom)
the Bill	Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016
the Code of Conduct	<i>Good medical practice: a code of conduct for doctors in Australia</i> (Medical Board of Australia)
the committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
the Crimes Act	<i>Crimes Act 1958</i> (Vic)
the Criminal Code	<i>Criminal Code Act 1899</i> (Qld)
the National Law	<i>Health Practitioner Regulation National Law Act 2009</i> (Qld)
TORUM Act	<i>Transport Operations (Road Use Management) Act 1995</i> (Qld)
UDHR	<i>Universal Declaration of Human Rights</i>
UK	United Kingdom
UN	United Nations
USA	United States of America
WHO	World Health Organisation

## Chair's foreword

This Report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, introduced by Mr Rob Pyne MP, independent Member for Cairns on 10 May 2016. Concurrent with its consideration of the Bill, the committee was also required to report on a broader terms of reference, received from the Legislative Assembly on 26 May 2016 (see page 1 of this report).

This report summarises the main issues considered by the committee in response to the terms of reference, and the committee's consideration of the Bill.

Any public discourse regarding abortion law can be expected to attract a high level of interest, as occurred in this inquiry. Community opinions about abortion are divergent, and often based on deeply held values. It is unlikely that public consensus about abortion can be achieved, and legislation cannot impose consensus.

The committee received over 1,400 submissions. Public hearings were held in Brisbane, Emerald and Cairns, with regional hearings attracting both media and public attention.

The committee gave careful consideration to the complex policy and legislative issues in regulating termination of pregnancy. The committee has recommended that the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 not be passed. The committee was unable to support the Bill as it failed to address a number of important policy issues and to achieve a number of its own stated objectives.

The committee has reported on a range of issues in its terms of reference and canvassed some options that might be considered in future.

On 17 August 2016 the Member for Cairns, Mr Rob Pyne MP, introduced a second Bill, the Health (Abortion Law Reform) Amendment Bill 2016. The committee had not commenced its inquiry into the second Bill at the time of finalising this report. The committee notes that the second Bill proposes to regulate some of the matters that have been raised during the committee's current inquiry. The contents of this report should not be taken as comment on the second Bill.

I would like to thank the Deputy Chair, the Member for Caloundra and my fellow committee members for their genuine and thoughtful contributions during the inquiry. On behalf of the committee, I would like to thank the many individuals and organisations who made written submissions and those who appeared at the committee's public briefings and public hearings.

Finally, I would like to acknowledge the significant assistance provided by the committee secretariat, the administrative work undertaken by Committee Support Officers who arranged public hearings, and processed and published over 1,400 submissions; Parliamentary Library researchers, and Hansard. In particular my thanks go to Inquiry Secretary, Sue Cawcutt.

I commend the report to the House.



Leanne Linard MP  
Chair





## Recommendation

The committee's recommendation pertains only to the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, introduced into the Legislative Assembly on 10 May 2016.

### **Recommendation 1**

The committee recommends that the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 not be passed.

On 17 August 2016 the Member for Cairns, Mr Rob Pyne MP, introduced another Bill, the Health (Abortion Law Reform) Amendment Bill 2016. That second Bill was referred to the committee for consideration on 17 August 2016. The committee has not begun its inquiry into the second Bill. The contents of this report should not be taken as comment on the second Bill.



## 1 Introduction

### 1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the committee) is a portfolio committee of the Queensland Legislative Assembly. The committee, formerly known as the Health and Ambulance Services Committee, commenced on 27 March 2015 under the *Parliament of Queensland Act 2001* (POQA) and the Standing Rules and Orders of the Legislative Assembly.<sup>1</sup> On 16 February 2016, the Legislative Assembly agreed to amend Standing Orders, renaming the committee and expanding its area of responsibility.<sup>2</sup>

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention, and
- Disability Services and Seniors.

Section 92 of the POQA provides that a portfolio committee is to deal with an issue referred to it by the Legislative Assembly or under another Act, whether or not the issue is within its portfolio area.

### 1.2 Terms of reference

On 10 May 2016 Mr Rob Pyne MP, the Member for Cairns, introduced the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (the Bill) as a Private Member's Bill.<sup>3</sup>

The Bill was referred to the committee for consideration on 10 May 2016. On 26 May 2016 the Legislative Assembly expanded the inquiry to include detailed terms of reference for the committee to consider and report on, concurrent with its examination of the Bill.

That the committee, concurrent with its consideration of the Bill, consider, report and make recommendations on aspects of the law governing termination of pregnancy in Queensland to the House on options regarding:

1. existing practices in Queensland concerning termination of pregnancy by medical practitioners
2. existing legal principles that govern termination practices in Queensland
3. the need to modernise and clarify the law (without altering current clinical practice), to reflect current community attitudes and expectations
4. legislative and regulatory arrangements in other Australian jurisdictions including regulating terminations based on gestational periods; and
5. provision of counselling and support services for women.

The committee is required to report by Friday 26 August 2016.

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<sup>1</sup> *Parliament of Queensland Act 2001*, section 88 and Standing Order No. 194.

<sup>2</sup> Hon Sterling Hinchliffe MP, Leader of the House, Queensland Parliament, Record of Proceedings, 16 February 2016, pp 18-20.

<sup>3</sup> Rob Pyne MP, Queensland Parliament, Record of Proceedings, 10 May 2016, p 1526.

### **1.3 Inquiry process**

The committee advertised the inquiry on its website and emailed stakeholders, including health, legal, and other professional groups, and women's, family, religious and non-government organisations to inform them of the inquiry and to invite written submissions. In addition over 1,100 subscribers to committee updates were notified of the inquiry and invited to make submissions.

The committee's consideration of the referral included calling for public submissions, and conducting public briefings and a series of public hearings.

To enable it to consider the significant issues in the terms of reference, including divergent community attitudes on abortion, the committee deliberated extensively on the material and evidence before it.

Material considered by the committee included: submissions, transcripts of committee proceedings, research published in refereed journals, clinical standards and guidelines, reports prepared by government and non-government organisations, legislation in other Australian jurisdictions, and research undertaken by the Parliamentary Library and committee staff. The committee also commissioned an independent expert assessment of community opinion surveys (see Chapter 8).

Submissions, transcripts of public briefings and hearings, papers tabled at hearings, and responses to questions taken on notice at the briefings and hearings are available from the committee's webpage.<sup>4</sup>

#### **1.3.1 Submissions**

The closing date for submissions was 30 June 2016. The committee received and considered 1,445 submissions. Many submitters addressed only whether or not they supported the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, rather than the broader terms of reference.

#### **1.3.2 Public proceedings**

The committee held public proceedings on eight days between June and August 2016. During its public briefings and public hearings the committee heard 31 hours of evidence and perspectives from stakeholders.

Three public briefings were held in Brisbane. The first was a briefing on the Abortion Law (Woman's Right to Choose) Amendment Bill 2016 by Mr Rob Pyne MP on 15 June 2016. The committee invited experts to brief it on 12 July 2016 about current practices concerning termination of pregnancy by medical practitioners, professional guidelines and standards, the psychological impacts of termination and lack of access to termination, and the provision of counselling and support services for women. On 13 July 2016 the committee was briefed by experts in health law and ethics about the current law, the need to clarify and modernise the law, and ethics and termination of pregnancy. The people who briefed the committee on 12 and 13 July represented nine organisations and are listed in Appendix C.

The committee held public hearings in Emerald on 14 July 2015, Cairns on 15 July 2016 and Brisbane on 1, 2 and 4 August 2016 (see Appendix C). Witnesses at public hearings included representatives of 25 organisations and 18 individuals who appeared in a private capacity.

The purpose of public hearings was to hear witnesses expand on their written submissions and provide supplementary information and answer questions from the committee. The committee was aware that many more stakeholders wished to present oral evidence than was possible in the time available; however, the committee considers it has heard from stakeholders with a broad range of perspectives and expertise.

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<sup>4</sup> [Abortion Law Reform \(Woman's Right to Choose\) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland](#)

### **1.3.3 Second Private Member's Bill introduced**

On 17 August 2016 the Member for Cairns, Mr Rob Pyne MP, introduced another Bill, the Health (Abortion Law Reform) Amendment Bill 2016. That second Bill was referred to the committee for consideration on 17 August. The committee has not begun its inquiry into the second Bill at the time of finalising this report. The committee notes that the second Bill proposes to regulate some of the matters that have been raised during the committee's current inquiry.

The committee is required to report to the Legislative Assembly on the second Bill by 17 February 2017.

The contents of this report should not be taken as comment on the second Bill.



# PART 1: CURRENT LAW AND PRACTICE

## 2 Current Queensland law

### 2.1 Introduction

Under Queensland law, abortion is a criminal offence, except as defined in court rulings which interpret the relevant provisions of the *Criminal Code Act 1899* (the Criminal Code).

This chapter provides an overview of the current criminal law in Queensland, including relevant case law, and summarises legislation that regulates abortion services in the private sector. It also outlines the law relating to informed consent to medical treatment and consent by a person who does not have the capacity to consent.

### 2.2 Offences relating to procuring an abortion

There are three sections of the Criminal Code which create offences related to abortion, set out below.

- Section 224 **Attempts to procure abortion** is the principal offence and provides that:

*Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.*<sup>5</sup>

- Section 225 **The like by women with child** applies to a woman who intends to procure her miscarriage:

*Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.*<sup>6</sup>

- Section 226 **Supplying drugs or instruments to procure abortion** applies to a person who supplies things such as drugs or instruments, knowing it is intended to procure a miscarriage:

*Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment for 3 years.*<sup>7</sup>

Sections 224, 225 and 226 refer to the 'unlawful' procurement of an abortion but do not define when an abortion may be considered unlawful. The inclusion of the word 'unlawful' in each of the three provisions implies that there are circumstances where an abortion is lawful.

### 2.3 Offences for killing an unborn child

In addition to the specific offences for procuring an abortion, the Criminal Code creates offences for killing an unborn child who is about to be delivered.

Section 313 **Killing unborn child** provides that it is a crime to prevent a child from being born alive when a woman is about to deliver a child:

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<sup>5</sup> Criminal Code Act 1899, s 224.

<sup>6</sup> Criminal Code Act 1899, s 225.

<sup>7</sup> Criminal Code Act 1899, s 226.

*(1) Any person who, when a female is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, the person would be deemed to have unlawfully killed the child, is guilty of a crime, and is liable to imprisonment for life*<sup>8</sup>

This section has been interpreted by Justice McGuire in *R v Bayliss and Cullen* (see section 2.4.4) as referring only to a child 'capable of being born alive'.<sup>9</sup>

*It is also an offence to assault a pregnant woman and destroy the life of an unborn child or cause grievous bodily harm or transmission of a serious disease to the child before birth:*

*(2) Any person who unlawfully assaults a female pregnant with a child and destroys the life of, or does grievous bodily harm to, or transmits a serious disease to, the child before its birth, commits a crime.*

*Maximum penalty—imprisonment for life.*<sup>10</sup>

The offence of assault of a pregnant female was added to the Criminal Code in 1997 in response to a case in which a woman's former boyfriend kicked her in the stomach, resulting in the death of her unborn child.<sup>11</sup>

## **2.4 When is abortion lawful in Queensland?**

### **2.4.1 'Unlawful' not defined in the Criminal Code**

The Criminal Code contains no explicit defence or exemption relating to abortion offences.<sup>12</sup> While sections 224, 225 and 226 of the Criminal Code refer to 'unlawful' acts, the term is not defined in the legislation. Court rulings about when an abortion is unlawful are described below.

### **2.4.2 Defence to liability under section 282 of the Criminal Code**

Section 282(1) provides:

*A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—*

*(a) a person or an unborn child for the patient's benefit; or*

*(b) a person or an unborn child to preserve 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.*<sup>13</sup>

While not originally intended to provide a defence in relation to procuring an abortion, the section was intended to be a defence to the offence of unlawful killing under section 313, following the interpretation of the section in *R v Bayliss and Cullen* (see section 2.4.4 below) that it is the defence available to health professionals.<sup>14</sup>

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<sup>8</sup> Criminal Code, s 313(1).

<sup>9</sup> *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, p 37

<sup>10</sup> Criminal Code, s 313(2).

<sup>11</sup> Hansard, *Transcript of proceedings*, Criminal Law Amendment Bill, 20 March 1997

<sup>12</sup> Katherine Kerr, 'Queensland Abortion Laws: Criminalising One in Three Women', *QUT Law Review*, 14(2), 2014, p 20.

<sup>13</sup> Queensland Criminal Code, section 282(1).

<sup>14</sup> Ben White and Lindy Willmott 'Termination of a minor's pregnancy: Critical issues for consent and the criminal law', (2009) 17 *Journal of Law and Medicine*, p 255.



The defence is relevant where the abortion is performed to preserve the mother's life, 'in one form or another',<sup>15</sup> but does not apply in circumstances where the treatment or operation is 'for the patient's benefit'.<sup>16</sup> However, the section 282 defence does not apply to women seeking an abortion, only to health professionals.<sup>17</sup>

It should be noted that section 282 was amended by the *Criminal Code (Medical Treatment) Amendment Act 2009* to include a reference to 'medical treatment' in addition to 'surgical operation'. This amendment followed the prosecution of a couple for procuring and using an abortion medication (*R v Brennan & Leach*, see section 2.4.6) and subsequent concerns raised by health professionals that they, and women prescribed abortifacient, could be similarly charged.<sup>18</sup> The amendment meant that it may be possible for the section 282 defence to apply where an abortion was brought about by medication, as well as surgery.<sup>19</sup>

According to the explanatory notes for the 2009 amendment:

*... [t]he proposed amendment to section 282 will not extend the set of circumstances in which a treatment, including a termination, may be lawfully administered. The section will still require that the treatment be administered in good faith, with reasonable care and skill, and for the benefit of the patient or (in relation to procedures that are intended to adversely affect an unborn child) the preservation of the mother's life. It will merely allow the treatment to be administered medically (for example, through the prescription of drugs) as an alternative to surgical treatment.*<sup>20</sup>

### 2.4.3 Menhennitt ruling

In 1969, a landmark Victorian Supreme Court ruling in *R v Davidson* established that an abortion may be lawful if the accused held an honest belief on reasonable grounds that the abortion was both necessary and proportionate.<sup>21</sup> An abortion may be lawful if it is necessary to protect the physical or mental health of the woman, provided that the danger involved in the abortion does not outweigh the danger which the abortion was designed to prevent. The ruling became known as the Menhennitt ruling after the trial judge.

The defendant, a doctor, was charged on four counts of unlawfully using an instrument or other means with intent to procure the miscarriage of a woman and one count of conspiring unlawfully to procure the miscarriage of a woman.<sup>22</sup>

At the time of the case, the relevant provisions in the *Crimes Act 1958* (Vic) (the Crimes Act) were similar to the current Queensland legislation. Both the Victorian and Queensland law were adopted from the *Offences Against the Person 1861* (UK).<sup>23</sup> The relevant offence provision, section 65 of the Crimes Act, stated:

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<sup>15</sup> Mark Rankin, 'Contemporary Australian abortion law: The description of a crime and the negation of a woman's right to abortion', *Monash Law Review*, 2001, 27(2), p 236; *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8,41

<sup>16</sup> Queensland Criminal Code, section 282(4).

<sup>17</sup> Explanatory Notes, Criminal Code (Medical Treatment) Amendment Bill 2009; Katherine Kerr, 'Queensland abortion laws: Criminalising on the three women', *QUT Law Review*, 2014, 14(2), p 22.

<sup>18</sup> Katherine Kerr, 'Queensland abortion laws: Criminalising on the three women', *QUT Law Review*, 2014, 14(2), p 22.

<sup>19</sup> Explanatory Notes, Criminal Code (Medical Treatment) Amendment Bill 2009, p 1.

<sup>20</sup> Explanatory Notes, Criminal Code (Medical Treatment) Amendment Bill 2009, p 2.

<sup>21</sup> *R v Davidson* [1969] VicRp 85; [1969] VR 667 (3 June 1969) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VicRp/1969/85.html>

<sup>22</sup> *R v Davidson*

<sup>23</sup> *R v Davidson*

*Whosoever being a woman with child with intent to procure her own miscarriage unlawfully administer to herself any poison or other noxious thing or unlawfully uses any instrument or other means, and whosoever with intent to procure the miscarriage of any woman whether she is or is not with child unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses and instrument or other means with the like intent, shall be guilty of an indictable offence, and shall be liable to level 5 imprisonment (10 years maximum).<sup>24</sup>*

Inclusion of the word 'unlawfully' in the section which was not defined in statute implied that, in certain circumstances, procuring a miscarriage may be lawful:

*Justice Menhennitt reasoned that the word "unlawfully" was meaningfully included in both the United Kingdom and Victorian legislation and implied that some abortions may therefore be performed lawfully; giving rise to exceptions under the legislation. Justice Menhennitt determined that lawful exceptions to offences are often adopted on grounds of necessity and proportionality. With consideration to Victorian and British case law Justice Menhennitt agreed that the deliberate inclusion of "unlawfully" and the very nature of the offence created (it would be medically and socially impractical to disallow all abortions) gave rise to the appropriate application of the principle of necessity.<sup>25</sup>*

The court ruled that a defence to abortion exists if the doctor honestly believed on reasonable grounds that the abortion was necessary to preserve the woman from serious danger to her life or her physical or mental health. The doctor must also honestly believe that, in the circumstances, the risks of the abortion are in proportion to those of continuing the pregnancy.<sup>26</sup>

In the words of Justice Menhennitt:

*For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him was (a) necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.<sup>27</sup>*

The Menhennitt ruling was significant because it:

*... laid the ground for broadening the common law by recognising the defence of necessity and by imposing a heavy onus of proof for a prosecution under section 65 of the Crimes Act 1958. The Crown must prove beyond reasonable doubt that the 'miscarriage' was procured by the accused and the crown must also negative the elements of necessity and proportion. According to this 'subjective/objective' test, for an abortion to be lawful the medical practitioner must prove that he or she honestly believed on reasonable grounds that it was necessary to protect the woman from serious danger to her life or physical or mental health.<sup>28</sup>*

The ruling is no longer in force in Victoria as section 65 of the Crimes Act was repealed. Abortion has not been a criminal offence in Victoria since the introduction of the *Abortion Law Reform Act 2008* (Vic).

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<sup>24</sup> *Crimes Act 1958* (Vic), section 65.

<sup>25</sup> Katherine Kerr, 'Queensland Abortion Laws: Criminalising One in Three Women', *QUT Law Review*, 14(2), 2014, pp 20-21.

<sup>26</sup> Caroline de Costa, *Never Ever Again: Why Australian Abortion Law Needs Reform*, Boolarong Press, 2010, p 37.

<sup>27</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, March 2008, <<http://www.lawreform.vic.gov.au/content/law-abortion-final-report-html-version>>, p 19.

<sup>28</sup> Antony Anghie and Garry Sturgess, *Legal Visions of the 21st Century: Essays in Honour of Judge Christopher Weeramantry*, Martinus Nijhoff Publishers, 1998, p 171.

#### 2.4.4 R v Bayliss and Cullen

In the 1986 case of *R v Bayliss and Cullen*, Judge McGuire of the District Court confirmed that the Menhennitt ruling applies in Queensland.<sup>29</sup> Two doctors were charged with unlawfully using force to a woman with intent to procure her miscarriage, contrary to section 224 of the Criminal Code. Judge McGuire followed Justice Menhennitt's reasoning and determined that the inclusion of 'unlawfully' in the legislation only criminalised those procedures that had not been performed lawfully.<sup>30</sup>

*R v Bayliss and Cullen* remains the current law in Queensland. It was affirmed by a single judge of the Queensland Supreme Court in *Veivers v Connolly*,<sup>31</sup> (see below).

While Judge McGuire adopted the Menhennitt ruling in allowing the section 282 defence to apply to abortion,<sup>32</sup> his Honour clarified this position by stipulating that

*...[t]he law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on whim or caprice does not insidiously filter into our society. There is no legal justification for abortion on demand<sup>33</sup>*

While affirming that the Menhennitt ruling applies in Queensland, Judge McGuire excluded consideration of the social and economic effects of continuing with the pregnancy, which had been permitted in New South Wales following the decision in *R v Wald*.<sup>34</sup>

As *R v Bayliss and Cullen* remains the current law, for an abortion to be legal the health professional must be satisfied that the circumstances meet the legal threshold, that is:

- termination of pregnancy is necessary to prevent serious danger to the woman's physical or mental health, and
- the danger of the medical or surgical treatment is not out of proportion to the danger intended to be averted.<sup>35</sup>

#### 2.4.5 Veivers v Connolly

The Menhennitt ruling, while not explicitly referenced, was affirmed in the Queensland 1994 civil case of *Veivers v Connolly*. The court held that as a result of her doctor's negligence in failing to adequately test for rubella, the woman was unable to lawfully terminate her pregnancy, leading to the birth of a severely handicapped child.<sup>36</sup> The child was 18 years old at the time of the case, profoundly deaf, blind and with serious learning difficulties, and required 24 hour care. The child's condition had no hope of improvement.

The woman stated that, had she known she had contracted rubella in the early stages of pregnancy, she would have requested that the pregnancy be terminated on account of the potential damage to the foetus.<sup>37</sup>

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<sup>29</sup> (1986) 6 QLR 8.

<sup>30</sup> *R v Bayliss and Cullen* (1986) 8 Qld Lawyer Reps 8, 45, cited in Katherine Kerr, 'Queensland Abortion Laws: Criminalising One in Three Women', *QUT Law Review*, 14(2), 2014, p 21.

<sup>31</sup> (1995) 2 Qd R 326.

<sup>32</sup> Note that s 282 of the *Criminal Code Act 1899* was amended in 2009 and that the decision in *R v Bayliss and Cullen* was handed down prior to the amendment. In making his decision, Judge McGuire relied on an earlier version of s 282.

<sup>33</sup> *R v Bayliss and Cullen* (1986) 123-4

<sup>34</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, March 2008, <<http://www.lawreform.vic.gov.au/content/law-abortion-final-report-html-version>>, p 21; *R v Wald* [1971] 3 DCR (NSW), 25.

<sup>35</sup> Queensland Health, *Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013.

<sup>36</sup> (1995) 2 Qd R 326, 327.

<sup>37</sup> (1995) 2 Qd R 326, 327.

Justice de Jersey stated:

*Ultimately it came to essentially this: the defendant negligently failed to carry out a proper course of blood testing to determine whether or not the first plaintiff was suffering from rubella; proper blood testing would have revealed that she was; in those circumstance, he would prudently have advised her of the possibility of terminating the pregnancy; and the pregnancy would in all probability have been terminated.*<sup>38</sup>

His Honour concluded that had the infection been detected, and known to have been contracted in such an early stage of pregnancy, the doctor would have been aware that there was an extremely high risk that the child would be disabled.

His Honour considered that a key test for establishing whether a termination would have been lawful was whether such a procedure would have been categorised as an operation ‘...upon an unborn child for the preservation of the mother’s life’, as defined under section 282 of the Code.<sup>39</sup>

Justice de Jersey stated:

*This has been interpreted to encompass, as relevant here, an operation necessary to preserve the woman from a serious danger to her mental health which would otherwise be involved should the pregnancy continue... I am satisfied that in Queensland, ... were it known that a woman had been infected with rubella in the early stages of pregnancy, therapeutic terminations commonly occurred, provided the necessary certificates and consents were obtained.*<sup>40</sup>

#### **2.4.6 R v Brennan & Leach**

In the 2010 case of *R v Brennan & Leach* a Queensland woman was charged under section 225 of the Criminal Code with procuring her own miscarriage, by using abortion drugs imported from overseas.<sup>41</sup> Her partner was charged under section 226 with supplying the drugs. The offence in section 225 is that a woman ‘unlawfully administers to herself any poison or other noxious thing...’. The couple were acquitted on the grounds that the drug used was not a substance ‘noxious’ to the woman.<sup>42</sup>

Following *R v Brennan & Leach*, section 282 of the Code was amended to relieve a person from criminal responsibility for the administration of medical treatment. The amendment ensured that the legal protection was provided to medical practitioners for the appropriate use of medical and surgical procedures alike.<sup>43</sup>

#### **2.4.7 Recognition of common law to explain legislation**

The Australian Centre for Health Law Research (ACHLR) observed that the courts have ‘...recognised that the application of the common law in Queensland, a code jurisdiction, is limited’.<sup>44</sup> The ACHLR cited Mr RS O’Reagan QC, on the section 282 defence:

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<sup>38</sup> (1995) 2 Qd R 326, 327.

<sup>39</sup> Please note that s 282 of the *Criminal Code Act 1899* was amended in 2009 and that the decision in *Veivers v Connolly* was handed down prior to the amendment.

<sup>40</sup> (1995) 2 Qd R 326, 329-330.

<sup>41</sup> (2010) QDC 329.

<sup>42</sup> Kerry Petersen, ‘Abortion Laws and medical developments: a medico-legal anomaly in Queensland’, *J. Law Med*, 18(3), March 2011.

<sup>43</sup> Explanatory Notes, Criminal Code (Medical Treatment) Amendment Bill 2009, pp 1-2.

<sup>44</sup> Submission 1221, p 7, citing *State of Queensland v Nolan* (2002) 1 Qd R 454, 7, where Justice Chesterman stated: ‘[t]he doctrine [of necessity] is, however, a creature of the common law and finds only a very limited role in the Code’; *R v Bayliss and Cullen* (1986) 6 QLR 8, 34-35; and Belinda Bennett and Kerry Petersen, ‘Abortion’ in Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia*, 2nd ed., 2014, Thomson Reuters, p 448.

*Resort to common law principles to supplement and explain statute law ... must be regarded as very unusual in Queensland, which has a comprehensive Criminal Code, and one which does not have common law defences.*<sup>45</sup>

The ALHR concluded that ‘...the legal regulation of abortion in Queensland rests on shaky legal foundations...’ and ‘...is complex and uncertain’.<sup>46</sup> Views about uncertainty of the current law are discussed in further detail in Chapter 12.

## **2.5 Licence required to operate private hospitals and day hospitals**

### **2.5.1 Standards applying to all private and day hospitals**

Private and day hospitals in Queensland (collectively referred to as ‘private health facilities’) must be licensed under the *Private Health Facilities Act 1999*. Under that Act, the Chief Health Officer makes standards with which licensed private health facilities must comply, including, for example, standards for infection control, ethics, clinical privileges, and patient care.<sup>47</sup>

### **2.5.2 Specific standards for termination services**

Additional standards apply under the *Private Health Facilities Act 1999* to private health facilities which provide ‘speciality health services’. The ‘speciality health services’ include termination of pregnancy. These additional standards require private hospitals and day hospitals that provide terminations, comply with:

- Queensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities and Companion Document for Licensed Private Health Facilities, and
- appropriate college / professional body guidelines.

The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities (CSCF)* and *Companion Document for Licensed Private Health Facilities*<sup>48</sup> sets out six levels of clinical service, ranging from low complex ambulatory care services (Level 1) to high complex inpatient and ambulatory care services (Level 6). The CSCF specifies requirements for each of the six levels of facility, for example in anaesthesia, surgery and pharmacy.

A private health facility that provides termination of pregnancy services is designated a Level 3 service. Facilities that provide termination of pregnancy services must comply with additional requirements, for example:

- services are provided to low risk patients
- medical practitioners have credentials in surgery or anaesthesia
- 24 hour access to a registered medical practitioner
- access to registered medical specialists with credentials in surgery for advice
- suitably qualified and experienced nursing staff

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<sup>45</sup> Submission No. 1221, p 7, citing RS O’Reagan, ‘Surgery and Criminal responsibility under the Queensland Criminal Code’, *Criminal Law Journal*, 14(73), 1990, pp 80-81.

<sup>46</sup> Submission 1221, p 7.

<sup>47</sup> Queensland Health, *Private health facilities: legislation, standards and building codes*, < <https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards/default.asp>>.

<sup>48</sup> Queensland Health, *Private health facilities: clinical services capability framework*, < <https://www.health.qld.gov.au/system-governance/licences/private-health/cscf/default.asp>>.

- access to psychological counselling pre-termination from qualified professionals (for example, psychologist, social worker, counsellor).<sup>49</sup>

As noted above, a licensed private health facility must provide services in accordance with appropriate college and professional body guidelines. Chapter 4 describes the guidelines of specialist medical colleges and professional bodies that are relevant to termination of pregnancy.

## 2.6 Informed consent to treatment

The common law governs consent to medical treatment of all kinds, including termination of pregnancy. Health professionals have a legal obligation to obtain a patient's consent prior to performing the medical treatment;<sup>50</sup> consent may be written, verbal or implied.<sup>51</sup> Consent will only be valid if the consent is voluntary<sup>52</sup> and not obtained fraudulently or with reckless indifference.<sup>53</sup>

A health professional must provide sufficient information for a woman to make an informed decision about whether to consent to the termination procedure. The information should include advice about the material risks or possible complications associated with the procedure and the likelihood of complications occurring, and alternative treatment options.<sup>54</sup> The exact nature of the information that must be disclosed depends on the circumstances:

*What a careful and responsible doctor would disclose depends upon the circumstances. The relevant circumstance include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient and the general surrounding circumstances.*<sup>55</sup>

### 2.6.1 Capacity to consent

#### 2.6.1.1 Consent in relation to an adult

A patient must be a competent adult with capacity to consent to medical treatment. A woman aged 18 or over is presumed to be competent to make her own decisions in the absence of evidence that she does not understand the nature of her condition or the medical treatment.<sup>56</sup>

A woman aged 18 or over with impaired cognitive capacity (for example because of intellectual disability or a health condition) who does not have sufficient understanding and intelligence to make a decision cannot consent to the termination of her pregnancy.<sup>57</sup> Consent must be provided by the Queensland Civil and Administrative Tribunal.<sup>58</sup>

#### 2.6.1.2 Consent in relation to a minor

A minor can consent to medical treatment if they have sufficient maturity and intelligence to understand the nature and consequences of the treatment; they are referred to as

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<sup>49</sup> Queensland Health, *Termination of pregnancy services: CSCF companion manual*, v 4.3, <  
<https://www.health.qld.gov.au/publications/system-governance/licences/private-health/cscf-comp-terminat-pregnancy.pdf>>.

<sup>50</sup> *Rogers v Whittaker* (1992) 175 CLR 479.

<sup>51</sup> *Re T (adult: refusal of medical treatment)* (1992) 4 All ER 649, p 653.

<sup>52</sup> *Norberg v Wynrib* (1992) 2 SCR 226; (1992) 92 DLR (4th) 449.

<sup>53</sup> *Dean v Phung* (2012) NSWCA 223.

<sup>54</sup> *F v R* (1983) 33 SASR 189, p 192 confirmed in *Rogers v Whittaker* (1992) 175 CLR 479, p 490.

<sup>55</sup> *F v R* (1983) 33 SASR 189, p 192-193, confirmed in *Rogers v Whittaker* (1992) 175 CLR 479, p 488.

<sup>56</sup> *Re C (adult: refusal of medical treatment)* (1994) 2 FCR 151.

<sup>57</sup> *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, p 237, 238; applying the test in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC 112.

<sup>58</sup> Guardianship and Administration Act 2000, s 68 and sch 2(7).

'Gillick-competent'.<sup>59</sup> Therefore, if a girl is under 18 and has sufficient understanding and intelligence to make a decision to terminate her pregnancy, she is able to provide a valid legal consent to the procedure.

If a girl is not Gillick-competent, she cannot consent to the termination of her pregnancy, and the legal position in Queensland is that a decision must be made by a court; it is beyond the scope of parental decision-making to consent.<sup>60</sup>

Young women and the capacity to consent is discussed further in Chapter 11.

### **2.6.2 Treatment without consent in emergency**

In an emergency, a health professional may treat a patient without obtaining their consent, providing they reasonably believe the treatment is necessary to save the patient's life.<sup>61</sup>

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<sup>59</sup> Secretary, *Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, p 237, 238; applying the test in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC, 112.

<sup>60</sup> Australian Centre for Health Law Research, submission 1221, p 13.

<sup>61</sup> *Rogers v Whitaker* (1992) 175 CLR 479.

### 3 Law in other Australian jurisdictions

#### 3.1 Overview

The committee was required by its terms of reference to consider the legislative and regulatory arrangements in other Australian jurisdictions, including regulation of terminations based on gestational periods. This chapter provides a snapshot of the law in other Australian jurisdictions. More detailed information about the law is contained in Appendix A of this report.

#### 3.2 Decriminalisation

Three Australian jurisdictions – Australian Capital Territory (ACT), Tasmania and Victoria – have decriminalised abortion. In both Victoria and Tasmania, legislation provides additional requirements for abortion after gestation of 24 weeks and 16 weeks respectively.

##### 3.2.1 New South Wales

Similar to Queensland, abortion is an offence under the *Crimes Act 1900* (NSW) if it is performed 'unlawfully'. Court rulings have defined abortion as 'lawful' if the doctor considers it is necessary to preserve the woman from serious danger to her life or physical or mental health, and that the effects of economic or social stress may be taken into account in assessment mental health.

##### 3.2.2 Victoria

Abortion is no longer a crime as a result of the *Abortion Law Reform Act 2008* (Vic):

- up to 24 weeks gestation: a medical practitioner may perform an abortion on a woman upon request
- after 24 weeks gestation: a medical practitioner may only perform an abortion where the practitioner and at least one other medical practitioner reasonably believes that the abortion is appropriate in all the circumstances.

##### 3.2.3 South Australia

Under the *Criminal Law Consolidation Act 1935* (SA):

- up to 28 weeks gestation: abortion is lawful if two medical practitioners agree the woman's physical and/or mental health is at greater risk by continuing the pregnancy than from termination, or that the child is at risk of being seriously handicapped. A two-month residency requirement applies
- after 28 weeks gestation: the termination must be necessary to save the woman's life or prevent grave injury to her physical or mental health.

##### 3.2.4 Western Australia

Abortion is illegal under the Western Australia Criminal Code unless performed by a medical practitioner in good faith, with reasonable care and skill and is justified under the *Health Act 1911*:

- up to 20 weeks gestation: abortion is justified with the informed consent of the woman
- after 20 weeks gestation: abortion is not justified unless two appointed medical practitioners agree the woman or unborn child has a severe medical condition and the procedure is performed in an approved facility.



### **3.2.5 Tasmania**

Abortion is no longer a crime under the Tasmanian *Criminal Code Act 1924*. Under the *Reproductive Health (Access to Terminations) Act 2013*:

- up to 16 weeks gestation: abortion is allowed with the woman's consent
- after 16 weeks gestation: two medical practitioners must agree that the woman's physical and/or mental health is at greater risk by continuing the pregnancy.

### **3.2.6 Australian Capital Territory**

Abortion is no longer a crime under the *Crimes Act 1900 (ACT)*. Under the *Medical Practitioners (Maternal Health) Amendment Act 2002*, abortion is available on request.

### **3.2.7 Northern Territory**

Abortion is illegal under the *Criminal Code Act* but is lawful in certain circumstances provided in the *Medical Services Act (NT)*:

- up to 14 weeks gestation: if two medical practitioners agree the woman's physical and/or mental health is at greater risk by continuing the pregnancy, or there is substantial risk of the child being seriously handicapped; an abortion must be performed in a hospital.
- after 14 weeks and up to 23 weeks gestation: abortion is lawful if immediately necessary to prevent serious harm to the woman's physical or mental health.

After 23 weeks, abortion is an offence under the *Criminal Code Act*.

## **3.3 Conscientious objection**

The law in Victoria, South Australia, Western Australia, Tasmania, the ACT and Northern Territory provides that a person is not under a duty to participate in the performance of an abortion if they have a conscientious objection. However, in an emergency to save a woman's life or prevent serious injury, a health practitioner with a conscientious objection cannot refuse to treat the woman.

Queensland law does not specifically provide for conscientious objection; however, guidelines set out the expectations of health practitioners with a conscientious objection (see Chapter 4 for a summary of relevant guidelines). Conscientious objection is discussed in more detail in Chapter 16 of this report.

## **3.4 Safe access zones**

Victoria, Tasmania and the ACT have legislated to create safe access zones around health facilities where abortions are provided. In those zones it is an offence for a person to harass or threaten a person. The legislation is outlined in more detail in Chapter 17 of this report.

## **4 Regulation of medical practitioners and the termination of pregnancy**

### **4.1 Medical Board of Australia – Health Practitioner National Law**

#### **4.1.1 Registration**

All medical practitioners, nurses, psychologists, and eleven other health professions must be registered under the *Health Practitioner Regulation National Law Act 2009* (the National Law).

The Australian Health Practitioner Regulation Agency (AHPRA) provides services to the national boards, such as the Medical Board of Australia, which is responsible for regulating health practitioners. The primary role of the Medical Board of Australia, and other national boards, is to protect the public. They set standards and policies that registered health practitioners must meet.

#### **4.1.2 Disciplinary action under the Health Practitioner National Law**

The National Law sets out a framework for the registration and discipline of registered health professionals.

If a medical practitioner is not meeting the standards of the profession, they may be subject to disciplinary action, with outcomes including conditions on a medical practitioner's registration or suspension of registration resulting in inability to practice for a specified period. The most serious disciplinary action is cancellation of a medical practitioner's registration.

#### **4.1.3 Medical Board – Code of conduct for doctors**

The Medical Board of Australia has issued a code of conduct for doctors: *Good medical practice: a code of conduct for doctors in Australia* (the Code of Conduct). The explanation of use of the Code of Conduct includes:

*If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration.*<sup>62</sup>

The Code of Conduct addresses matters such as professional values and qualities, good patient care, confidentiality, shared decision-making, access to medical care, and treatment in an emergency.

In relation to professional values and qualities, the Code of Conduct includes:

*Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.*

*Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.*

*Doctors have a responsibility to protect and promote the health of individuals and the community.*

The Code of Conduct in relation to conscientious objection states that good medical practice involves both:

*2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.*

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<sup>62</sup> Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, 2014, <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>>, p 4.

and:

*2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.*<sup>63</sup>

## 4.2 Guidelines and standards for the medical profession

### 4.2.1 Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the specialist medical college responsible for training and accreditation of specialists in obstetrics and gynaecology. It also supports research into women's health and acts as an advocate for women's health care by forging productive relationships with individuals, the community and professional organisations, both locally and internationally.<sup>64</sup>

Standards and publications issued by RANZCOG informed the committee's consideration of the matters in its terms of reference. The relevant standards and guides and a brief summary of relevant content follows.

#### 4.2.1.1 College Statement: Termination of Pregnancy, March 2016

*Termination of Pregnancy* emphasises the importance of a national sexual and reproductive health strategy and states that prevention of unintended pregnancy should be a priority. RANZCOG specifically supports ready access to a wide range of safe and reliable contraceptive measures and encourages professional and community education about long-acting reversible contraception.

RANZCOG states that access to termination services should be on the basis of health care need. It notes the importance of a woman's physical, social, emotional and psychological needs in the course of counselling and decision-making. Pregnancy termination services should be subject to all appropriate standards for clinical assessment, safety and aftercare. The College Statement states, 'Women should be provided with accurate information including that termination of pregnancy is a safe procedure for which major complications are rare.'<sup>65</sup>

#### 4.2.1.2 College Statement: Late Termination of Pregnancy May 2016

*The College recognises special circumstances where late termination of pregnancy may be regarded by the managing clinicians and the patient as the most suitable option in the particular circumstance. The following are some rare but important circumstances where this might be deemed necessary:*

- *where one foetus in a multiple pregnancy has a severe abnormality and the others do not*
- *a serious foetal abnormality where the prognosis may not be known until late in the pregnancy*
- *where a diagnosis is not known until late in pregnancy.*<sup>66</sup>

Late termination of pregnancy is discussed in chapter 7 of this report.

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<sup>63</sup> Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, 2014, <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>>, p 7.

<sup>64</sup> RANZCOG, *Vision and Mission*, <<http://www.ranzcog.edu.au/the-ranzcog/about-the-college/vision-and-mission.html>>.

<sup>65</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *College Statement: Termination of pregnancy*, C-Gyn 17, March 2013.

<sup>66</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *College statement: Late termination of pregnancy*, May 2016.

#### 4.2.1.3 *The use of Mifepristone for medical termination of pregnancy, reviewed February 2016*

The RANZCOG statement provides up-to-date information on clinical recommendations for the use of mifepristone for termination. Chapter 7 contains more information about medical abortion.

#### 4.2.1.4 *Termination of pregnancy: a resource for health professionals, November 2005*

The resource booklet provides an overview of the methods that may be used to terminate a pregnancy prior to 20 weeks gestation. It is cited in later chapters of this report.

### 4.2.2 Australian Medical Association

The Australian Medical Association (AMA) is a member-based advocacy organisation to which a significant proportion of doctors belong. The AMA is not responsible for regulation of doctors; however, it issues position statements and policies to provide guidance to doctors.

The AMA Position Statement *Sexual and Reproductive Health* was published in 2014. It recommends a coordinated national strategy for sexual and reproductive health and focuses on primary prevention, including ready access to safe and affordable contraception, including emergency hormonal contraception.

### 4.2.3 Queensland Health Clinical Guidelines and Standards

The Queensland Health Clinical Guideline *Therapeutic termination of pregnancy*<sup>67</sup> is referenced in Chapter 7 of this report. The Clinical Guideline applies to public hospitals, and, as a requirement of licensing under the *Private Health Facilities Act 1999*, it also applies to licensed private health facilities (private hospitals and day hospitals) which undertake terminations (see section 2.5). Other relevant Queensland Health Clinical Guidelines are *Perinatal care at the threshold of viability*<sup>68</sup> and a supplement to that guideline.

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<sup>67</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, <  
<https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>>.

<sup>68</sup> Queensland Health, *Perinatal care at the threshold of viability*, 2014 <https://www.health.qld.gov.au/qcg/documents/g-viability.pdf>

## 5 International human rights law

### 5.1 Overview

International instruments relevant to the consideration of abortion include the Universal Declaration of Human Rights (UDHR), as well as:

- the *International Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW)
- the *International Covenant on Economic, Social and Cultural Rights* (ICESCR)
- the *International Covenant on Civil and Political Rights* (ICCPR), and
- the *Convention on the Rights of the Child* (CRC).

The First Optional Protocol to the ICCPR and two optional protocols under the CRC are also relevant to the consideration of abortion. The optional protocols introduce complaints systems that allow individuals, who have exhausted all remedies available in domestic law, to bring a complaint about a breach of rights under the treaty for consideration by a committee of independent experts.<sup>69</sup>

The Commonwealth Government has ratified the international instruments and protocols outlined above, indicating an intention to implement the obligations in the instruments in good faith and to legislate in accordance with the principles of the instruments.<sup>70</sup> However, ratifying the instruments does not automatically create rights and duties enforceable by individuals in Australia. The rights and duties contained in these instruments will only have force in Australia if they are incorporated into Australian legislation.<sup>71</sup>

It is also important to note that under the Australian Constitution, international instruments can only be entered into and ratified by the Commonwealth; Queensland has no authority to enter into international treaties.

### 5.2 Recognition of the right of women to equality

In ratifying the CEDAW, Australia accepted an obligation to eliminate discrimination against women through legislative and service interventions that embody the principle of equality of men and women in all matters.

This includes, in article 2(g) of the CEDAW, a requirement that ratifying countries repeal provisions that constitute discrimination against women.

Article 16(1)(e), furthermore, requires countries to:

*...take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations, and in particular shall ensure on a basis of equality of men and women... the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.*

The CEDAW Committee has stated in relation to these articles that 'it is discriminatory for a [country that is a party to the convention] to refuse to legally provide for the performance of certain

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<sup>69</sup> United Nations Office of the High Commissioner for Human Rights, *Human Rights Bodies - Complaints Procedures*, [www.ohchr.org/EN/HRBodies/TBPetitions/Pages/HRTBPetitions](http://www.ohchr.org/EN/HRBodies/TBPetitions/Pages/HRTBPetitions).

<sup>70</sup> Martin Flynn, *Human Rights in Australia: Treaties, Statutes and Cases*, LexisNexis Butterworths, 2003, p 5.

<sup>71</sup> *Teoh* (1995) 183 CLR 273; *Kioa v West* (1985) 159 CLR 550.

reproductive health services for women'. Further, 'the criminalisation of health services that only women require, including abortion, is a form of discrimination against women'.<sup>72</sup>

### 5.3 Recognition of the right of women to control their sexual and reproductive health

Although no international instruments contain an explicit reference to a 'right to abortion', a number of instruments do recognise certain rights in relation to sexual and reproductive health and family planning and establish associated legislative and service provision requirements for ratifying countries.

The CEDAW committee recognises a range of rights including bodily autonomy and reproductive choice, and article 3 requires ratifying countries to take appropriate measures to guarantee the enjoyment and exercise of these rights. The CEDAW committee has stated that forcing women to continue a pregnancy, especially in circumstances where the pregnancy is a result of rape or incest, or where there is a threat to the woman's health, violates the woman's right to health and right to be free from cruel, inhuman and degrading treatment.<sup>73</sup> The CEDAW Committee, in its general recommendations, has also called on countries to 'ensure that measures are taken to prevent coercion in regard to fertility and reproduction'.<sup>74</sup>

Article 12 of the ICESCR also provides for 'the right to the highest attainable standard of physical and mental health', a right that is mirrored in relation to children in article 24 of the CRC.

The supervisory committee for the ICESCR has interpreted the right to health to include 'the right to control one's health and body, including sexual and reproductive freedom'. This interpretation has been affirmed and clarified by the Special Rapporteur on the right to health, who has asserted that laws criminalising abortion 'infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health'.<sup>75</sup>

The Committee on the Rights of the Child has similarly recommended countries 'work to ensure that girls can make autonomous and informed decisions on their reproductive health' in accordance with their evolving capacities, including providing 'education and guidance on sexual health, contraception and safe abortion'.<sup>76</sup>

In keeping with the directions of these human rights bodies, the OHCHR has issued an information series on sexual and reproductive health rights, which provides specific guidance for law and policy makers and judiciaries in relation to abortion to support the effective implementation of laws and policies which reflect these directions.<sup>77</sup>

### 5.4 Recognition of the right of women to access termination services

Article 12 of the CEDAW requires health services, including abortion, be made available to all women in ratifying countries.

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<sup>72</sup> OHCHR, Information series on sexual and reproductive health and rights: Abortion, <[www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)>.

<sup>73</sup> OHCHR, Information series on sexual and reproductive health and rights: Abortion, <[www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)>.

<sup>74</sup> Committee on the Elimination of All Forms of Discrimination against Women, *General Recommendation No. 19: Violence against women*, 11<sup>th</sup> session, 1992, [24].

<sup>75</sup> United Nations General Assembly, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 66<sup>th</sup> session, UN Doc A/66/254, 2011, [21].

<sup>76</sup> Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24), UN Doc CRC/C/GC/15, 17 April 2013, [56].

<sup>77</sup> OHCHR, Information series on sexual and reproductive health and rights: Abortion, <[www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)>.

The CEDAW committee, in its general recommendations, has called on countries to ensure women are not forced to seek unsafe medical procedures such as illegal termination because of lack of appropriate services in regard to fertility control.<sup>78</sup>

In February 2014, the CEDAW Committee further stated:

*States parties [countries] should legalize abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe foetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. States parties [countries] should also remove punitive measures for women who undergo abortion.*<sup>79</sup>

On 9 June 2016, the UNHRC called on Ireland to remove its ban on terminations and to compensate a woman who was refused a termination after her foetus was diagnosed with a congenital heart defect. The UNHRC found that the woman (who was made to choose between carrying her foetus to term knowing it would not survive, or seeking an abortion abroad) was subjected to discrimination and 'cruel, inhuman or degrading treatment' as a result of Ireland's legal prohibition of abortion in contravention of article 7 of the ICCPR.<sup>80</sup>

The UNHRC concluded that Ireland must amend its law to ensure compliance with the ICCPR, including effective, timely and accessible procedures for abortion, and take measures to ensure healthcare providers are in a position to supply full information on safe abortion services without fear of being subjected to criminal sanctions.<sup>81</sup>

The Committee on the Rights of the Child has also called for the decriminalisation of abortion in response to the health consequences of unsafe terminations, recommending that countries 'ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal'.<sup>82</sup> The Committee on the Rights of the Child has found that safe access to terminations is necessary for the right to enjoyment of the highest standard of health.<sup>83</sup>

## 5.5 Access to services to ensure the recognition of women's rights

The OHCHR has emphasised that legal reform alone is not enough to fulfil human rights obligations, as in some cases ambiguity surrounding the implementation of the law or ancillary service provision issues may obstruct access to services required by women's recognised right to health.<sup>84</sup>

This may include:

- access issues associated with conscientious objection
- a lack of access to pregnancy termination services in public hospitals, which disadvantages women on low incomes who may be unable to pay for a termination at a private clinic, and

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<sup>78</sup> Committee on the Elimination of All Forms of Discrimination against Women, *General Recommendation No. 19: Violence against women*, 11<sup>th</sup> session, 1992, [24].

<sup>79</sup> OHCHR, *Information series on sexual and reproductive health and rights: Abortion*, <[www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)>.

<sup>80</sup> Human Rights Committee, Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication No. 2324/2013, 116<sup>th</sup> session, UN Doc CCPR/C/116/D/2324/2013, 31 March 2016 [7.6].

<sup>81</sup> OHCHR, Press release: Ireland termination ban subjected woman to suffering and discrimination – UN experts, <[www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20077&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20077&LangID=E)>.

<sup>82</sup> Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24), UN Doc CRC/C/GC/15, 17 April 2013, [70].

<sup>83</sup> *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24.

<sup>84</sup> Office of the High Commissioner for Human Rights, *Information series on sexual and reproductive health and rights: Abortion*, <[www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)>.

- inadequate services in regional areas.

The UN has expressed concerns about abortions, even where legally available, being practically inaccessible due to the operation of conscientious objection and health professionals' refusal to perform abortions.

The OHCHR determined that countries must organise health services to ensure that 'the exercise of conscientious objection by health professionals does not prevent women from obtaining access to health services'.<sup>85</sup> The CEDAW Committee has stated that 'if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers'.<sup>86</sup> The Committee on the Rights of the Child has also requested countries ensure that 'adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections'.<sup>87</sup>

The CEDAW Committee has also more broadly called on countries to secure the enjoyment of reproductive rights by guaranteeing access to abortion services in public hospitals.<sup>88</sup>

Further, article 14(2)(b) of the CEDAW requires countries to ensure women in rural areas have access to adequate health care facilities, including information, counselling and services in family planning.

## 5.6 International law and recognition of foetal rights

International instruments, while clearly recognising the right to life, are silent on whether the rights and protections conferred by the instruments are accorded to a foetus. 'Proposals to explicitly recognise the right to life of the unborn child [in international instruments] have been consistently rejected ...'.<sup>89</sup>

The right to life, as an absolute right, is recognised in article 3 of the Universal Declaration of Human Rights and article 6 of the ICCPR. It has been argued that these articles should be interpreted to protect the right to life of the unborn. Article 6(5) of the ICCPR in particular, which states that 'Sentence of death... shall not be carried out on pregnant women', has been cited as providing interpretive context for such a conclusion due to the implicit acknowledgment of the existence of a foetus and value of the foetus' life. It is argued that article 6(5) ostensibly extends the protection of human life under article 6(1) to a foetus.<sup>90</sup>

The preamble of the CRC, which states that children require 'special safeguards and care, including appropriate legal protection, before as well as after birth...',<sup>91</sup> has similarly been interpreted to confer the protections of the CRC on a foetus.<sup>92</sup> However, a preamble does not in itself impose any

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<sup>85</sup> Office of the United Nations High Commissioner for Human Rights, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and morbidity, 2011, UN Doc A/HRC/18/27, [30].

<sup>86</sup> Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, 12<sup>th</sup> session, 1999, UN Doc A/54/38, [11].

<sup>87</sup> Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, 62<sup>nd</sup> session, 2013, UN Doc CRC/C/GC/15, [69].

<sup>88</sup> Committee on the Elimination of Discrimination against Women, *Concluding Comments on Croatia*, 1998, UN Doc A/53/38, [117].

<sup>89</sup> Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', *Human Rights Quarterly*, 1990, 12, p 178.

<sup>90</sup> Rita Joseph, *Human Rights and the Unborn Child*, Martinus Nijhoff Publishers, 2009, p 14.

<sup>91</sup> *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

<sup>92</sup> Rita Joseph, *Human Rights and the Unborn Child*, Martinus Nijhoff Publishers, 2009, p 111.



obligations.<sup>93</sup> Rather a preamble may be used to supplement the interpretation of a convention.<sup>94</sup> In the context of the CRC, and the use of the preamble to define who is considered to be a 'child',

*...there is no obvious reason why the preamble would be resorted to in order to interpret what would otherwise appear to be a natural and ordinary meaning of the term 'child'*<sup>95</sup>

There is no precedent in international law for the terms 'child', 'human being' or 'human person' to be interpreted to include a foetus. Where international law is intended to apply to a foetus, the practice is to specify that the law extends to a foetus.<sup>96</sup> While it has been argued that article 6(5) of the ICCPR, prohibiting the death sentence from being carried out on pregnant women, applies the right to life to a foetus,<sup>97</sup> it would appear from the draft General Comment on the article that this was not the intent. This General Comment supports the position that rights under the ICCPR would not attach until birth. The 2015 draft General Comment (No.36), provides at paragraph 7:

*...the Covenant does not explicitly refer to the rights of unborn children, including to their right to life. In the absence of subsequent agreements regarding the inclusion of the rights of the unborn within article 6 and in the absence of uniform State practice which establishes such subsequent agreements, the Committee cannot assume that article 6 imposes on State parties [countries] an obligation to recognize the right to life of unborn children. Still, State parties [countries] may choose to adopt measures designed to protect the life, potential for human life or dignity of unborn children, including through recognition of their capacity to exercise the right to life, provided that such recognition does not result in violation of other rights under the Covenant, including the right to life of pregnant mothers and the prohibition against exposing them to cruel, inhuman and degrading treatment or punishment. Thus, any legal restrictions on the ability of women to seek abortion must not jeopardize their lives or subject them to severe physical or mental pain or suffering. States parties [countries] whose laws generally prohibit voluntary terminations of pregnancy must, nonetheless, maintain legal exceptions for therapeutic abortions necessary for protecting the life of mothers, inter alia by not exposing them to serious health risks, and for situations in which carrying a pregnancy to term would cause the mother severe mental anguish, such as cases where the pregnancy is the result of rape or incest or when the foetus suffers from fatal abnormalities. Furthermore, State parties [countries] should not regulate pregnancy or abortion in a manner that would compel women to seek clandestine illegal abortions that could endanger their lives. ... Nor should States parties [countries] introduce excessively burdensome or humiliating requirements for seeking permission to undergo abortion, including the introduction of lengthy mandatory waiting periods before a legal abortion can be carried out. The duty to protect the lives of women against the health risks associated with the termination of undesirable pregnancies requires State parties [countries] to provide women, and, in particular, adolescents, with information about reproductive options, with access to contraception and with access to adequate prenatal health care.*<sup>98</sup>

While a foetus may have some rights as a potential person, all rights must be weighed against the rights of others. Any rights of the foetus must be balanced against the rights of the woman, and there

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<sup>93</sup> Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', Human Rights Quarterly, 1990, 12, p 169.

<sup>94</sup> United Nations, United Nations Conference on the Law of Treaties, UN Doc A/CONF.39/27, 1969 cited in Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', Human Rights Quarterly, 1990, 12, p 170

<sup>95</sup> Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', Human Rights Quarterly, 1990, 12, p 170

<sup>96</sup> Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', Human Rights Quarterly, 1990, 12, p 170

<sup>97</sup> Rita Joseph, *Human Rights and the Unborn Child*, Martinus Nijhoff Publishers, 2009, p 14.

<sup>98</sup> Shany and Nigel Rodley, *Draft general comment No. 36: Right to life*, 115<sup>th</sup> session, 2 September 2015, UN Doc CCPR/C/GC/R.36.

is an emerging international norm under which the rights of the woman are given priority over the rights of the foetus.<sup>99</sup> As the European Court of Human Rights has stated:

*...the unborn child is not regarded as a 'person' directly by Article 2 of the Convention [right to life] and that if the unborn do have a 'right' to 'life' it is implicitly limited by the mother's rights and interests.*<sup>100</sup>

International instruments, while not themselves applying rights to a foetus, do not preclude countries from providing the foetus with a legal right to life, 'provided that other human rights guarantees are not thereby violated.'<sup>101</sup> Indeed, some countries have chosen to specifically recognise the rights of the foetus in domestic law or make a reservation against a treaty to apply the protections to the foetus. For example, the Irish Constitution

*...acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect and, as far as practical, by its laws to defend and vindicate that right.*<sup>102</sup>

Alternately, Argentina lodged a declaration that article 1 of the CRC should be interpreted to mean a child is a human being from conception.<sup>103</sup>

Australia has not adopted either of these approaches to specifically recognise the rights of the foetus, and the Commonwealth Government has expressed a view that the right to life under the ICCPR 'was not intended to protect life from the point of conception but only from the point of birth'.<sup>104</sup>

## **5.7 Recognition of freedom of religion and belief – conscientious objection**

The right to freedom of thought, conscience and religion is recognised in the UDHR and by article 18 of the ICCPR. Described by the HRC as 'far-reaching and profound', it encompasses freedom of thought and personal conviction on all matters. This includes a right to manifest a belief individually or in a community with others, both in public or in private.<sup>105</sup> As a 'fundamental right', it is interpreted strictly, with limitations permitted only to the extent that they are 'prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others'.<sup>106</sup>

This right may be enlivened in relation to abortion when health professionals, who may be called to perform an abortion, conscientiously object to providing abortion services on the basis of a religious or moral belief.

As with all rights, the health professionals' right to freedom of thought, conscience and religion must be weighed against the rights of the woman. As noted above, to balance these conflicting rights the CEDAW Committee has stated that if a health professional has a conscientious objection there should be measures to ensure that women are referred to an alternative health professional.<sup>107</sup>

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<sup>99</sup> Abby Janoff, 'Rights of the pregnant child v rights of the unborn under the conventions of the rights of the child', *Boston University International Law Journal*, 2004 (22), pp 165-166.

<sup>100</sup> *Vo v France*, App No 53924/00, Eur. Ct HR, 80, 2004; *A B and C v Ireland*, App No 25579/05, Eur Ct HR 237 238, 2010.

<sup>101</sup> Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child', *Human Rights Quarterly*, 1990, 12, p 172.

<sup>102</sup> Irish Constitution, art 40(3).

<sup>103</sup> Committee on the Rights of the Child, Reservations, declarations and objections relating to the Convention of the Rights of the Child, 1994, UN Doc CRC/C/2/Rev.3, p 11.

<sup>104</sup> Attorney-General's Department, Joint Standing Committee on Treaties public hearing transcript, Canberra, 16 June 2015, p 6.

<sup>105</sup> Australian Human Rights Commission, *Freedom of thought, conscience and religion or belief*, <[www.humanrights.gov.au/freedom-thought-conscience-and-religion-or-belief](http://www.humanrights.gov.au/freedom-thought-conscience-and-religion-or-belief)>.

<sup>106</sup> *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS (entered into force 23 March 1976) art 18(3).

<sup>107</sup> Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, 12<sup>th</sup> session, 1999, UN Doc A/54/38, [11].

## 5.8 Recognition of freedom of expression

The UDHR, ICCPR and other human rights instruments recognise the right to freedom of opinion and expression, including the freedom to seek, receive and impart information in the method and media of one's choosing.<sup>108</sup>

In the context of reproductive health, this obligation is reinforced by article 10(H) of the CEDAW, which states that women shall have 'access to specific educational information to help ensure the health and well-being of families including information and advice on family planning'.

This freedom and an associated right to freedom of conscience may be interpreted as a right to demonstrate and distribute materials outside abortion clinics. This has been a topic of considerable debate, as a number of national and international jurisdictions have sought to impose restrictions on freedom of expression within legislated 'safe access zones' or 'exclusion zones' outside abortion clinics in response to concerns about the safety, wellbeing and privacy of patients and staff being jeopardised by intimidation and harassment from protestors (discussed further in Chapter 17).

A number of national and international court judgements provide guidance on the consistency of such measures with recognised human rights principles and law. Recognising that freedom of speech carries with it special duties and responsibilities and may therefore be subject to restrictions, article 19(3) specifies that any restrictions shall only be such as are provided by law and are necessary to ensure 'respect of the rights or reputations of others' or 'for the protection of national security or of public order' or of 'public health or morals'. Where this may be the case, article 5 of the ICCPR establishes the importance of balancing and reconciling competing rights as far as possible to minimise limitations and avoid imposing any restrictions 'to a greater extent than is provided for in the present Covenant'.

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<sup>108</sup> *Universal Declaration of Human Rights*, 10 December 1948, art 19; *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS (entered into force 23 March 1976) art 19.

## 6 Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016

### 6.1 Referral of the Bill

Mr Rob Pyne MP, the independent Member for Cairns, introduced the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (the Bill) as a Private Member's Bill. The Bill was referred to the committee for detailed consideration.

The Bill forms one part of the committee's terms of reference (see Chapter 1). Some of the views expressed by stakeholders about the impact of the Bill are summarised in this chapter and also discussed elsewhere in this report.

### 6.2 Policy objectives of the Bill

The primary objective of the Bill is to remove abortion from the Criminal Code.<sup>109</sup> According to the explanatory notes:

*This Bill will protect vulnerable Queensland women and the doctors that are currently risking prosecution to assist them.*<sup>110</sup>

When introducing the Bill in the Legislative Assembly Mr Pyne stated:

*Removing sections 224, 225 and 226 will remove the necessity to rely on these section 282 components (a) establishing an exceptional case; and (b) serious danger to the mother's life or her physical or mental health. Should this bill pass, the decision for the doctor would simply need to be that continuing the pregnancy poses a bigger risk to the woman than terminating it.*<sup>111</sup>

Mr Pyne also referred to the case of *R v Brennan & Leach* (see section 2.4.6), stating:

*The ridiculous nature of the current situation was on public display in 2009-10 when a Cairns couple were charged under the Queensland legislation. Although they were acquitted after jury trial, they were subjected to 18 months of glaring negative publicity.*<sup>112</sup>

Mr Pyne also described his concern that the parliament reform the law, and that he hoped a point could be reached where there was majority support for amendments. However during the explanatory speech and when briefing the committee Mr Pyne acknowledged that additional regulation would be required if reforms were to be made to abortion law in Queensland.<sup>113</sup>

During the public briefing, the committee asked Mr Pyne whether he thought that matters other than removing the abortion offences from the Criminal Code should be dealt with in legislation:

*...Things like conscientious objection for medical and other health professionals, the information and counselling that is available to a woman who is making decisions, the rights of groups to protest or distribute information near a place where abortions are performed or the lack of rights to do that, and regulations around late-term abortions. Do you think these matters should be dealt with in legislation?*

*Mr Pyne: I think for this bill to pass they will have to be, and I would anticipate that happening by the second reading speech.*<sup>114</sup>

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<sup>109</sup> Explanatory notes, p 1.

<sup>110</sup> Explanatory notes, p 1.

<sup>111</sup> Mr Rob Pyne MP, Member for Cairns, Explanatory Speech, *Hansard*, 10 May 2016, p.1572

<sup>112</sup> Mr Rob Pyne MP, Member for Cairns, Explanatory Speech, *Hansard*, 10 May 2016, p.1572

<sup>113</sup> Mr Rob Pyne, Explanatory Speech, *Hansard*, 10 May 2016, and Public briefing, 15 June 2016

<sup>114</sup> Mr Rob Pyne MP, Member for Cairns, Public briefing transcript, 15 June 2016, pp.4-5

In response to further questions Mr Pyne advised the committee that he had drafted amendments to the Health Act that include a gestational period but did not want to put his amendments forward 'if it is not going to be passed by the parliament.'<sup>115</sup>

Mr Pyne MP also told the committee that the case of *Central Queensland Hospital and Health Service v 'Q'* (see Chapter 2) prompted him to introduce the Bill:

*I have been more recently prompted to move on this private member's bill through the case in Rockhampton of a 12-year-old girl seeking an abortion. ... The hurdles that had to be jumped through to get that 12-year-old girl to have an abortion were certainly not acceptable to [the doctor involved] and, I would think, a majority of Queenslanders.*<sup>116</sup>

Mr Pyne also referred to the case of *R v Leach & Brennan* and said:

*... the young couple were put on trial and faced the full glare of public scrutiny with the most intimate aspects of their relationship and medical situation paraded before the whole community. I thought that was just wrong and would not happen if the law were to be changed.*<sup>117</sup>

### 6.3 Provisions in the Bill

#### 6.3.1 Removal of offences from the Criminal Code

Section 2.2 of this report sets out the current offence provisions of the Criminal Code regarding abortion. The offences are to procure a miscarriage (section 224), for a woman to procure her miscarriage (section 225), and to supply drugs or instruments to procure a miscarriage (section 226).

The Bill proposes to achieve its primary policy objective by removing sections 224, 225 and 226 from the Criminal Code. In introducing the Bill, Mr Pyne MP described these sections as '...archaic, outdated...' and as having 'no place in a modern, liberal democracy'.<sup>118</sup> He said that omitting these sections of the Criminal Code would remove the existing reliance on the section 282 defence.<sup>119</sup>

#### 6.3.2 Consequential amendment – school crossing supervisors

The Bill also proposes an amendment to the *Transport Operations (Road Use Management) Act 1995* (TORUM Act) consequential to the proposed removal of section 226 from the Criminal Code.

The TORUM Act authorises a scheme to help children to safely cross roads and authorises crossing supervisors under the scheme.<sup>120</sup> The TORUM Act lists 'disqualifying offences' under the Criminal Code which apply to crossing supervisors, one of which is section 226 of the Criminal Code 'Supplying drugs or instrument to procure abortion'.<sup>121</sup>

Under the TORUM Act, a crossing supervisor may not be authorised for the role if they have been convicted of or charged with a disqualifying offence and the charge has not been finally dealt with.<sup>122</sup> If an existing crossing supervisor is charged with or convicted of such an offence, their authority as a crossing supervisor may be amended, suspended or cancelled.<sup>123</sup> The proposed amendment would remove the reference to section 226 of the Criminal Code.

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<sup>115</sup> Mr Rob Pyne, Member for Cairns, Public briefing transcript, p 6

<sup>116</sup> Mr Rob Pyne MP, Member for Cairns, Public briefing transcript, 15 June 2016, p.2

<sup>117</sup> Mr Rob Pyne MP, Member for Cairns, Public briefing transcript, 15 June 2016, p.2

<sup>118</sup> Queensland Parliament, Record of Proceedings, 10 May 2016, p 1526.

<sup>119</sup> Queensland Parliament, Record of Proceedings, 10 May 2016, p 1527.

<sup>120</sup> Transport Operations (Road Use Management) Act 1995, s 122A.

<sup>121</sup> Transport Operations (Road Use Management) Act 1995, schedule 2.

<sup>122</sup> Transport Operations (Road Use Management) Act 1995, s 122C(a) & (b).

<sup>123</sup> Transport Operations (Road Use Management) Act 1995, s 122I.

## 6.4 Consultation

Mr Pyne MP told the committee that he had discussions and meetings with certain stakeholders prior to the introduction of the Bill:

*I met with Children by Choice, a very active local group in Brisbane; and, as I said earlier, with Dr Caroline de Costa, who I think is probably the leading medical and academic commentator in this area nationally; Dr Heather McNamee, who is a local practitioner; and Dr Carole Ford, who was awarded an OAM in the Queen's Birthday awards a couple of days ago for her services to women—and Pro-choice.<sup>124</sup>*

Mr Pyne MP stated that the views of these stakeholders were consistent, and that he had not met with stakeholders who may have had a differing view.<sup>125</sup>

## 6.5 Submitters views on the Bill

The committee received 1,445 submissions with divergent views about the Bill and abortion. The committee considered the views expressed in all of the submissions, a summary of which is below.

Submissions are available on the committee's web site.

### 6.5.1 Support for the Bill

#### 6.5.1.1 Overview

The following summary outlines reasons given by submitters for support of the Bill. Later chapters of this report discuss other potential forms of regulation, in line with the committee's terms of reference.

#### 6.5.1.2 Current law and medical practice

Submitters suggested that the requirements of the current law are not reflected in medical practice in Queensland,<sup>126</sup> and that national legislative uniformity is needed so that the law is in step with modern medical practice. Submissions noted that Commonwealth Medicare and Pharmaceutical Benefit Scheme rebates are available to support abortion procedures and women should therefore have equal access to abortion services.<sup>127</sup>

In this vein, access to abortion was often framed by submitters who support the Bill as a health care decision and not a matter of criminality or morality. Many submitters argued that abortion is a health service that should be provided with the same standards of safety, effectiveness and regard to patient rights as any other health service. Abortion was characterised as a decision made between a woman and her doctor, which should be governed by the same legal principles that apply to other health care, and on which the state should not intrude through regulation in the Criminal Code.<sup>128</sup>

Submitters stated that the removal of abortion from the criminal law would be a significant step towards ensuring that women in Queensland have access to the best practice sexual and reproductive health care.<sup>129</sup>

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<sup>124</sup> Public briefing transcript, Brisbane, 15 June 2016, p 1.

<sup>125</sup> Public briefing transcript, Brisbane, 15 June 2016, p 1.

<sup>126</sup> See for example submissions 652, 848.

<sup>127</sup> See for example submissions 768, 783, 836.

<sup>128</sup> See for example submissions 498, 501, 537, 770, 835, 837, 839, 845, 1222.

<sup>129</sup> See for example submissions 537, 770, 775, 848.

### 6.5.1.3 *Current law and community attitudes*

Many submitters argued that the laws criminalising abortion are outdated,<sup>130</sup> and some expressed surprise that abortion is still illegal under Queensland legislation.<sup>131</sup> Submitters often referred to legislation in other states, which has partially or completely removed abortion from criminal law, and argued that women in Queensland should have the same rights to abortion as those in other states.<sup>132</sup>

Submitters suggested the current law does not reflect current community attitudes and expectations.<sup>133</sup> Submitters referred to polling showing that the majority of the population supports a woman's right to choose.<sup>134</sup> An assessment of community opinion polls is at Chapter 8.

The case of a Cairns couple charged under the Criminal Code (summarised in section 2.4.6), in which the jury took less than an hour to find the couple not guilty, was also cited by submitters as an example of current community attitudes and expectations.<sup>135</sup>

### 6.5.1.4 *Reasons for abortion*

It was argued that no woman wants to have an abortion and that the decision to terminate a pregnancy is not taken lightly.<sup>136</sup> Submitters identified many reasons why women cannot continue a pregnancy and estimated that one in four women in Australia will have an abortion at some time in their life.<sup>137</sup>

Some submitters stated that women seeking abortions are victims of domestic violence and sexual assault, women with mental health conditions, disadvantaged Aboriginal and Torres Strait Islander women, financially disadvantaged women, women for whom contraception has failed, women who did not think they could fall pregnant, and women who found themselves pregnant and did not wish to be.<sup>138</sup> Submitters argued that these factors are varied, personal and should not be subject to the scrutiny of public opinion and that a woman has a right to decide.<sup>139</sup> Submitters referred to estimates that half of all pregnancies in Australia are unplanned, that unplanned pregnancy does not discriminate and women from all backgrounds access abortions.<sup>140</sup>

Submitters suggested that criminalisation of abortion leads to inequity, as the current laws result in access to services being constrained by geographic location and access to resources.<sup>141</sup> Submitters argued that criminalisation of abortion can obstruct services and disproportionately impact on women who are already disadvantaged—such as those who are young; experiencing poverty, violence or mental health issues; live in rural, regional and remote locations; and often Indigenous women who do not have access to such services.<sup>142</sup>

### 6.5.1.5 *Human rights to reproductive health services and self-determination*

A number of submitters referred to international human rights bodies and instruments, such as the OHCHR and the ICCPR in relation to a woman's reproductive rights (Chapter 5 summarises the relevant international law). Abortion was seen by these submitters as a fundamental human right and it was

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<sup>130</sup> See for example submissions 498, 771, 792, 804, 848.

<sup>131</sup> See for example submissions 775, 848.

<sup>132</sup> See for example submissions 498, 537, 780, 781, 787, 798, 801, 845, 857.

<sup>133</sup> Zig Zag Young Women's Resource Centre Inc, submission 647.

<sup>134</sup> See for example submissions 498, 768, 782, 787, 775, 794, 799, 839, 848.

<sup>135</sup> Young Queenslanders for the Right to Choose, submission 848.

<sup>136</sup> See for example submissions 498, 533, 542, 801.

<sup>137</sup> See for example submissions 498, 501, 783.

<sup>138</sup> Darren Russell, submission 542.

<sup>139</sup> See for example submissions 542, 770, 838, 647, 801, 804.

<sup>140</sup> See for example submissions 647, 768, 838.

<sup>141</sup> See for example submissions 523, 533, 775, 804, 835.

<sup>142</sup> See for example submissions 498, 527, 533, 542, 647, 738, 768, 771, 794, 798, 799, 804, 835, 848.

argued that to eliminate discrimination against women, and to ensure women's right to health and other fundamental human rights, abortion should be decriminalised. It was also argued that a right to life does not apply to a foetus under human rights law, and that any application of human rights law should not subordinate the rights of the woman in favour of the unborn.<sup>143</sup>

For example, submitters referred to:

- abortion as a fundamental human right recognised by the United Nations via the ICCPR<sup>144</sup>
- statements made by the OHCHR that '[c]riminalisation of health services that only women require, including abortion, is a form of discrimination against women and represents a barrier to women's access to health care,<sup>145</sup> and
- articles of the CEDAW that require State parties to ensure women have equal rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise their rights.<sup>146</sup>

#### 6.5.1.6 Impact of decriminalisation on rate of abortion

Submitters argued that decriminalising abortion does not lead to an increase in abortions and could lead to a decrease. It was argued that there is no correlation between the legality of abortions and the number of abortions performed in any given jurisdiction.<sup>147</sup>

Some submitters suggested that the rate of abortion cannot be predicted by the restrictiveness of legislation but is instead related to the rate of unplanned pregnancy and the availability and use of contraception.<sup>148</sup>

Submitters also asserted that criminalising abortion does not prevent it but can cause women to seek illegal services or methods or create unsafe medical practices, including leading women to take steps to induce an unsafe and potentially life-threatening abortion by themselves.<sup>149</sup> To reduce the potential for unsafe practices, it was argued that government should legalise and regulate abortion rather than let this continue to happen.<sup>150</sup>

### **6.5.2 Opposition to the Bill**

This section summarises the reasons given by submitters for opposing the Bill.

#### 6.5.2.1 Respect for human life

Submissions opposing the Bill referred to the sanctity of human life, the belief that human life begins at conception, and that every person, whether within or outside the womb, is precious and should be protected to ensure his or her survival.<sup>151</sup> These submitters stated that abortion involved taking a human life,<sup>152</sup> and that while women should have rights over their bodies, this should not be the case when it involves their unborn child.<sup>153</sup>

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<sup>143</sup> See for example submissions 769, 848.

<sup>144</sup> See for example submissions 527, 769, 848.

<sup>145</sup> See for example submissions 769, 848.

<sup>146</sup> See for example submissions 652, 769, 848.

<sup>147</sup> See for example submissions 771, 857.

<sup>148</sup> See for example submissions 652, 848.

<sup>149</sup> See for example submissions 498, 527, 542, 781, 848.

<sup>150</sup> Rail Tram and Bus Union (Qld Branch), submission 771.

<sup>151</sup> Queensland Baptists, submission 807.

<sup>152</sup> See for example submissions 455, 479, 810.

<sup>153</sup> See for example submissions 551, 541, 803.



Counter to the submissions that supported the Bill, which stated that the current law is outdated, submissions opposing the Bill emphasised that respecting human life from conception and advocating for options other than abortion for unwanted pregnancies is by no means an antiquated attitude, nor one better suited to previous centuries.<sup>154</sup>

Many submitters also argued that the value of the life of a foetus should not be determined by whether it is wanted or not and that one child's life is not more worthy of love and care than the next.<sup>155</sup> Submitters argued that no person has the right to take another's life.<sup>156</sup>

#### 6.5.2.2 *Human right to life*

Similar to submitters who supported the Bill stated that human rights bodies and instruments support a woman's right to choose; submitters who did not support the Bill also referred to human rights and international instruments and conventions to support an unborn child's right to life.<sup>157</sup> Submitters particularly cited:

- article 3 of the UDHR, which states that 'everyone has the right to life, liberty and security of person'<sup>158</sup>
- article 6(1) of the ICCPR, which states that 'every human being has the inherent right to life', and
- articles 1 and 2 of the CRC, which respectively state that 'State Parties recognize that every child has the inherent right to life' and 'shall ensure to the maximum extent possible the survival and development of the child'.<sup>159</sup>

Submitters argued that the various provisions in international human rights law should dictate that the unborn child be afforded protection for its development and survival, noting that there is nothing in the provisions that differentiates between the unborn and born child. In contrast to the submissions made by those supporting the Bill, these submissions stated that the various human rights conventions do not support the notion of the right of a woman to abort an unborn foetus.<sup>160</sup>

The intended meaning and implications of international human rights law and its application is considered in Chapter 5.

#### 6.5.2.3 *Abortion as a criminal act*

Submitters argued that the same principles that guard the taking of human life after birth must inform the law governing the termination of pregnancy,<sup>161</sup> and that the unborn child deserves the protection of the law.<sup>162</sup> Submitters viewed the act of abortion as murder,<sup>163</sup> and some stated that the Bill before the committee would allow abortion up until birth, and borders on infanticide. They suggested that criminalising abortion acts as a deterrent and sends the message that the unborn child has value.<sup>164</sup>

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<sup>154</sup> Lina Martin, submission 551.

<sup>155</sup> C Dogger, submission 623.

<sup>156</sup> See for example submissions 541, 735.

<sup>157</sup> See for example submissions 797, 810, 1216.

<sup>158</sup> See for example submissions 553, 810, 1216.

<sup>159</sup> See for example submissions 553, 810.

<sup>160</sup> See for example submissions 553, 735, 790.

<sup>161</sup> D McPherson, submission 530.

<sup>162</sup> See for example submissions 553, 641.

<sup>163</sup> See for example submissions 563, 593, 641, 809.

<sup>164</sup> See for example submissions 551, 1216.

There was also concern that the Bill provides no legislative support for women who wish to consider alternatives.<sup>165</sup> The current law is seen by these submitters as a safeguard for women who may feel pressured by their partners or family, as well as being a defence for medical practitioners who refuse to perform abortions.<sup>166</sup>

Some submitters argued that no change is required to the legislation because of the number of abortions already performed in Queensland, which they suggest shows that women are able to access abortions in Queensland under the defence in section 282 of the Criminal Code.<sup>167</sup> Submitters also said that there have been no recent successful criminal prosecutions against women who have procured an abortion or any medical practitioners performing abortions.<sup>168</sup>

Some submitters argued that the Bill proposes to remove any legal protections for unborn children<sup>169</sup> and recommended that any changes to the law should equally give worth and protection to both pregnant women and to unborn human life from conception.<sup>170</sup>

Submitters questioned the sense of the Bill when section 313(2) of the Criminal Code specifies that a person who harms or kills the baby of a pregnant women has committed a crime, and yet the Bill essentially mean that a foetus would have no rights under this legislation.<sup>171</sup> The application of section 313 is outlined in Chapter 2; it differs from the sections of the Criminal Code that the Bill proposes to remove.

Submitters also argued that there is no correlation between the legality of abortions and the number of abortions performed.<sup>172</sup>

#### 6.5.2.4 Conscientious objection

Concerns were raised in submissions that medical practitioners would be required to perform an abortion or be required to refer a woman to a doctor who will perform the abortion, where this may be against their beliefs and their 'mandate of being called to save and preserve lives'.<sup>173</sup> Some submitters suggested that health professionals who believe a foetus is an unborn child should have a choice to maintain their commitment to not harm that life.<sup>174</sup> Submitters referred to survey results indicating that 79 per cent of Queenslanders support conscientious objection provisions that would allow health practitioners to opt out of performing abortions.<sup>175</sup> It should be noted that neither the current law nor the Bill address conscientious objection, which is discussed in Chapter 16 of this report.

#### 6.5.2.5 Impact of termination on the mother and father

One of the consistent arguments against the decriminalisation of abortion was that abortion has physical and psychological impacts on women, both at the time of the abortion and subsequently.<sup>176</sup> Submitters suggested that the physical impacts of abortion included uterine perforation, cervical incompetence, risk of haemorrhage, infection, future infertility, an increased risk of premature delivery

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<sup>165</sup> See for example submissions 786, 772.

<sup>166</sup> Australian Family Association, submission 831.

<sup>167</sup> See for example submissions 455, 551, 777.

<sup>168</sup> See for example submissions 551, 782, 831, 832.

<sup>169</sup> C Burrell, submission 479.

<sup>170</sup> See for example submissions 605, 773.

<sup>171</sup> Lina Martin, submission 551.

<sup>172</sup> See for example submissions 771, 857.

<sup>173</sup> See for example submissions 479, 772, 773.

<sup>174</sup> See for example submissions 779, 803.

<sup>175</sup> See for example submissions 535, 785, 788, 773, 796.

<sup>176</sup> See for example submissions 553, 777, 1176, 495.

in future pregnancy, hysterectomy, and a causal link with breast cancer and death.<sup>177</sup> Other suggested consequences of abortion included post-traumatic stress disorder, drug and alcohol abuse, self-harm, psychiatric illness, depression, relationship problems, domestic violence, and an increased risk of suicide.<sup>178</sup> Submitters also argued that the termination of pregnancy is traumatic for partners.<sup>179</sup> Chapter 12 discusses the impacts of abortion.

#### 6.5.2.6 *Community attitudes to law and to termination of pregnancy*

A number of submitters argued from opinion polls that the Queensland community does not support the total removal of laws governing abortion. As assessment of the reliability of recent opinion polls and what can be said about community attitudes to abortion is provided in Chapter 8.

#### 6.5.2.7 *Alternatives to abortion*

Counselling about the alternatives to abortion was recommended by submitters. Many submitters suggested that women should be provided with better options and support, educated on the impacts of abortion, and advised of alternatives to abortion, including adoption.<sup>180</sup>

Many submitters suggested adoption as an alternative to abortion, asserting that the adoption laws should be relaxed and pregnant women should be encouraged to carry their children to full-term and then put them up for adoption, with financial counselling support as necessary.<sup>181</sup>

It was also suggested that support for pregnant women should be improved through greater flexibility to continue with educational aspirations. After birth, to support women who may not see other alternatives, submitters suggested the provision of family based care and support, onsite child care at university or vocational training facilities, mother mentoring programs for vulnerable women, and family friendly workplaces.<sup>182</sup>

## 6.6 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'.<sup>183</sup> The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The abrogation of rights and liberties from any source must be justified, whether the rights and liberties are under the common law, statute, or arising out of Australia's international treaty obligations.<sup>184</sup>

The committee received advice about the application of the fundamental legislative principles to the Bill. As previously detailed, there is some debate regarding the unborn child's right to life under international human rights law. However, the prevailing rights of all women to be able to access safe pregnancy termination procedures, lawfully, have been recognised in multiple international treaties

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<sup>177</sup> Kara and Daniel Thomas, submission 535.

<sup>178</sup> See for example submissions 479, 551, 553, 1176, 535, 563.

<sup>179</sup> See for example submissions 832, 1176.

<sup>180</sup> See for example submissions 455, 800, 809, 833.

<sup>181</sup> See for example submissions 535, 553, 563, 777, 833.

<sup>182</sup> See for example submissions 535, 800.

<sup>183</sup> *Legislative Standards Act 1992*, s 4.

<sup>184</sup> Queensland Government, *Queensland Legislative Handbook*, <<http://www.premiers.qld.gov.au/publications/categories/policies-and-codes/handbooks/legislation-handbook.aspx>>.

and by key committees and bodies as fundamental tenets of equal human treatment and self-determination.

The Bill's provisions, in decriminalising abortion, effectively align the law of Queensland with Australia's international legal obligations as a ratifying country to the UDHR, ICCPR, ICESCR, CEDAW and the CRC.

## 6.7 Explanatory notes

Part 4 of the *Legislative Standards Act 1992* (Legislative Standards Act) relates to explanatory notes. It requires that an explanatory note be circulated when a Bill is introduced into the Parliament, and section 23 sets out the information an explanatory note should contain.

Explanatory notes were tabled with the introduction of the Bill. The committee notes that a Private Member does not have the resources of a department to prepare explanatory notes; however, the committee considers that the explanatory notes fell short of the requirements set out in section 23 of the Legislative Standards Act as they did not contain some of the information required.

For example, the committee considers the explanatory notes could have provided more information about the policy objectives of the Bill. The committee notes that the explanatory notes do not detail consultation undertaken on the Bill but rather state the 'issue has been debated for many years and further consultation will take place while the Bill is in Committee.'<sup>185</sup> The explanatory notes do not include a simple explanation of the intended operation of each clause, which would have assisted understanding of the Bill.

## 6.8 Committee comments

### 6.8.1 Policy to be given effect by the Bill

The *Parliament of Queensland Act 2001* provides that the committee's responsibility when examining a Bill is to consider 'the policy to be given effect by the legislation'.<sup>186</sup>

Overall, the committee considers that the policy to be given effect by the Bill was not sufficiently developed and lacks rigour. The policy objective stated in the explanatory notes tabled on 10 May 2016 was to remove abortion offences from the Criminal Code. However, when Mr Pyne briefed the committee, he agreed with the committee that other matters, such as conscientious objection and late term abortion may need to be regulated. Mr Pyne told the committee on 15 June that he had:

*.. drafted some amendments to the Health Act that include a gestational period, but I am not prepared to flag those because I do not want to put something like that forward, whether it is 20 weeks or 24 weeks—24 weeks is the situation in Victoria—if it is not going to be passed by the parliament. I think this law needs to be changed and updated to contemporary standards. While I have tabled my position, I accept that there will be views somewhere between no change and what I have tabled. Hopefully we can reach some sort of legislative reform.*<sup>187</sup>

The committee considers that constructive law reform should start with thorough policy development. Legislation introduced into the Legislative Assembly should be the means to implement coherent policy rather than partially developed proposals.

When introducing the Bill in the Legislative Assembly, Mr Pyne said his main concern 'is that this parliament get together and pass law reform in this area'.<sup>188</sup> The committee does not consider the

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<sup>185</sup> Explanatory note, p 1

<sup>186</sup> Parliament of Queensland Act 2001, section 93

<sup>187</sup> Mr Rob Pyne MP, Member for Cairns, Public briefing transcript, 15 June 2016, p.6

<sup>188</sup> Public briefing transcript, 15 June 2016 p 6

introduction of a Bill to be an appropriate catalyst for policy development and consultation which should appropriately be done before introduction of a Bill.

The lack of rigour and foresight in policy development is evidenced by the introduction of a second Bill on 17 August 2016. That Bill is not part of the referral from the Legislative Assembly and is therefore not considered in this report. The committee will separately examine and report on the recently introduced Bill.

### 6.8.2 Does the Bill achieve its policy objectives?

The main stated policy objective of the Bill is to remove abortion offences from the Criminal Code.<sup>189</sup> The committee notes that the Bill, if passed, would achieve that policy objective.

The explanatory notes also indicate that the Bill's objective, by decriminalising abortion, is 'to protect vulnerable Queensland women and the doctors that are currently risking prosecution to assist them'.<sup>190</sup> The committee does not consider the Bill fully achieves the objective of protecting women and doctors from the risk of prosecution. Mr Pyne pointed to the case of *R v Brennan and Leach* to highlight the impact of prosecution. However, the committee noted that, at the time of the case, charges may have been possible for importation of a drug without a permit (*Customs Act 1901, (Cwth)*); or for possession of a restricted drug under the Health (Drugs and Poisons) Regulation 1996.<sup>191</sup> In similar circumstances in future, people could still be prosecuted.

#### 6.8.2.1 *Other matters*

When briefing the committee Mr Pyne agreed that other matters such as regulating late term abortion, conscientious objection, and protests outside abortion facilities should be dealt with in legislation. He said, 'I think for this bill to pass they will have to be, and I would anticipate that happening by the second reading speech.'<sup>192</sup> Those issues were aired during the committee's consultations. None of those issues are addressed in the Bill, and the committee considers that the policy objectives stated by Mr Pyne are not achieved by the Bill.

Mr Pyne advised the committee that he was 'prompted to move on this private member's bill' by the case of *Central Queensland Hospital and Health Service v 'Q' ....* I thought that was just wrong and would not happen if the law were to be changed.'<sup>193</sup> The committee notes that the Bill does not address the legal principles in that case.

#### 6.8.2.2 *Recommendation*

After considering the Bill and all of the evidence and views presented to its inquiry, the committee has significant concerns about the Bill.

The committee considers that the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 should not be passed.

#### **Recommendation 1**

The committee recommends that the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 not be passed.

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<sup>189</sup> Explanatory notes, p 1

<sup>190</sup> Explanatory notes, p 1

<sup>191</sup> Queensland Parliamentary Library and Research Service, Research Brief, *R v Brennan & Leach*

<sup>192</sup> Mr Rob Pyne MP, Public briefing transcript, 15 June 2016, p 5

<sup>193</sup> Mr Rob Pyne MP, Public briefing transcript, 15 June 2016, p 2

## 7 Termination of pregnancy – current clinical practice

### 7.1 Guidelines and standards

As outlined in Chapter 4, termination of pregnancy services in public and private hospitals in Queensland are provided within the Queensland Health Clinical Services Capability Framework and the Queensland Health Clinical Guideline *Therapeutic termination of pregnancy* (the Clinical Guideline).<sup>194</sup> Queensland Health advised the committee that the clinical recommendations for achieving safe therapeutic termination of pregnancy outlined in the Clinical Guideline, including medical and surgical methods, are consistent with the best known evidence internationally.<sup>195</sup> The RANZCOG guidelines described in Chapter 4 also apply to specialist obstetricians and gynaecologists and other medical practitioners.

### 7.2 Method of termination

A pregnancy may be terminated using a medical or surgical approach, or a combination of the two.<sup>196</sup> The decision regarding the most appropriate procedure depends on factors including the clinician's expertise, the service capabilities, the availability of pharmacological agents and the woman's choice.<sup>197</sup>

#### 7.2.1 Medical termination

Medical terminations use the drugs mifepristone (commonly known as RU486) and misoprostol to induce a termination. It may be administered in hospital or in an outpatient setting, the latter being more common.

The Clinical Guideline states that the most appropriate setting for medical termination requires consideration of the local service capabilities and the individual circumstances of the woman, including geographic distances to be travelled should emergency care be required, and should involve social worker support where appropriate. The Clinical Guideline provides that women cared for on an outpatient basis should:

- be less than 9 weeks gestation
- be accompanied by a support person who has been adequately informed about what to expect until the termination of pregnancy is complete
- have immediate access to transport and telephone
- be able to communicate by telephone (e.g. have an interpreter available if required)
- have the capacity to understand and follow instruction
- be able to access a healthcare facility
- have follow-up arrangements in place.<sup>198</sup>

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<sup>194</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013.

<sup>195</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 11.

<sup>196</sup> RANZCOG, *Termination of pregnancy: A resource for health professionals*, < [http://www.ranzcog.edu.au/editions/doc\\_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html](http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html)>, 2005, p 8.

<sup>197</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 12.

<sup>198</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 16.

### 7.2.1.1 *Can medical termination be reversed?*

There is some contention as to whether the effects of medical termination can be reversed should a woman change her mind after taking pharmaceuticals for a medical abortion.

A representative from Priceless Life told the committee that there is a medical protocol for reversing mifepristone, the first medication in medical terminations, and that the organisation was aware of five instances where this had occurred.<sup>199</sup> A number of other organisations also promote the view that the effects of mifepristone can be reversed.<sup>200</sup>

While the nature of the treatment that Priceless Life refer to is not clear, one US study has been identified that endorses the use of progesterone to reverse the effects of mifepristone.<sup>201</sup> The study had a small sample of six and may therefore have limited applicability in a broader clinical setting. The American College of Obstetricians and Gynaecologists does not consider the treatment to be an established practice.<sup>202</sup>

A 2015 systematic review of the literature about the effectiveness of reversal of medical termination following mifepristone found no credible evidence that any treatment is effective in reversing the effects of mifepristone and ensuring a continuing pregnancy.<sup>203</sup>

Professor Michael Permezel, President of RANZCOG, indicated that to his knowledge the effects of mifepristone cannot be reversed.<sup>204</sup>

Mifepristone is prescribed as an abortifacient in combination with misoprostol. Termination occurs after use of mifepristone alone in less than 3 per cent of cases.<sup>205</sup> Therefore, while there is insufficient evidence to support the view that a treatment can reverse the effects of mifepristone, not taking misoprostol may result in a continuing pregnancy.

### 7.2.2 **Surgical termination**

The Clinical Guideline recommends that surgical curettage is generally suitable for pregnancy up to 14 weeks and if the pregnancy is between 14 and 16 weeks gestation, the procedure should only be performed by experienced practitioners.<sup>206</sup>

The committee was advised that surgical termination:

- can be provided from around five to six weeks gestation onwards
- in the first trimester, the procedure takes between three and ten minutes; however, the average length of time spent at a clinic is between three and four hours, including pre - and post-operative care, and

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<sup>199</sup> Public hearing transcript, Brisbane, 1 August 2016, pp 36-38.

<sup>200</sup> For example Real Choices Australia, at <[www.realchoices.org.au/reverse-medical-abortion](http://www.realchoices.org.au/reverse-medical-abortion)>; Australian Mifepristone Reversal, at <[www.mifepristone.org.au/mifepristone-reversal](http://www.mifepristone.org.au/mifepristone-reversal)>.

<sup>201</sup> George Delgado and Mary Davenport, 'Progesterone use to reverse the effects of mifepristone', *The Annals of Pharmacotherapy*, 2012 (46).

<sup>202</sup> Daniel Grossman *et al*, 'Continuing pregnancy after mifepristone and reversal of first-trimester medical abortion: a systematic review', *Contraception*, 2015 (92), p 207.

<sup>203</sup> Daniel Grossman *et al*, 'Continuing pregnancy after mifepristone and reversal of first-trimester medical abortion: a systematic review', *Contraception*, 2015 (92), p 210.

<sup>204</sup> Public hearing transcript, Brisbane, 2 August 2016, p 9.

<sup>205</sup> Therapeutic Goods Administration, *Australian Public Assessment Report for mifepristone/misoprostol*, October 2014, Attachment 1, p 10; Tang O, *et al*, 'Second trimester medical abortion with mifepristone and gemeprost: a review of 956 cases', *Contraception*, 2001 (64), pp 29-32.

<sup>206</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 19.

- a different procedural technique and timeframe applies for terminations after about 14 weeks and terminations can be more difficult and expensive to access after this gestation.<sup>207</sup>

### 7.2.3 Late abortion

Late abortion, generally above 20 weeks gestation, are performed in instances of very severe and/or lethal foetal anomaly by induction of labour; labour is induced and a birth occurs. In the majority of these cases, potassium chloride is given to the foetus which stops the heart prior to the induction of labour. If foeticide is performed, 'Best practice is to observe the heart over a period of time, usually up to an hour, to ensure the procedure has been successful,' prior to the induction.<sup>208</sup> Foeticide is not performed at gestations of less than 22 weeks; at over 22 weeks foeticide is performed if the woman chooses to have the procedure performed.<sup>209</sup>

Professor Ellwood explained bereavement care is provided following termination of pregnancy as, it is following stillbirth for any other reason.<sup>210</sup> Some women:

*... choose to do all of the things that might be done following a stillbirth which might include naming the baby, obtaining hand and footprints, photographs—all sorts of ways of remembering the baby. ...There is no one approach. It is very much discussed beforehand and planned with the woman and whatever she really wants to do.*<sup>211</sup>

As private clinics are only registered or credentialed to perform abortions up to a gestation period of 20 weeks, all late terminations are performed in public hospitals.<sup>212</sup> Professor Ellwood advised that late terminations are generally performed by very experienced health professionals in the 'major tertiary maternity hospitals such as the Gold Coast, Royal Brisbane and Townsville'.<sup>213</sup>

Professor Ellwood also outlined the approval process in a public sector hospital prior to a late termination being performed:

*I will then get a second specialist to see her to make the same assessment that I have made that the continuation of the pregnancy is likely to cause significant harm to the woman. There is then a referral to the head of the department to convene what at my hospital is called an ethics committee. The ethics committee then considers the request. I will go to the committee to present the case and to discuss the reasons for requested termination of pregnancy. There may be then a request from the committee for further information or for the woman to receive another assessment. It might be a psychiatric assessment or it might be a social work assessment. Then once the committee has made their decision that is then referred on to a senior medical administrator within the hospital to give the final approval.*<sup>214</sup>

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<sup>207</sup> Submission 794, p 8.

<sup>208</sup> Professor David Elwood, public hearing transcript, Brisbane, 4 August 2016, p 21.

<sup>209</sup> Professor David Elwood, public hearing transcript, Brisbane, 4 August 2016, p 18.

<sup>210</sup> Professor David Elwood, public hearing transcript, Brisbane, 4 August 2016, p 18.

<sup>211</sup> Professor David Elwood, public hearing transcript, Brisbane, 4 August 2016, p 18.

<sup>212</sup> Dr Carol Portmann, public hearing transcript, Brisbane, 4 August 2016, p 8.

<sup>213</sup> Public hearing transcript, Brisbane, 4 August 2016, p 17.

<sup>214</sup> Public hearing transcript, Brisbane, 4 August 2016, p 17.



## 7.2.4 Safety of abortion

### 7.2.4.1 *Safety of medical abortion*

The combination of mifepristone and misoprostol was considered to have a favourable safety profile in a published study which assessed, among other things, the reported complications of 13,345 early medical abortions across Australia for the two years from 1 September 2009.<sup>215</sup>

Complications arose in 519 (3.89%) of the 13,345 terminations conducted, including one death from sepsis (under 0.01% of cases). The complication in 465 cases (3.48%) was that the attempted termination was not successful. The other main complications were 21 (0.16%) suspected infections and 11 (0.08%) haemorrhages that required blood transfusions.

Research in the Cochrane Database of Systematic Reviews compared medical methods used in first trimester abortion from 58 studies, finding that:

*An important aspect of this review is the overall very low rate of major complications reported among the various medical abortion regimens. The most common complication is the need for blood transfusion (about 0.2%).*<sup>216</sup>

A study in the Bulletin of the World Health Organization compared the effectiveness, safety and acceptability of medical abortions at home and in clinics, using nine studies including 4,522 participants. The study found that:

*Serious complications were rare. Four women had severe bleeding that required transfusion, and Suspected infection requiring hospitalization occurred in one case.*<sup>217</sup>

Dr Darren Russell, a Queensland-based doctor who performs medical terminations, stated that:

*Of the more than 3000 medical abortions we have performed over the last 10 years there have been no fatalities and very few significant complications.*<sup>218</sup>

### 7.2.4.2 *Safety of surgical abortion*

As noted above, the RANZCOG guide, *Termination of pregnancy*, draws on best practice advice from the United Kingdom Royal College of Obstetricians and Gynaecologists (RCOG). It highlighted the following potential complications as a result of a surgical abortion:

- cervical trauma – the risk of damage is no more than 1 in 100 and is lower for first-trimester abortions; trauma is less likely if cervical preparation is undertaken in line with best practice (described separately in the guide), and
- uterine perforation – the risk is in the order of 1 to 4 in 1,000 and is lower for first-trimester abortion.<sup>219</sup>

The British Pregnancy Advisory Service (BPAS) advises that following a dilatation and evacuation termination, very heavy bleeding occurs in around 1 in 800 cases, perforation of the uterus/womb occurs in 1 in 2,500 cases and death occurs in fewer than 1 in 100,000 cases.<sup>220</sup>

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<sup>215</sup> Philip Goldstone *et al*, 'Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study', *Medical Journal of Australia*, 197(5), 2012, p 282.

<sup>216</sup> Regina Kulier *et al*, 'Medical methods for first trimester abortion', *Cochrane Database of Systematic Reviews*, 9 November 2011, <<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002855.pub4/full#CD002855-sec2-0009>>.

<sup>217</sup> Thoai D Ngo *et al*, 'Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review', *Bulletin World Health Organisation*, 89(5), May 2011, p 360.

<sup>218</sup> Submission 542, p 1

<sup>219</sup> Royal College of Obstetricians and Gynaecologists (UK), *Best practice in comprehensive abortion care*, June 2015.

<sup>220</sup> British Pregnancy Advisory Service, *Dilatation and evacuation*, <<https://www.bpas.org/abortion-care/abortion-treatments/surgical-abortion/dilatation-and-evacuation/>>.

Following a vacuum aspiration abortion, the BPAS advises that perforation of the uterus/womb occurs in 1 in 6,500 cases, very heavy bleeding occurs in 1 in 8,000 cases and death occurs in fewer than 1 in 100,000 cases.<sup>221</sup>

#### 7.2.4.3 *Safety of late termination*

Professor Ellwood noted that there is a risk of complications with any birth, and that it:

*...would be very unusual to identify a situation where the termination of pregnancy itself carried any greater risk than the continuation of the pregnancy.*<sup>222</sup>

The Clinical Guideline states that haemorrhage is a possible complication of abortions performed at greater than 20 weeks with a risk of 4 in 1,000 terminations.<sup>223</sup>

A United States study which analysed the safety of termination using potassium chloride to abort a foetus found that of 192 terminations only one caused complications. This was when a patient with a known seizure disorder had a seizure after the needle had been inserted but before any potassium chloride could be injected.<sup>224</sup>

Research in the UK found that the use of potassium chloride in the abortion of 239 pregnancies of at least 20 weeks gestation did not cause complications for any women.<sup>225</sup>

Abortion is considered by medical professional organisations to be a clinically safe procedure. The RANZCOG guide *Termination of pregnancy* draws on the United Kingdom RCOG advice. It states in its best practice guidelines on abortion that women seeking an abortion should be advised that:

*Abortion is a safe procedure for which major complications and mortality are rare at all gestations. If performed in line with best practice, abortion is safer than childbirth.*<sup>226</sup>

The American College of Obstetricians and Gynaecologists states that:

*Legal abortion in the United States is among the safest of medical procedures.*<sup>227</sup>

The Victorian Government health information website states that abortion is one of the most common and safest types of surgery in Australia.<sup>228</sup>

## 7.3 Decision-making and consent

### 7.3.1 Legal considerations

The Clinical Guideline recommends that consideration be given to each woman's circumstances on an individual basis, with the following legal test to be applied:

- whether a termination of the pregnancy is necessary to preserve the woman from serious danger to her life or her physical or mental health and

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<sup>221</sup> British Pregnancy Advisory Service, Vacuum aspiration, <<https://www.bpas.org/abortion-care/abortion-treatments/surgical-abortion/vacuum-aspiration/>>.

<sup>222</sup> Professor David Elwood, public hearing transcript, Brisbane, 4 August 2016, p 17.

<sup>223</sup> Public hearing transcript, Brisbane, 4 August 2016, p 14.

<sup>224</sup> <http://www.jultrasoundmed.org/content/33/2/337.long>

<sup>225</sup> <http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01639.x/epdf>

<sup>226</sup> Royal College of Obstetricians and Gynaecologists (UK), *Best practice in comprehensive abortion care*, June 2015, p 1.

<sup>227</sup> Phillip Stubblefield *et al*, 'Methods for induced abortion', *Clinical Gynaecological Series: an expert's view*, 104(1), July 2004, p 174.

<sup>228</sup> Victorian State Government, *Abortion procedures – surgical*, <<https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-surgical>>.

- that in the circumstances, the danger of the medical treatment or surgical operation is not out of proportion to the danger intended to be averted.<sup>229</sup>

The Clinical Guideline further recommends that the legal test be applied in the light of the woman's social, economic and medical circumstances.

### 7.3.2 Foetal abnormalities

The Clinical Guideline states that an abnormal foetus with high likelihood of disability or death is not in itself a basis for a lawful termination. It recommends that the effect on the woman of the foetal abnormality be explored as to how it affects the woman and that it may be important to have documented advice from a paediatrician regarding the prognosis for the foetus if the pregnancy were to continue.<sup>230</sup> Queensland Health reiterated the advice in the Clinical Guideline that foetal abnormality alone is not sufficient to meet the current legal requirements for lawful termination in Queensland.<sup>231</sup>

### 7.3.3 Consent

As with all medical procedures, informed consent is required for an abortion. The law of consent is discussed in Chapter 2 of this report.

### 7.3.4 Hospital approval mechanisms

The Clinical Guideline states that each health facility should determine the local approval structure and mechanisms appropriate to its service and strongly recommends that the treating obstetrician observe those requirements. The recommended approval mechanisms are provided below.

#### 7.3.4.1 *All cases*

Two medical specialists, one of whom must be a specialist obstetrician, consider the circumstances of each individual case:

- ideally, one specialist should be the practitioner performing or overseeing the procedure
- the specialty of the second medical practitioner should be relevant to the circumstances of the individual case, and
- consider local facility approval requirements which may include notification to or approval from the Executive Director of Medical Services or equivalent (for example, Medical Superintendent).

#### 7.3.4.2 *Complex cases*<sup>232</sup>

Where there are complex issues, a case review is recommended to consider the complexities specific to the individual case, including:

- in addition to the treating obstetrician, include a minimum of one other health professional in the case review *as appropriate for the individual case*

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<sup>229</sup>

<sup>230</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 10.

<sup>231</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 11.

<sup>232</sup> Complex cases may be those which in the judgement of the treating health professional(s), there are circumstances that complicate the decision making process and/or care and management of a woman requesting a termination of pregnancy, see Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p. 4.

- other health professionals may include (but are not limited to) a social worker, psychiatrist, obstetrician, general practitioner, maternal fetal medicine specialist or paediatrician, and
- other members of the case review consider all the circumstances and provide an opinion to the treating obstetrician and the Executive Director of Medical Services (or equivalent) on whether or not the criteria for termination under section 282 are met.<sup>233</sup>

### 7.3.5 Access to termination services

The Queensland Health Clinical Guideline includes the following 'good practice points' in relation to access to termination of pregnancy services:

- women requesting termination of pregnancy require assessment by a medical officer who is not a conscientious objector
- where termination of pregnancy is considered lawful but the service is not locally available, support women to access the service as would occur for any specialist procedure as per local Hospital and Health Service (HHS) policy for consultation and referral
- provide documented information to consumers, external service providers and support agencies within the local HHS on the choices available within the service, and on routes of access to these services
- facilitate access to termination of pregnancy services as early as possible in the pregnancy to reduce the likelihood of associated health risks
- ideally, offer an assessment appointment within 5 days of referral
- provide dedicated clinic time for the assessment appointment separate from antenatal clinics where feasible, and
- ideally, provide termination of pregnancy within 2 weeks of the decision to proceed.<sup>234</sup>

### 7.3.6 Referral

The Clinical Guideline states that where service level capabilities as defined in the CSCF<sup>235</sup> are insufficient to provide termination of pregnancy, timely referral and transfer procedures to a hospital with the requisite capabilities should be established.<sup>236</sup>

In relation to mental health issues, the Clinical Guideline recommends:

- women be offered referral to a mental health service where there is a pre-existing mental health problem
- services consider the need for support and care for all women who request a termination of pregnancy because the risk of mental health problems increases whatever the pregnancy outcome, and

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<sup>233</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p. 9.

<sup>234</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p. 8.

<sup>235</sup> Queensland Health, Clinical Services capability framework, < <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/default.asp> >.

<sup>236</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8.

- involve social worker support where feasible.<sup>237</sup>

### 7.3.7 Counselling and information provision

The Clinical Guideline states that HHSs should involve social worker support in the care of women requesting and accessing termination of pregnancy services. The guideline also provides good practice points for counselling which include:

- offer confidential, nonjudgmental support and counselling
- counselling should be provided by someone (e.g. social worker, psychologist, counsellor) who is appropriately qualified and/or trained, is familiar with the issues surrounding termination of pregnancy and has no vested interest in the pregnancy outcome
- where feasible, offer counselling 'close to home' to aid the establishment of longer-term counselling support, and
- consider the requirement for formal mental health referral especially if there is a history of mental illness.<sup>238</sup>

## 7.4 Incidence of abortion in Queensland

### 7.4.1 Introduction

#### 7.4.1.1 *Data limitations*

There are limitations on the data available on the incidence of abortion in Queensland. RANZCOG noted in 2005 that there is no national monitoring of abortion in Australia, so accurate national data is not available.<sup>239</sup>

Multiple factors contribute to incomplete data about the incidence of abortion in Queensland. Those factors include the nature of Medicare data, the lack of common data definitions, and the arrangements for licensing and distribution of Mifepristone and Misoprostol in Australia which effect Pharmaceutical Benefits Scheme data. In addition, there was significant evidence presented to the committee that the criminal offences for abortion in Queensland contribute to limits on data collection and transparency.

The data presented in this chapter draws on admitted patient episodes for licensed private health facilities, Medicare data, Queensland perinatal data collection and prescriptions for Mifepristone and Misoprostol.

#### 7.4.1.2 *Estimated number of abortions*

It is estimated that between 10,000 and 14,000 abortions have been performed annually in recent years in Queensland. The majority of abortions are performed in the first trimester of pregnancy.<sup>240</sup>

An analysis of the various data sources by the Australian Institute of Health and Welfare in 2003 estimated that just over 14,000 Queensland women had abortions in 2003, and 11.5 per cent had the

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<sup>237</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 13.

<sup>238</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 13.

<sup>239</sup> RANZCOG, *Termination of pregnancy: A resource for health professionals*, <[http://www.ranzcog.edu.au/editions/doc\\_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html](http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html)>, 2005, p 5.

<sup>240</sup> Submission 116

procedure outside their state of residence.<sup>241</sup> Since 2003, it is likely that the number of medical terminations has increased following licensing of Mifepristone and Misoprostol; and the number of surgical terminations has been decreasing steadily for some years (see 7.5.1).

### 7.4.1.3 *Private providers*

In Queensland, private providers operate the majority of termination services. Queensland Health advised that while it can oversee implementation of the recommendations in the Clinical Guideline in the public health system in public hospitals, it could not comment specifically on how the Clinical Guideline may or may not be used in private settings.<sup>242</sup>

## 7.4.2 Incidence of terminations in licensed private health facilities

Termination of medically uncomplicated pregnancies are most commonly carried out in the private sector.<sup>243</sup> The Minister for Health and Ambulance Services provided the following data and advised that it represents admitted patient episodes of care for pregnancy termination services reported as occurring in licensed private health facilities under the *Private Health Facilities Act 1999* from 2005 to 2015.<sup>244</sup>

**Table 1 Admitted patient episodes for care for termination of pregnancy in licensed private health facilities**

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
12,387	13,232	13,996	14,302	14,330	12,744	11,432	11,630	11,756	10,963	10,403

Source: Queensland Hospital Admitted Patient Data Collection, Statistical Services Branch, Department of Health, Queensland

These figures do not represent all terminations as they exclude public hospital procedures and medical abortion provided by general practitioners and sexual health clinics.<sup>245</sup>

## 7.5 Public providers

Limited termination services are provided in Queensland hospitals. Most of the terminations performed in public hospitals in Queensland are for foetal abnormalities, maternal illness or complications, and the public hospital system's role in 'early therapeutic terminations is probably limited'.<sup>246</sup> It is estimated that less than one per cent of abortions were performed in the public hospital system in 2015.<sup>247</sup> Statistics provided to the committee by Queensland Health show the number of therapeutic terminations provided in public hospitals has increased in recent years to 295 in the 2015 calendar year.<sup>248</sup>

### 7.5.1 Medicare data on incidence of surgical procedures – abortions and other procedures

Medicare data for Queensland in 2015 shows 13,092 surgical procedures, many of which are assumed to have been abortions. The Medicare item numbers do not differentiate the purpose of a curettage

<sup>241</sup> Hargreaves J, Grayson N & Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. Perinatal statistics series no. 17. Cat. no. PER 30. Canberra: AIHW. Viewed 24 August 2016 <<http://www.aihw.gov.au/publication-detail/?id=6442467790>>.

<sup>242</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 13.

<sup>243</sup> L Hilder *et al*, 'Australia's mothers and babies 2012', *Perinatal statistics series no. 30*, cat. No. PER 69, Canberra, Australian Institute of Health and Welfare, 104, p 102.

<sup>244</sup> Queensland Parliament, *Answer to Question on Notice No. 883*, asked on 24 May 2016.

<sup>245</sup> Children by Choice Association, submission 794, p 55.

<sup>246</sup> John Wakefield, Public briefing transcript, Brisbane, 12 Jul 2016, p 13

<sup>247</sup> John Wakefield, Public briefing transcript, Brisbane, 12 Jul 2016, p 10

<sup>248</sup> John Wakefield, Public briefing transcript, Brisbane, 12 Jul 2016, p 10

procedure, which may have been to terminate a pregnancy or, for example, to treat a woman after an unplanned miscarriage:

- *Medicare items 35639 and 35640* – curettage of uterus, with or without dilatation under general anaesthetic or major nerve block, where undertaken in a hospital (includes procedures that are not abortions, such as those carried out following a miscarriage)<sup>249</sup>
- *Medicare Item 35643* – evacuation of the content of the gravid uterus by curettage or suction curettage (includes procedures that are not abortions, such as those carried out following a miscarriage).<sup>250</sup>

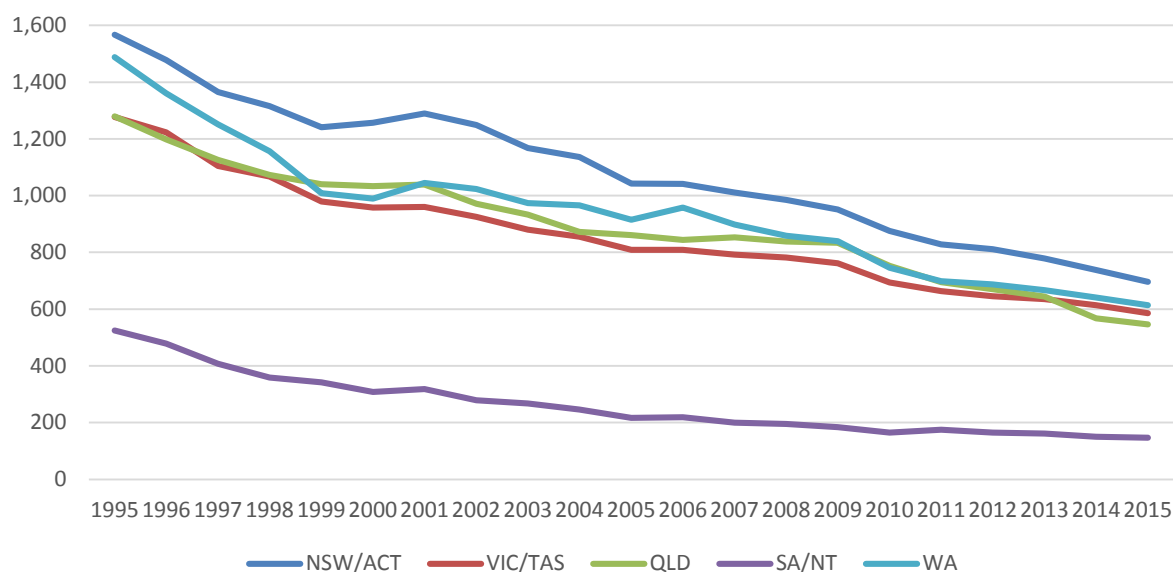
The Medicare data shows 111 incidents of second trimester labour in Queensland in 2015, based on:

- *Medicare Item 16525* – management of second trimester labour, with or without induction, for intra-uterine foetal death, gross foetal abnormality or life threatening maternal disease (includes procedures that are not abortions, such as circumstances of intra-uterine foetal death).<sup>251</sup>

The incidence of surgical procedures that include abortions (Medicare items 35639, 35640, 35643, 16525) have declined over the past 20 years in Queensland, in line with the trend in other Australian jurisdictions, as shown in the graph below.

**Figure 1 Instances of surgical termination (Medicare items 35639, 35640, 35643, 16525) per 100,000 of the female population in Australian states and territories, 1995-2015**

*Prepared using data from Department of Human Services and the Australian Bureau of Statistics.*<sup>252</sup>



<sup>249</sup> Australia. Department of Human Services, 'Medicare Australia Statistics: Requested Medicare items processed from January 2015 to December 2015', Items 35639 and 35640, (accessed on 15 August 2016).

<sup>250</sup> Australia. Department of Human Services, 'Medicare Australia Statistics: Requested Medicare items processed from January 2015 to December 2015', Item 35643, accessed on 15 August 2016.

<sup>251</sup> Australia. Department of Human Resources, 'Medicare Australia Statistics: Requested Medicare items processed from January 2015 to December 2015', Item 16525, (accessed on 15 August 2016).

<sup>252</sup> Australia. Department of Human Services, 'Medicare Australia Statistics: Requested Medicare items processed from January 1995 to December 2015', Item 35639, 35640, 35643, 16525, (accessed on 15 August 2016); Australian Bureau of Statistics, 'Australian Demographic Statistics - Estimated Resident Population, States and Territories (Number)' (accessed on 15 August 2015).

### 7.5.2 Incidence of later gestation terminations (private and public health facilities)

The Queensland Perinatal Data Collection includes all live births and stillbirths of at least 20 weeks gestation and/or at least 400 grams in weight. This data shows 136 perinatal deaths in Queensland due to termination of pregnancy in public and private facilities in 2014.<sup>253</sup>

The incidence of later gestation terminations reported in the Queensland perinatal death statistics shows an increase each year since 2005 as outlined in Table 2 below.

**Table 2 Late terminations (at least 20 weeks and/or 400 grams) in Queensland 2005-2014**

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
3	21	66	81	86	90	99	104	115	136

Source: Queensland Health, [Perinatal annual reports](#)

Queensland Health advised that it has noted 112 later gestation terminations in public hospitals and 18 in the private sector in 2015.<sup>254</sup>

### 7.5.3 Incidence of medical terminations

Queensland Health advised that it does not have data on those patients who access a medical abortion in an ambulatory (day hospital) or outpatient setting. Medical abortions are generally performed in an outpatient setting in relation to pregnancies up to nine weeks.<sup>255</sup>

Data from the Pharmaceutical Benefits Scheme (PBS) provide indication of the incidence of medically induced terminations generally, but do not accurately reflect the number in Queensland. This data shows there were 5,444 prescriptions for medical termination of pregnancy issued in Queensland in 2015. The number of prescriptions in Queensland is significantly higher than other states because one pharmacy group supplies mifepristone and misoprostol to health professionals in other states.<sup>256</sup>

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<sup>253</sup> Queensland Health, *Perinatal Statistics 2014*, Table 10.13, Oct 2015, < <https://www.health.qld.gov.au/hsu/peri/peri2014/10-deaths2014.pdf>>; Australian Institute of Health and Welfare, *Data Collection Overview: Queensland Perinatal Data Collection*, < <http://maternitymatrix.aihw.gov.au/Pages/CollDetails.aspx?DataCollID=13>>.

<sup>254</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 11.

<sup>255</sup> John Wakefield, public briefing transcript, Brisbane, 12 Jul 2016, p 11.

<sup>256</sup> Children by Choice Queensland, Submission 794



## **PART 2: VIEWS ABOUT ABORTION & REGULATION**

### **8 Community attitude surveys**

#### **8.1 Introduction**

The inquiry terms of reference require the committee to consider the need to modernise and clarify the law to reflect current community attitudes and expectations. Public debate about abortion law is dominated by interest groups with strong views on both sides of the debate, as is evidenced by the submissions received by the committee. Queenslanders hold divergent views about abortion, and about the way it is regulated. Those views are informed by a range of philosophical, religious and ethical perspectives. The committee recognises that the views that are most prominent in public debate may not reflect the full range of community views.

With the objective of understanding broader community views, the committee commissioned Professor Matthew Gray and colleagues from the Australian National University (ANU) to assess the reliability of seven Australian community attitude surveys and opinion polls about abortion undertaken since 2007. These surveys were either identified by the committee as being of interest, referred to in submissions, or identified by ANU in a search of existing surveys for questions on community attitudes towards abortion.

The surveys analysed were:

- Galaxy Research 'What Queenslanders Really Think about Abortion' 2016
- Australian Election Studies 2010 and 2013
- Second Australian Study of Health and Relationships 2013
- World Values Survey (Australian component) 2012
- Auspoll 'Queensland Voters' Views on Abortion' 2009
- Australian Survey of Social Attitudes 2009
- Crosby Textor 'Australian attitudes to early and late abortion' survey 2008.

This chapter summarises the results of the ANU's analysis of these surveys. More detail is provided in Appendix D.

#### **8.2 Assessment of reliability of community attitude surveys**

The ANU assessed that the 'What Queenslanders Really Think about Abortion' (2016) and 'Queensland Voters' Views on Abortion' (2009) do not provide reliable information on community attitudes towards abortion.

The 'Australian Attitudes to Early and Late Abortion Survey 2008' has some question marks over the representativeness of the sample and therefore the results should be treated with some caution. Nonetheless the more nuanced nature of questions asked as compared to some of the other surveys makes this a worthwhile survey to consider when assessing community attitudes.

The 'Australian Election Study' (2010 and 2013), 'Australian Survey of Social Attitudes' (2009), 'World Values' (Australian component 2012) and the 'Second Australian Study of Health and Relationships' (2013) are all independent surveys based on a probability sample and with questions which are not leading. Where comparable questions are asked, these surveys all provide broadly consistent results on community attitudes towards abortion.

**Figure 2 Features of the community attitude surveys assessed**

	<b><i>Galaxy Research 'What Queenslanders Really Think about Abortion' 2016</i></b>	<b><i>Australian Election Study 2013</i></b>	<b><i>Australian Election Study 2010</i></b>	<b><i>'Australian attitudes to early and late abortion' – de Crespigny et al. 2008</i></b>
<b>Sample frame</b>	'Telephone list'	Electoral roll	Electoral roll	Online panel
<b>Mode</b>	CATI	Mail & online	Mail & online	Online
<b>Sample size</b>	400	3,955	2,003	1,050
<b>Coverage</b>	Queensland	National	National	National
	<b><i>Queensland voters' views on abortion 2009</i></b>	<b><i>Australian Survey of Social Attitudes 2009</i></b>	<b><i>World Values Survey (Australian component) 2012</i></b>	<b><i>Second Australian Study of Health and Relationships 2013</i></b>
<b>Sample frame</b>	Online panel	Electoral roll	Electoral roll	Telephone list
<b>Mode</b>	Online	Mail	Mail	CATI
<b>Sample size</b>	1,016	1,718	1,477	20,094
<b>Coverage</b>	Queensland	National	National	National

### 8.3 Summary of community attitudes about abortion

This section provides a summary of current and longitudinal public opinion towards abortion in Australia, with an emphasis on Queensland residents. The Australian Election Study, World Values Survey (Australian component) (2012), Australian Survey of Social Attitudes 2009 and the Second Australian Study of Health and Relationships (2013) provide the most representative estimates of Australian community attitudes about abortion. While the Australian Attitudes to Early and Late Abortion Survey 2008 is not as technically strong, it contains a wide range of questions than the technically stronger surveys. The findings of the 2008 Victorian Law Reform Commission *Law of Abortion: Final Report* are also drawn upon in the summary.

The summary of community attitudes about abortion below comprises three parts; current support for abortion in Australia, trends in support for abortion in Australia, and limits to support for abortion in Australia.

#### 8.3.1 Current support for abortion in Australia

Recent surveys of attitudes towards abortion in Australia suggest that approximately 60 per cent of the Australian population supports women being able to obtain an abortion readily, a substantial sized minority (between one quarter and one third) support abortion only in special circumstances and a smaller group (somewhere between 5 and 20 per cent) believe abortion is never acceptable.

Question wording appears to introduce variations in the percentage of respondents expressing support for abortion across different surveys. According to the Australian Election Study surveys, the proportion of Australians who believe women should be able to obtain abortion readily when they want one is around 60 per cent (Australian Election Studies 2010 and 2013). Around 30 per cent of Australians think that abortion should be allowed only in special circumstances. Around five per cent of Australians think that abortion should not be allowed under any circumstances.

Data from the 2003 and 2005 Australian Survey of Social Attitudes reveal that about 80 per cent of Australians strongly agree or agree with the statement that 'A women should have the right to choose whether or not she has an abortion'.<sup>257</sup>

The 2012 World Values Survey indicates that 16 per cent of Australians believe abortion is never justifiable; 84 per cent of the population appear to believe that abortion is justifiable in some circumstances, if not all circumstances.

The data from the 2012 World Values Survey is broadly consistent with the data from the Second Australian Study of Health and Relationships, in which 70 per cent of respondents *disagree* with the statement that abortion is always wrong (Second Australian Study of Health and Relationships).

Where state breakdowns are available, the views of Queensland residents are not statistically distinguishable from national averages, nor from the averages of similarly sized states such as New South Wales and Queensland (Table 3).

**Table 3 Abortion support, Australian Election Study 2010 and 2013 (column percentages)**

*'Which one of these statements comes closest to how you feel about abortion in Australia?'*

	2010		2013	
	QLD	Total	QLD	Total
<i>Women should be able to obtain an abortion readily when they want one</i>	54	58	58	60
<i>Abortion should be allowed only in special circumstances</i>	31	31	30	27
<i>Abortion should not be allowed under any circumstances</i>	4	4	3	4
<i>Don't know</i>	7	6	6	7
<i>No response</i>	1	1	3	2
<i>Total %</i>	100	100	100	100
<i>Number of observations</i>	398	2059	743	3,862

Source: 2010 and 2013 Australian Election Studies. Weighted percentages.

#### 8.4 Trends in Australian community attitudes about abortion

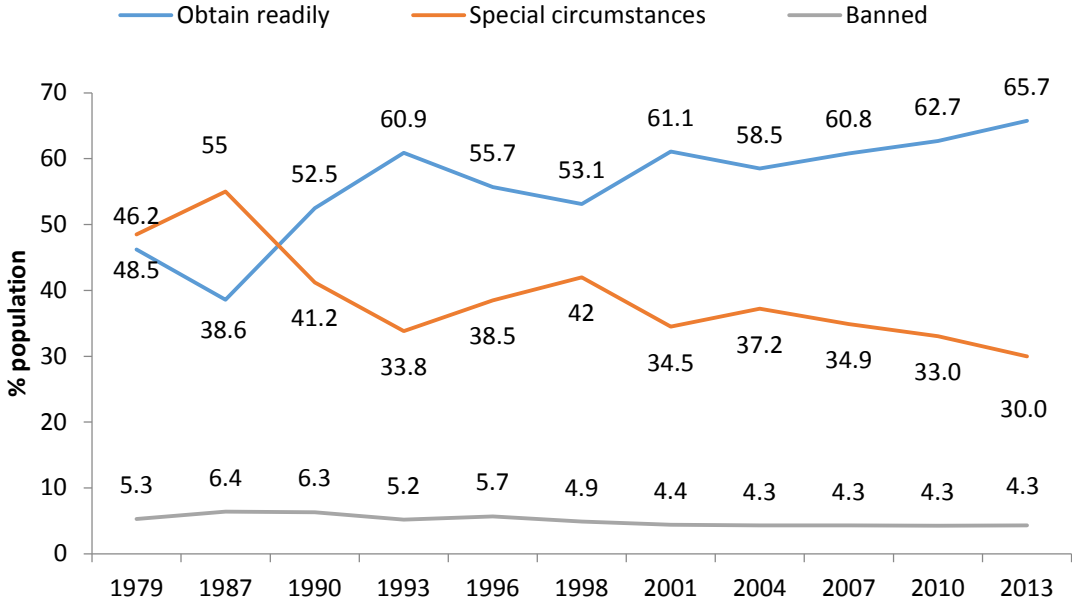
The Australian Election Study (and its predecessor, the Australian National Political Attitudes Survey Program) provides the clearest picture of how community attitudes towards abortion in Australia have changed since the late 1970s (Figures 4 and 5). The proportion of Australians who believe 'women should be able to obtain an abortion readily when they want one' has increased from 48.5 per cent in 1979 to 65.7 per cent in 2013. Over the same period, the percentage of Australians who believe that 'abortion should be allowed only in special circumstances' has decreased from 46.2 per cent to 30 per cent. The percentage that believes abortion should be banned has remained remarkably stable over the 41-year time frame, at approximately five per cent of the population.

<sup>257</sup> Reported in 2008 Victorian Law Reform Commission report *Law of Abortion: Final Report*.

**Figure 3 Abortion support, Australian National Political Study 1979 and Australian Election Study 1987 to 2013**

*Do you think women should be able to obtain an abortion easily when they want one, or do you think abortion should be allowed only in special circumstances? (Australian National Political Attitudes Survey 1979, Australian Election Study 1987).*

*Which one of these statements comes closest to how you feel about abortion in Australia? 1) Women should be able to obtain an abortion readily when they want one 2) Abortion should be allowed only in special circumstances 3) Abortion should not be allowed under any circumstances (Australian Election Study 1990-2013)*



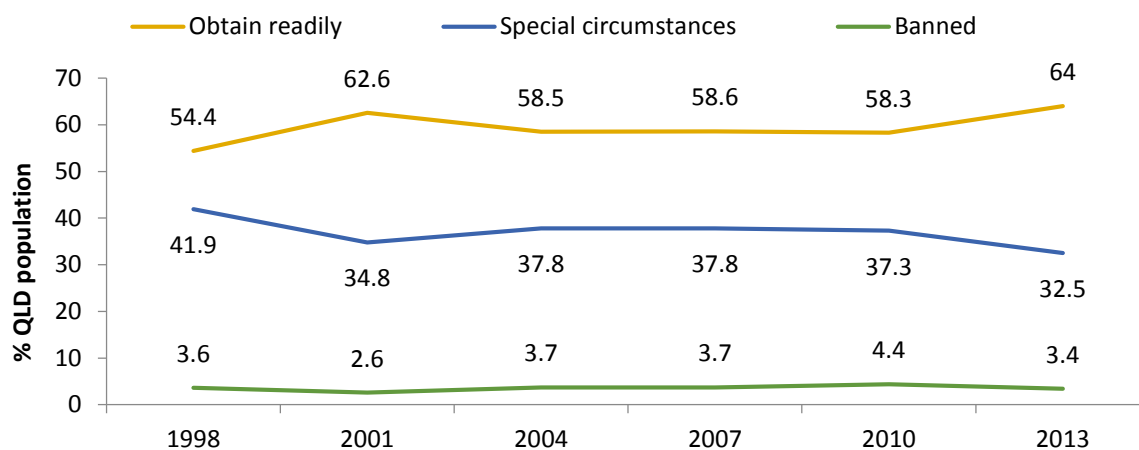
Source: McAllister, I. and Cameron, S. (2010). Trends in Australian Political Opinion: Results from the Australian Election Study, 1987-2013, The Australian National University, <http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/australian-election-study/publications/aes-trends>

Public opinion among residents of Queensland shows similar trends. Australian Election Study data have included respondents' state of residence since 1996. Between 1996 and 2013, the percentage of Queenslanders believing women should be able to readily obtain an abortion has increased by ten percentage points, from 54.4 per cent to 64 per cent. Similarly, the percentage believing abortion should only be allowed in special circumstances has fallen from 41.9 per cent to 32.5 per cent over the 17-year period. The percentage of Queenslanders who believe abortion should be banned has remained stable between 2.6 per cent (in 2001) and 4.4 per cent (in 2010).

**Figure 4 Abortion support among Queensland residents only, Australian Election Study 1996 to 2013**

*Do you think women should be able to obtain an abortion easily when they want one, or do you think abortion should be allowed only in special circumstances? (Australian National Political Attitudes Survey 1979, Australian Election Study 1987).*

*Which one of these statements comes closest to how you feel about abortion in Australia? 1) Women should be able to obtain an abortion readily when they want one 2) Abortion should be allowed only in special circumstances 3) Abortion should not be allowed under any circumstances (Australian Election Study 1990-2013)*



Source: Australian Election Study 1998-2013 data files, available at <http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/australian-election-study/voter-studies>.

#### 8.4.1 Limits to support for abortion in Australia

Several recent studies of community attitudes to abortion in Australia have shown that support for abortion depends upon the circumstances. Specifically, Australians are more supportive of abortion when it is performed for the sake of the physical or mental health of the mother or the baby (AUSSA 2009). For instance, eight per cent of Australians believe that abortion is 'always wrong', in the case that 'there is a strong chance of serious defect in the baby' (AUSSA 2009). In the same study, 23 per cent of Australians responded that abortion is 'always wrong', in the case that 'the family has a very low income and cannot afford any more children' (AUSSA 2009). Across the population, there appears to be substantially more support for abortion as a means of preventing physical and mental pain or disability than as a means of not bringing children into poverty.

## 9 Decreasing the incidence of abortion

### 9.1 Introduction

The committee heard evidence from submitters that a wide variety of circumstances, including lack of knowledge about contraception and contraceptive failure, lead to unintended pregnancies.

Professor Eleanor Milligan, Professor of Ethics and Professional Practice, School of Medicine, Griffith University, advised that international research confirms that women seeking termination are more likely to be young, less financially secure, lacking in education, and to have less access or poor access to appropriate medical care.<sup>258</sup> The Health Consumer's Queensland submission stated that the average age of women seeking terminations was 20 to 24 years and that 'Sadly it is these younger women who are at a disadvantage of not knowing where to access information and services on reproductive health'.<sup>259</sup>

Stakeholders who addressed the issue of prevention generally agreed that reducing the number of unintended pregnancies is the best way to reduce the incidence of pregnancy termination. For example, the RANZCOG submitted that preventing unintended pregnancy should be a priority.<sup>260</sup> One medical practitioner who strongly supported prevention strategies stated 'termination of pregnancy should however be a rare procedure as it is traumatic for the women involved and staff providing the service'.<sup>261</sup>

Various strategies suggested to the committee to assist in mitigating the wide variety of circumstances that lead to unintended pregnancies are discussed below.

### 9.2 Safe reliable, affordable and effective contraception

While no contraception is 100 per cent effective and can fail even when used correctly and consistently,<sup>262</sup> enhancing access to a wide range of safe, affordable and effective contraception was seen as a key strategy by some stakeholders to reduce the number of unplanned pregnancies.<sup>263</sup>

Mr Alexis Apostolellis, the Chief Executive Officer of the Marie Stopes International – Australia, said he believes access to contraception is one of the factors contributing to the significantly lower rate of abortion in countries such as the Netherlands. While he agreed that contraception is readily available in metropolitan Queensland, Mr Apostolellis said there are still access issues relating to price and choice of contraception:

*We know, again anecdotally, the most effective contraception methods are what we call LARC, long-acting reversible contraception... Like Implanon, and IUD, a Mirena<sup>264</sup>— those are not easily accessible in Australia. Most GPs do not provide that service because it takes a bit longer, it does not exactly fit in the billing with Medicare items, the procedure takes a bit longer and it is a skill. Our clinics do provide that service, but we know anecdotally from various states, including Queensland, that there is a public waiting list if want a Mirena or an IUD of three to six months. By that time, you are pregnant. That is probably one of the primary reasons why it is accessible*

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<sup>258</sup> Public briefing transcript, Brisbane, 13 July 2016, p 31.

<sup>259</sup> Submission 830, p 4.

<sup>260</sup> Submission 845, p 1.

<sup>261</sup> Christopher Weekes, Submission 150, p 2.

<sup>262</sup> Carla Gorton, public hearing transcript, Brisbane, 2 August 2016, p. 45.

<sup>263</sup> See for example submission 852, p 2; submission 845, p 1; submission 837, p 8.

<sup>264</sup> A Mirena is a long-acting hormonal IUD

*but the choice is not always accessible, and the most effective means of contraception is not accessible.*<sup>265</sup>

Dr Heather McNamee advised the committee that Australia has the second highest termination rate in the western world, second only to America, and one of the key reasons is the lack of uptake of long-acting, reliable contraceptives. She argued that the focus on prevention should be on improving the uptake of these methods of contraception in Australia.<sup>266</sup>

The Women's Legal Service provided evidence that access to contraception is often compromised for women in domestic violence relationships and that they are aware of cases where birth control has been deliberately sabotaged.<sup>267</sup> Ending Violence Against Women Queensland Inc. submitted that there is a well-established link between unplanned pregnancy and intimate partner violence, with unintended pregnancies being two to three times more likely to be associated with intimate partner violence than planned pregnancies.<sup>268</sup>

Ms Jody Currie, representing the Institute for Urban Indigenous Health, advised that the issue of violence within Indigenous communities and the use of pregnancy as a way of controlling women mostly occurs in the most marginalised communities, whether in remote, urban and rural areas, locations with lower-socio-economic groups and densely populated areas. Ms Currie pointed to the need to have access to good reproductive education and health to empower both men and women, noting that men also need to be responsible for their role in contraception.<sup>269</sup>

Submitters made a number of other suggestions to improve access to effective contraception, including:

- making contraception freely available, specifically for all public hospitals and family planning clinics to offer free condoms, morning after pill (emergency contraception) and basic oral contraceptive pill and for the Implanon and Mirena and Copper IUD, and long-acting reversible contraceptives also being offered free of charge to women and easily accessible<sup>270</sup>
- GPs and health services to encourage more effective forms of contraception<sup>271</sup>
- recommending long-acting reversible contraceptives to young women at high risk of pregnancy, due to poor social circumstances, previous pregnancy or drug use<sup>272</sup>
- increasing awareness of diverse and alternative methods of contraception that may be safer for women dealing with domestic violence to use, including some of the long-acting reversible contraceptive methods, and<sup>273</sup>
- organisations working at public health and individual health care levels to address fertility control.<sup>274</sup>

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<sup>265</sup> Public hearing transcript, Brisbane, 2 August 2016, p 20.

<sup>266</sup> Public hearing transcript, Cairns, 15 July 2016, p 12.

<sup>267</sup> Public hearing transcript, Brisbane, 2 August 2016, p 43.

<sup>268</sup> Submission 838, p 2.

<sup>269</sup> Public hearing transcript, Brisbane, 2 August 2016, p 57.

<sup>270</sup> Christopher Weekes, Submission 150, p 2.

<sup>271</sup> Public hearing transcript, Brisbane, 2 August 2016, p 37.

<sup>272</sup> Christopher Weekes, Submission 150, p 2.

<sup>273</sup> Public hearing transcript, Brisbane, 2 August 2016, p 43.

<sup>274</sup> Public Health Association of Australia, submission 763, p 10.

### 9.3 Education and information regarding contraception and access reproductive health services

A number of stakeholders raised significant issues about disseminating information about contraception, reproductive health services and the prevention of unintended pregnancy. For example, Young Queenslanders for the Right to Choose provided evidence that young people receive with very little information about contraception at some schools and tertiary institutions.<sup>275</sup>

The Public Health Association of Australia (PHAA) agreed there is an issue with disseminating information, and cited the example of emergency contraception where a random sample of the population found that over half of the women were not aware that emergency contraception was available over the counter.<sup>276</sup>

The UN Women National Committee Australia supported the view that providing comprehensive sexuality education reduces the number of unplanned pregnancies. They submitted that evidence has confirmed that sexuality education does not hasten sexual activity, but has a positive impact on safer sexual behaviours, and can delay sexual debut and increase condom usage. The submission suggested the Queensland Government review and improve the evidence-based, comprehensive sexuality education embedded in the education system.<sup>277</sup>

The Queensland Nurses' Union (QNU) pointed to a critical need for increased education and access to services for women of all ages, particularly ensuring equitable access to reproductive health services across Queensland. The QNU emphasised the importance of access to services for the most disadvantaged women, including those from rural and remote areas, Indigenous women and those from lower-economic backgrounds. The QNU suggested that nurses and midwives could do more in terms of the scope of their role in educating women.<sup>278</sup>

Children by Choice provided details of its community education programs which include sexuality and relationships education to young people through schools and youth centres. Most of this work targets young people who are disengaged from mainstream education and is delivered through alternative education programs, community organisations, and behavioural groups with 300 young people taking part in the programs in 2014-15. Children by Choice also provides professional development training for the health and community sector.<sup>279</sup>

### 9.4 Public health and social policy measures

Professor Milligan submitted that international medical research confirms that it is through public health and social policy measures that termination rates are reduced. She concluded, therefore, that the harms (real and potential) associated with termination are best reduced using this framework.<sup>280</sup>

A number of stakeholders supported the development of state-wide and/or national sexual and reproductive health policies.<sup>281</sup> The PHAA argued that development of a comprehensive national sexual and reproductive health strategy can be expected to deliver the best health outcomes by addressing elements including:

- school-based education for safe, respectful relationships

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<sup>275</sup> Public hearing transcript, Brisbane, 2 August 2016, p 52.

<sup>276</sup> Public hearing transcript, 2 August 2016, p 37.

<sup>277</sup> Submission 766, p 3.

<sup>278</sup> Public hearing transcript, Brisbane, 2 August 2016, p 59.

<sup>279</sup> Submission 794, p 10.

<sup>280</sup> Submission 1213, p 1.

<sup>281</sup> See for example submission 746, p 2; submission 818, p 3.



- increasing health literacy with respect to contraception and prevention of unintended pregnancy
- a social determinants framework which takes account of factors such as partner violence and access to financial resources
- service development and planning which ensures equitable access to good quality services
- workforce development for health professionals, educators and others, and
- monitoring, evaluation and research.<sup>282</sup>

The Australian Medical Association Queensland (AMAQ) supported this approach suggesting that a whole-of-government public health plan could be developed by the Queensland Health Promotion Commission.<sup>283</sup> The AMA has also recommended the promotion of respectful, equitable, non-violent relationships and a reduction in binge drinking to help prevent unintended pregnancies.<sup>284</sup>

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<sup>282</sup> Submission 763, p 10.

<sup>283</sup> Submission 852, p 2.

<sup>284</sup> Australian Medical Association, submission 852, p 2.

## 10 Psychological and physical health effects of abortion

### 10.1 Introduction

Submitters presented a range of views about the psychological and physical effects of abortion. This chapter considers the main negative effects of abortion that were raised in submissions and public hearings and the published research and expert evidence available to the committee on those issues.

In considering these issues, the committee has relied on the evidence available from peer-reviewed studies, review articles and clinical experts. The committee considers that a decision to terminate a pregnancy is a serious one, and that discussion of the potential psychological and physical consequences of abortion should, to the extent possible, be based on evidence.

There was a common view among stakeholders that a decision to have an abortion is a serious one. One stated, 'no woman wants to have an abortion';<sup>285</sup> another concurred, stating that 'no woman takes this decision lightly'.<sup>286</sup>

### 10.2 Psychological effects of abortion

#### 10.2.1 Published studies

Over several decades, a large number of studies have been published which have respectively:

- indicated statistically significant associations between abortion and various adverse psychological outcomes, or, equally
- found no difference between mental health risks associated with terminating an unplanned pregnancy and carrying that pregnancy to term.

There has been significant debate among health professionals and academics about the effects of abortion on mental health indicators, including depression, anxiety, suicidal ideation and acts, drug and alcohol abuse, and self-esteem.<sup>287</sup>

Major reviews of literature have identified a wide range of questions about study design, methodologies and data analysis choices which may have served to create bias towards or against a specific directional claim.<sup>288</sup> Scholars have emphasised that further well-designed and rigorously conducted research may help to disentangle confounding factors and quantify the relative risks of abortion compared to its alternatives, as well as the significance of factors associated with variation in the magnitude and duration of emotional and psychological responses in women following abortion.<sup>289</sup> However, the diversity and complexity of women and their circumstances mean that longitudinal studies and systemic reviews of the literature may continue to offer the most comprehensive picture of effects and emerging trends.

#### 10.2.2 Studies identified by submitters

Submitters highlighted a number of longitudinal studies, reviews and associated clinical documents, including:

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<sup>285</sup> R Plath, submission 498.

<sup>286</sup> Mary Sidebotham, submission 533

<sup>287</sup> P Coleman, 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009', *The British Journal of Psychiatry*, 199(3), 2011, p 180

<sup>288</sup> J Steinberg and N Russo, 'Evaluating research on abortion and mental health', *Conception*, 80, 2009, p 500.

<sup>289</sup> J Bristow, 'Abortion, mental health, and the limits of science', *Abortion Review*, 18 December 2009.

- publications from a longitudinal study (Turnaway Study) of women seeking abortions between 2008 and 2010 at facilities across the United States, who were surveyed semi-annually over three years<sup>290</sup>
- a 2011 review by Coleman published in the *British Journal of Psychiatry*, providing a quantitative synthesis and analysis of 22 peer reviewed studies published between 1995 and 2009<sup>291</sup>
- a 2011 systematic review of evidence prepared for the Academy of Medical Royal Colleges (AMRC) by the National Collaborating Centre for Mental Health, London, which examined studies published between 1990 and 2011 that assessed outcomes in a follow-up period of at least 90 days (44 studies)<sup>292</sup>
- a 2008 review by the American Psychological Association's Taskforce on Mental Health and Abortion, which evaluated all empirical studies published in English in peer-reviewed journals in the 20 years post-1989<sup>293</sup>
- a 2008 publication authored by Fergusson *et al* from a 30-year longitudinal study examining the pregnancy and mental health history of a birth cohort of over 500 women (up to age 30)<sup>294</sup>
- the 2005 Royal Australian and New Zealand College of Obstetricians and Gynaecologists' Guideline: *Termination of pregnancy: A resource for health professionals*,<sup>295</sup> and
- a 2001 summary of literature on the psychological effects of abortion from 1970 to 2000 (72 studies and 27 review articles), published by Bonevski and Adams from the Newcastle Institute of Public Health.<sup>296</sup>

### 10.2.3 Evidence about mental health impacts

In two of these key studies or reviews, links between abortion and an increased incidence of mental health indicators were identified. Coleman's 2011 study reported that women who had undergone abortion experienced an 81 per cent increased risk of mental health problems, of which nearly 10 per cent of the incidence of mental health problems was shown to be attributable to abortion.<sup>297</sup> The strongest subgroup estimates of increased risk occurred when abortion was compared with term pregnancy and when the outcomes pertained to substance use and suicidal behaviour.

In addition, Fergusson *et al*'s 2008 study identified that women who had abortions had rates of mental disorders that were about 30 per cent higher, with the estimated attributable risk of exposure to abortion accounting for between 1.5 per cent to 5.5 per cent of the overall rate of mental disorders.<sup>298</sup>

Some submitters cited the two studies as supporting the notion of a 'post-abortion syndrome' and provided additional anecdotal information on rates of women's access to mental health services after

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<sup>290</sup> National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC), submission 778, p 5; see also Lyn Shumack, public hearing transcript, Cairns, 15 July 2016, p 28.

<sup>291</sup> See for example submission 777, p. 4; submission 810, p.6; submission 831, p. 4; submission 1216, p.13; submission 1345, p. 513; Tim Coyle, public hearing transcript, Cairns, 15 July 2016, p 2.

<sup>292</sup> National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC), submission 778, p 5; Reproductive Choice Australia, submission 837, p 7; Heather Douglas, submission 879, p 13.

<sup>293</sup> National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC), submission 778, p 5; Pro Choice Australia, submission 783, p 9.

<sup>294</sup> Priceless Life, submission 1393, p 6.

<sup>295</sup> Public Health Association of Australia, submission 763, p 6.

<sup>296</sup> Pro Choice Australia, submission 783, p 9; Public Health Association of Australia, submission 763, p 6.

<sup>297</sup> P Coleman, 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009', *The British Journal of Psychiatry*, 199, 2011, pp 180-186.

<sup>298</sup> D Fergusson, *et al*, 'Abortion and mental health disorders: evidence from a 30-year longitudinal study', *The British Journal of Psychiatry*, 193(6), 2008, pp 444-451.

abortions, and broader public opinion on possible effects.<sup>299</sup> However, others noted that the findings of the two studies stand in contrast to a range of other longitudinal research and comprehensive reviews, and noted that the term 'post-abortion syndrome' is not a recognised clinical diagnosis. The term:

*... has not been widely accepted and is not recognised by the American Psychological Association or the American Psychiatric Association as a condition, nor is it found in the Diagnostic and Statistical Manual of Mental Disorders or the World Health Organisation's International Classification of Diseases.*<sup>300</sup>

The majority of the systematic analyses concluded that rates of mental health problems were the same for women with unwanted pregnancy whether they had an abortion or gave birth, and that, in general, abortion rarely causes lasting negative psychological consequences in healthy women.<sup>301</sup> Women report experiencing a range of emotions in response to abortion, both positive and negative, from feelings of relief to ambivalence, sadness and grief. While some women experience clinically significant outcomes such as depression or anxiety, these adverse mental health indicators may reflect pre-existing conditions and are likely to be shaped by a range of confounding variables.

#### 10.2.4 Risk factors for post-abortion mental health issues

There is broad academic consensus that a prior history of mental health issues is the most reliable predictor of post-abortion mental health issues. All of the cited studies – those of Coleman and Fergusson et al included – recognise that there are a range of other risk factors for poorer coping after abortion, which can increase the likelihood of adverse psychological effects.

Those other risk factors include childhood adversities, intimate partner violence and reproductive coercion, drug use, and poverty and social disadvantage. As Professor Permezel noted, a longitudinal study such as Fergusson et al is not controlled for the circumstances whereby women find themselves in a position requesting termination, and women who are disadvantaged or are prone to mental health issues are among those requesting termination.<sup>302</sup>

In addition, women's age, personal characteristics (level of self-esteem or personal control), relationship circumstances (for example, partner and family support), and other contextual factors (pregnancy intention, perceptions of stigma, or encountering picketers in front of the abortion clinic) have also been found to influence post-abortion psychological health risks.

#### 10.2.5 No causal relationship between abortion and mental health outcomes

Ultimately, despite some variation in results, it is clear that there is no established causal relationship between abortion and mental health outcomes. A 2009 evaluation of the quality of research on the topic, which rated studies based on methodological factors, found:

*...the highest quality studies had findings that were mostly neutral, suggesting few, if any, differences between women who had abortions and their respective comparison groups in terms*

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<sup>299</sup> Dr Tim Coyle, public hearing transcript, Cairns, 15 July 2016, p 2; ACL, submission 777, p 4; Family Voice Australia, submission 810, p 6; Women's Forum Australia, submission 1345, p 5.

<sup>300</sup> Lyn Shumack, public hearing transcript, Cairns, 15 July 2016, p 28.

<sup>301</sup> M Biggs, *et al*, 'Mental Health Diagnoses 3 years after receiving or being denied an abortion in the United States', *American Journal of Public Health*, 105(12), 2015, pp 2557-2563; Academy of Medical Royal Colleges, *Induced Abortion and Mental Health – A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors*, 2011; American Psychological Association, Task Force on Mental Health and Abortion, *Report of the Task Force on Mental Health and Abortion*, Washington, 2008; RANZCOG, *Termination of pregnancy: A resource for health professionals*, <[http://www.ranzcog.edu.au/editions/doc\\_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html](http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html)>, 2005, p 25; B Bonevski and J Adams, *Psychological aspects of termination of pregnancy: a literature review*, Newcastle Institute of Public Health, 2000.

<sup>302</sup> Professor Michael Permezel, RANZCOG, Public hearing transcript, Brisbane, 2 August 2016, p 7

*of mental health sequelae. Conversely, studies with the most flawed methodology found negative mental health sequelae of abortion.*<sup>303</sup>

Irrespective of the mental health effects of abortion, efforts to address confounding variables by working to reduce social stigma and provide voluntary therapeutic counselling may promote more beneficial mental health outcomes for affected women.<sup>304</sup>

### 10.3 Physical effects of termination

#### 10.3.1 Submitters' views

Some submitters suggested that a range of physical harms may result from abortion. They cited side effects including uterine perforation, cervical incompetence, infection, future infertility and a causal link to breast cancer.<sup>305</sup> A number of other submitters also suggested a link between adverse fertility implications and increased risk of cancer due to abortion.<sup>306</sup>

The Australian Christian Lobby suggested adverse effects of medical abortion. The use of mifepristone (RU486) was attributed to adverse outcomes including surgical intervention after the treatment failed, infection, haemorrhage, and the death of 'at least one Australian woman' from sepsis after taking the medication in 2010.<sup>307</sup>

Adverse physical effects were disputed by a number of submitters.<sup>308</sup> Dr Darren Russell reported that of the 'more than 3000' medical abortions performed at the Cairns Sexual Health Service in the last 10 years, there had been no fatalities and 'very few significant complications'.<sup>309</sup> He cited research conducted by himself and others in 2009 that found medical termination for up to 9 weeks gestation was a safe and effective form of induced abortion.<sup>310</sup>

The RANZCOG's view is that complication rates rise with gestation, but serious complications after abortion are rare, and mortality and serious morbidity occur less commonly with abortions than with pregnancies carried to term.<sup>311</sup>

#### 10.3.2 Breast cancer

In 2014 a study by Victorian cancer researchers found no link between breast cancer and abortion among Victorian women before their full-term pregnancy or with abortion in the first two trimesters.<sup>312</sup>

The RANZCOG publication *Termination of pregnancy: a resource for health professionals* noted the epidemiological debate about a possible association between induced abortion and breast cancer and

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<sup>303</sup> V Charles, *et al*, 'Abortion and long-term mental health outcomes: a systematic review of the evidence', *Contraception*, 78(6), 2008, p 436.

<sup>304</sup> National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC), submission 778, pp 3-4; J Steinberg, *et al*, 'Psychosocial factors and pre-abortion psychological health: The significance of stigma', *Social Science & Medicine*, 150, 2016, p 67; S Holmlund, *et al*, 'Psychological ill-being experienced by first-time mothers and their partners in pregnancy after abortion: a cohort study', *Journal of Psychosomatic Obstetrics & Gynaecology*, 35(4), 2014, p 132.

<sup>305</sup> See for example submissions 535, 813.

<sup>306</sup> See for example submissions 553, 1176.

<sup>307</sup> Submission 777, p 7. One death has been reported in the published literature, see section 7.2.5

<sup>308</sup> See for example submissions 542, 774, 794.

<sup>309</sup> Submission 542.

<sup>310</sup> S Downing *et al*, 'Three years on: a review of medical terminations of pregnancy performed in a sexual health service', *Sexual Health*, 2010 (7), p 214.

<sup>311</sup> RANZCOG, *Termination of pregnancy: A resource for health professionals*, < [http://www.ranzcog.edu.au/editions/doc\\_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html](http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html)>, 2005, p 10.

<sup>312</sup> K-A Phillips, *et al*, 'Abortion and breast cancer risk for Australian women', *Medical Journal of Australia*, 202 (7), p 381.

the inconsistent quality of studies. It cited a 2004 review that analysed 53 studies including 83,000 women with breast cancer and concluded that '... pregnancies that end as a spontaneous or induced abortion do not increase a women's risk of developing breast cancer'. RANZCOG also cited the position of its United Kingdom counterpart, that 'induced abortion is not associated with an increase in breast cancer risk'.<sup>313</sup>

Children by Choice listed a number of organisations that have rejected the link between abortion and breast cancer, including the World Health Organisation (WHO), AMA, RANZCOG, Australian Cancer Council, The Breast Cancer Network of Australia, The National Breast and Ovarian Cancer Centre (US) and The National Cancer Institute (US).<sup>314</sup>

### 10.3.3 Foetal pain

Some submitters argued that abortion should be restricted because a foetus feels pain and abortion inflicts pain on the foetus.<sup>315</sup> For example, the Australian Christian Lobby submitted that by eight weeks gestation there is a reaction to touch, and after 20 weeks there is a reaction to stimuli (e.g. recoiling) that would be recognized as painful if applied to an adult.<sup>316</sup> Particular concerns were raised about abortion procedures used in inducing late-term abortions.<sup>317</sup>

The committee explored the issue of foetal pain with specialist medical practitioners. Dr Carol Portmann advised that under 20 weeks gestation the brain is not capable of something that can be considered to be pain.

*The level of brain development would not suggest that a baby is capable of feeling pain [under 20 weeks]. However, one of the reasons that we choose to perform what we call foeticide over 16 weeks is because we still believe it is kinder to do that before doing a surgical procedure ... That is basically because we do not want any chance of pain.*<sup>318</sup>

Professor Ellwood noted that a lot of the concern about foetal pain is around late-term surgical procedures and reiterated that termination of pregnancy beyond 20 weeks gestation is through induction of labour. He said that it is not clear at what point in gestation the foetus begins to feel pain. Dr Gardener added that 'we take the view that if there is a possibility of the foetus feeling pain we provide pain relief for that procedure prior to the procedure.'<sup>319</sup>

The Queensland Health Clinical Guideline *Perinatal care at the threshold of viability* provides guidance for clinicians about palliative care and pain relief after delivery.<sup>320</sup>

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<sup>313</sup> RANZCOG RANZCOG, *Termination of pregnancy: A resource for health professionals*, [http://www.ranzcog.edu.au/editions/doc\\_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html](http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html), 2005, p 27

<sup>314</sup> Submission 794, p 52.

<sup>315</sup> See for example submissions 777, 832, 1216.

<sup>316</sup> Submission 777

<sup>317</sup> See for example submissions 535, 1216.

<sup>318</sup> Public hearing transcript, Brisbane 4 August 2016, p 9

<sup>319</sup> Public hearing transcript, Brisbane 4 August 2016, p 22

<sup>320</sup> Queensland Health, *Perinatal care at the threshold of viability*

## 11 Young women, abortion and consent

### 11.1 When can a young woman consent?

Generally, once a young woman reaches 18, she is considered to be a competent individual with full legal capacity to make decisions regarding medical treatment. However, a young woman under 18 can consent to medical treatment, including an abortion, providing she has sufficient intelligence and maturity to understand the nature and consequences of the treatment; she is Gillick-competent.<sup>321</sup>

A young woman who is not Gillick-competent, that is does not have ‘...sufficient understanding and intelligence to ... understand fully what is proposed’,<sup>322</sup> cannot consent to an abortion. Generally, when a girl is not-Gillick-competent her parents have the authority to consent to medical treatment.<sup>323</sup> However, in cases where the medical treatment is considered to be ‘special’, the courts have held that consent is beyond parental decision-making authority and decisions must be made by a court.<sup>324</sup>

This limitation on parental decision-making power was established by *Marion’s case*, in which the court held that the sterilisation of a girl who lacked decision-making capacity was a ‘special case’ beyond the scope of parental decision-making authority.<sup>325</sup>

The reasoning in *Marion’s case* was extended in *State of Queensland v B*<sup>326</sup> to apply to abortion. In this case, the permission was granted for a 12-year-old girl, ‘B’, to have an abortion. Justice Wilson found that B was not Gillick-competent, ‘being of less than average intelligence and maturity’, and therefore could not consent to the abortion herself.<sup>327</sup> In making the decision, Justice Wilson noted that it was unlikely that any average 12 year old could fully understand the significance of an abortion.<sup>328</sup>

Justice Wilson also concluded that ‘B’s parents should not be able to consent to the termination of her pregnancy’<sup>329</sup> as abortion was a ‘special case’ outside the scope of parental decision-making authority, and the decision must be made by a court.

This decision was reaffirmed by Justice McMeekin in *Central Queensland Hospital and Health Service v Q*.<sup>330</sup> In this case, Justice McMeekin granted permission for a 12-year-old girl, ‘Q’, to have an abortion. Justice McMeekin found that Q was not Gillick-competent, as while he was satisfied she understood the abortion procedure and associated risks, he was not satisfied that she had the ability to fully understand the long-term consequences of a decision to continue with the pregnancy.<sup>331</sup> Concurring with Justice Wilson in the *State of Queensland v B*, Justice McMeekin found that Q’s parents did not have the authority to consent to the abortion, and the decision must be made by a court.<sup>332</sup>

The decision in *State of Queensland v B*,<sup>333</sup> and reaffirmed in *Central Queensland Hospital and Health Service v Q*,<sup>334</sup> changed the law in Queensland in relation to parents’ power to consent to the

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<sup>321</sup> Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112.

<sup>322</sup> Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, cited in Submission 1221, p 13.

<sup>323</sup> Gillick v West Norfolk AHA [1986] AC 112; *Marion’s Case* pp 236-238.

<sup>324</sup> *Marion’s Case* (1992) 175 CLR 218.

<sup>325</sup> *Marion’s Case* (1992) 175 CLR 218.

<sup>326</sup> [2008] QCS 231.

<sup>327</sup> *State of Queensland v B* [2008] QCS 231, [16].

<sup>328</sup> *State of Queensland v B* [2008] QCS 231, [16].

<sup>329</sup> *State of Queensland v B* [2008] QCS 231, [17].

<sup>330</sup> *Central Queensland Hospital and Health Service v Q* [2016] QSC 89, [20].

<sup>331</sup> *Central Queensland Hospital and Health Service v Q* [2016] QSC 89, [30].

<sup>332</sup> *Central Queensland Hospital and Health Service v Q* [2016] QSC 89, [20].

<sup>333</sup> [2008] QCS 231.

<sup>334</sup> [2016] QSC 89, [20]

termination of their child's pregnancy. These cases established the legal position that the decision to terminate the pregnancy of a non-Gillick-competent child can only be made by a court.<sup>335</sup>

### Views on current law

The ACHLR supported the existing legal position that a Gillick-competent child is able to provide valid legal consent to abortion; however, it noted:

*If the legislature intends to pass law governing the termination of pregnancies, it may consider enshrining this proposition into the legislation to ensure this legal position is clear.*<sup>336</sup>

Conversely, the ACHLR raised concerns with the existing legal position requiring a court's consent for a non-Gillick competent child:

*While termination of pregnancy is a very serious matter, in our view the nature of the decision is not such as to deprive parents of the ability to provide consent in their child's best interests. Indeed, we consider that imposing a requirement of court approval for terminations of pregnancy for minors who are non-Gillick competent is an unjustifiable and inappropriate extension of Marion's case.*<sup>337</sup>

ACHLR submitted that abortion should fall within the scope of parental decision-making authority for a girl who is not Gillick competent because:

- *there are critical distinctions between the procedures of termination and sterilisation which justify these procedures being treated differently, and being afforded different levels of safeguards*
- *the need for court approval for the termination of pregnancy is incongruous with other powers of parents to make medical decisions that are in their child's best interests...*<sup>338</sup>

ACHLR further commented that

*...Queensland is the only Australian jurisdiction which appears to require judicial approval for termination of pregnancy of non-Gillick competent minors' and expressed concern on '...the impact and effect of the current law on pregnant girls.*<sup>339</sup>

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<sup>335</sup> Central Queensland Hospital and Health Service v Q [2016] QSC 89.

<sup>336</sup> ACHLR, submission 1221, p 13.

<sup>337</sup> Submission 1221, pp 13-14.

<sup>338</sup> Submission 1221, p 14.

<sup>339</sup> Submission 1221, p 14.



## 12 Impacts of the current law on medical practice and women

### 12.1 Legal uncertainty

#### 12.1.1 Potential criminal prosecution of women and health professionals

Some submitters said the current law has created uncertainty among doctors about how the law works in practice. They argued that threat of criminal prosecution acts as a deterrent to doctors, impeding the provision of a full range of safe, accessible and timely reproductive services for women.

It has been observed that criminalisation makes some health professionals wary of performing or becoming involved in providing abortion.<sup>340</sup> This is especially the case for those providing termination services within Queensland's public hospital system. Professor Nicholas Fisk, a maternal fetal medicine specialist, expressed uncertainty about the scope of the law and said the scope of their indemnity results in risk aversion in many public hospitals.<sup>341</sup>

Submitters suggested that, if the law was changed, health professionals concerned about the risk of prosecution would be able to follow clinical guidelines and provide quality and evidence based healthcare without uncertainty or fear of criminal proceedings.<sup>342</sup>

Evidence presented to the committee suggested that uncertainty about the law impacts on doctors' involvement in abortion services, particularly outside Brisbane. Limited access to termination services in regional and remote areas, as well as confusion about the legality of the process, were cited as significant causes for the delay in obtaining an abortion. While considered a safe medical procedure,<sup>343</sup> delays often resulted in later gestation abortion and with it, increased clinical risk.<sup>344</sup>

A number of submitters said that limited access due to location or financial hardship is restricting many women's access to safe termination providers.<sup>345</sup>

### 12.2 Impact on medical practice

The AMAQ submitted that the current laws are 'a barrier to a doctor's first duty - best patient care'.<sup>346</sup> The AMAQ would welcome 'any amendment that provides legal certainty to Queensland doctors when it comes to performing terminations of pregnancy'.<sup>347</sup>

According to the AMAQ, the non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies.<sup>348</sup> The committee heard that limited access to abortion services may lead to self-induced abortion.<sup>349</sup>

The experience in Victoria since law reform in 2008 is that clinicians can now focus on practicing in accordance with evidence based clinical standards to address women's health care needs, free of the

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<sup>340</sup> Submission 116.

<sup>341</sup> Submission 840.

<sup>342</sup> Submission 75.

<sup>343</sup> Royal College of Obstetricians and Gynaecologists (UK), *Best practice in comprehensive abortion care*, June 2015, p 2.

<sup>344</sup> Public hearing transcript, Brisbane, 13 July 2016, p 22; submission 813, p 3; Royal College of Obstetricians and Gynaecologists (UK), *Best practice in comprehensive abortion care*, June 2015, p 2.

<sup>345</sup> See for example submissions 498, 542, 771, 848.

<sup>346</sup> Australian Medical Association (Queensland), submission 852.

<sup>347</sup> Australian Medical Association (Queensland), submission 852.

<sup>348</sup> Australian Medical Association, *Women's Health 2014: position statement*, <<https://ama.com.au/position-statement/womens-health-2014>>.

<sup>349</sup> Public hearing transcript, Emerald, 14 July 2016, p 17.

threat of criminal proceedings. This, according to the Royal Women's Hospital in Melbourne, provides certainty for health professionals.<sup>350</sup>

Some stakeholders suggested that medical practitioners would benefit from consistent laws across Australia. This was emphasised by RANZCOG who stated that it is:

*..essential that health practitioners are aware of the legislation that applies in the jurisdiction in which they practice. Uniformity and clarity of legislation would benefit both health practitioners and the women for whom they care.*<sup>351</sup>

The committee heard of a lack of consistency in terms of doctors' responses to the presentation of an unwanted pregnancy. Dr Wendy Burton of the Royal Australian College of General Practitioners expressed concern over the potential for inconsistent responses to a request for a termination. She stated:

*When it comes to discussions on termination of pregnancy, I guess it is whether you consider that the woman's life in front of you is the paramount definitive life, or whether her life and the needs of her unborn child have equal weighting in your eyes and in the eyes of the law. This is difficult, and you will find that different general practitioners will give you different weightings. Some of the weightings do depend on gestational age and whether a child would be viable or non-viable. I think in the real world—not the theoretical world—there are weightings that are attached depending on the personal situation and circumstances.*<sup>352</sup>

If abortion was decriminalised, Dr Burton stated that general practitioners would uphold a high standard of care. She added:

*If termination were taken out of the legal aspect and put into medical procedure hands then I am sure at some point there would be oversight. It would become regulated as a medical or surgical procedure and therefore we would be answerable to AHPRA and our respective colleges, for example.*<sup>353</sup>

Some stakeholders contended that the current situation in Queensland drives desperate women to seek unsafe, unregulated medical practices.<sup>354</sup> One submitter stated that an unwanted pregnancy does not become a wanted pregnancy by way of restrictive legislation.<sup>355</sup> The committee heard that criminalising abortion does not prevent it happening,<sup>356</sup> nor does decriminalising the practice lead to more abortions being performed.<sup>357</sup>

### **12.1 Impact on medical practice - finding psychological factors**

A number of submitters expressed concern about the lengths to which doctors must document symptoms in their patient in order to justify a lawful termination.

Professor Heather Douglas and Professor Caroline de Costa *et al* have identified a practice in Queensland and New South Wales where doctors manufacture mental illness to justify a lawful abortion in accordance with section 282 of the Criminal Code.<sup>358</sup> This has resulted in doctors being the

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<sup>350</sup> Submission 826.

<sup>351</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, College Statement: Termination of pregnancy, C-Gyn 17, March 2013.

<sup>352</sup> Public hearing transcript, Brisbane, 12 July 2016, p 5. See also submissions 830, 835, 857.

<sup>353</sup> Public hearing transcript, Brisbane, 12 July 2016, p 7.

<sup>354</sup> Submission 498.

<sup>355</sup> Submission 771.

<sup>356</sup> See for example submissions 527, 781.

<sup>357</sup> See for example submissions 857; 848, p 14.

<sup>358</sup> H Douglas, K Black & C de Costa, 'Manufacturing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland', *Journal Law Medicine*, 20, 2013, p 564.

'sole gate keeper' of abortion services.<sup>359</sup> They alone must interpret the legal principles and assess whether the procedure is lawful or not. This frustrates doctors as it requires doctors to ensure that the procedure is defensible.<sup>360</sup> Professor de Costa stated:

*... the current legal situation in Queensland encourages doctors to refer patients to psychiatric assessments and to obtain second opinions that many of the doctors we spoke to stated were generally unnecessary.*<sup>361</sup>

Professor Douglas noted that, in their research, most doctors found the concept of 'serious danger' to a pregnant woman to be unclear and the perception that doctors had to ascribe a mental health problem to women seeking abortion as challenging.<sup>362</sup>

The study found that the current laws encourage medical practitioners to legally justify a termination by focussing on mental health concerns rather than physical health concerns of their patient in the diagnosis.<sup>363</sup> Professor de Costa noted:

*Consequently pregnant women and their doctors must claim psychiatric sequelae as a result of the diagnosis, in women who really wish simply to make an intelligent and private decision for themselves based on the implications for the infant and for their family as a whole.*<sup>364</sup>

The committee heard from Professor Douglas that the current law has adverse effects in medical practice. She stated:

*Often the doctors complained that they had to reframe the woman's view of her circumstances into a situation where she was worried about her mental health or they were worried about her mental health. They generally agreed that the current legal situation in Queensland encourages doctors to refer patients to various other assessments such as psychiatric assessments and to get second opinions. Many of the doctors we spoke to thought that they did not really think the second opinions or the psychiatric opinions were necessary, but they felt obliged to refer patients to them given the shadow of the criminal law here in Queensland.*<sup>365</sup>

Professor Douglas indicated that the current law raises ethical concerns as well, as doctors feel they must reframe the women's view of her circumstances. She stated:

*It may compromise the candidness of the doctor/patient relationship when doctors say, 'Why do you want this termination?' In a way women are being required to explain their request in a certain context.*<sup>366</sup>

## 12.2 Detection of a severe foetal abnormality

### 12.2.1 Late-term abortion

A very small number of abortions occur in Australia beyond 20 weeks gestation. Abortions after 24 weeks gestation only occurs in public hospitals.<sup>367</sup> In Queensland, abortions following a diagnosis of

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<sup>359</sup> Submission 768 p 2.

<sup>360</sup> Submission 768 p 2.

<sup>361</sup> Submission 879, p 2.

<sup>362</sup> H Douglas, submission 879. Following the Menhennitt ruling, adopted in Queensland, an abortion may be lawful if it is to prevent 'serious danger' to the woman.

<sup>363</sup> H Douglas, K Black & C de Costa, 'Manufacturing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland', *Journal Law Medicine*, 20, 2013, 574.

<sup>364</sup> Submission 116.

<sup>365</sup> Public hearing transcript, Brisbane, 13 July 2016, p 20.

<sup>366</sup> Public hearing transcript, Brisbane, 13 July 2016, p 20.

<sup>367</sup> Submission 775, p 4.

foetal abnormality are undertaken mainly in public hospitals and are assessed on a case-by-case basis, often with the involvement of a clinical ethics committee.<sup>368</sup>

An analysis of the causes of late terminations indicates the majority of terminations are because significant foetal abnormalities (physical or genetic) have been diagnosed or there is serious maternal illness.<sup>369</sup>

Currently a number of severe abnormalities can only be diagnosed at more than 16 weeks of pregnancy, and sometimes not until 24 weeks. In some cases the woman does not present to a health service until late in pregnancy, delaying diagnosis of foetal abnormalities.<sup>370</sup>

### 12.2.2 Pregnancy screening

Most Queensland women with continuing pregnancies are encouraged to undergo foetal testing at approximately 13 weeks and 18-20 weeks gestation. The primary purpose of testing is to discover if there are any foetal abnormalities. There have been significant improvements in the technologies available to identify birth abnormalities and testing is regularly offered to pregnant women.

While screening results can help parents prepare for potential learning and physical difficulties, a significant proportion of pregnancies are terminated based on detection of foetal chromosomal or structural abnormality.<sup>371</sup>

The committee heard that women may seek a late termination when a severe foetal abnormality is indicated, which may not be until late in the pregnancy. Some examples provided to the committee included diagnosis of a fatal abnormality in one of a set of twins and a diagnosis of brain abnormality.<sup>372</sup>

One submitter suggested that the circumstances which lead women to seek late terminations are 'rare and particular, and sometimes extreme'.<sup>373</sup> In circumstances where a foetal abnormality has been detected, 'very often these pregnancies are much wanted'.<sup>374</sup>

### 12.2.3 Psychological impact of diagnosis

According to support group Sands Queensland, the list of fatal or life-limiting conditions which can be revealed through pre-natal screening is 'long and heartbreaking'.<sup>375</sup>

Research on women undergoing a late termination has found that patient distress is to be expected.<sup>376</sup> After a late termination, women experience negative psychological reactions equivalent to those experienced by women who miscarry a wanted pregnancy or who experience a stillbirth or death of a newborn.<sup>377</sup> In such situations, post-abortion support from specialist organisations and counsellors may be beneficial.<sup>378</sup> Sands Queensland urged the committee 'to be mindful of the potential for further

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<sup>368</sup> Kirsten Black, Heather Douglas and Caroline de Costa, 'Women's access to abortion after 20 weeks' gestation for fetal chromosomal abnormalities: view and experiences of doctors in New South Wales and Queensland', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 55, 2015, p 145.

<sup>369</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *College Statement: Termination of pregnancy*, C-Gyn 17, March 2013; see submissions 116, 857.

<sup>370</sup> Submission 116.

<sup>371</sup> H Douglas, K Black & C de Costa, Manufacturing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland, *JLM*, 20, 2013, p 565.

<sup>372</sup> Public briefing transcript, Brisbane, 2 August 2016, p 2.

<sup>373</sup> Submission 537.

<sup>374</sup> Public hearing transcript, Brisbane, 12 July 2016, p 27.

<sup>375</sup> Submission 738.

<sup>376</sup> K Morris, K Savell and C Ryan, 'Psychiatrists and termination of pregnancy: clinical, legal and ethical aspects', *Australian & New Zealand Journal of Psychiatry*, 46(1), 2012, p 23.

<sup>377</sup> Submission 778.

<sup>378</sup> Submission 778, p 6.

harm and distress for parents who receive an adverse diagnosis for their baby during pregnancy'.<sup>379</sup>

*[T]he decision to continue or end a pregnancy after an adverse diagnosis is extremely difficult. Excessive legal restrictions and more complex approval process requirements have the potential to further compound and complicate parents' grief.*<sup>380</sup>

#### 12.2.4 Foetal abnormality not a lawful reason for abortion

Foetal abnormality alone is not a lawful reason for an abortion under Queensland law.<sup>381</sup> This leaves women with a difficult decision, compounded by the knowledge that there is a chance she, or her health practitioners, may be prosecuted for their actions. As submitted by Health Consumers Queensland:

*In the context of current Queensland laws, choosing to not continue the pregnancy makes her a criminal unless her doctor considers her physical and/or mental health to be at greater risk if she continues the pregnancy. It seems perverse to encourage testing, then not provide support and services for all possible results and outcomes.*<sup>382</sup>

Professor Nicholas Fisk expressed concern that there is currently no express provision in the current law for foetal abnormality as an indication for termination of pregnancy:

*... 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 foetal abnormality elect to undergo termination of pregnancy if offered.*<sup>383</sup>

Professor Fisk noted consequences of the current law, where medical staff are not obligated to counsel a woman with a foetal abnormality as to the availability of termination of pregnancy, only to respond to a woman who 'requests' termination.<sup>384</sup> He also said that:

*Women in such situations are often surprised to learn that foetal abnormality is not an allowable indication for termination of pregnancy, and that they too can be prosecuted under s225, especially at such a difficult emotional time.*<sup>385</sup>

Professor Fisk provided the committee with details of the implications of the current law in situations where a foetal abnormality is diagnosed. Concurring with the findings of Professors Douglas and de Costa *et al*, observed the practice of health professionals manufacturing mental illness and potential suicide risk in the mother as an allowable indication for legal termination:

*... currently a rational sane women after appropriate counselling and in full possession of the facts is not permitted to make a balanced decision regarding the future of her own family.*<sup>386</sup>

The submission from a group of maternal fetal medicine specialists expressed the view that the current legal position can make it 'extraordinarily difficult' for women with concerns about possible foetal abnormalities to navigate the health system and gain access to safe and timely clinical services.

*At a very difficult time, when women are faced with a distressing choice, there is a significant additional burden caused by the fact that abortion is a crime.*<sup>387</sup>

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379 Submission 738.

380 Submission 738.

381 Public hearing transcript, Brisbane, 12 July 2016, p 12.

382 Submission 830, p 4.

383 Submission 840, p 2.

384 Submission 840, p 2.

385 Submission 840.

386 Submission 840, p 2.

387 Submission 843.

### 12.2.5 Assessment and decision making

The committee was provided with an overview of the process in major public hospitals when a serious foetal abnormality is diagnosed and a termination of the pregnancy is sought. Professor David Ellwood outlined some of the key stages of this process:

- completion of an assessment that states a continuation of the pregnancy is likely to cause the woman serious psychological harm
- referral of the woman for psychiatric assessment
- consultation and approval from two specialists in relevant fields of gynaecology or psychiatry
- consideration of the case by an ethics committee within the hospital, and
- final approval from a senior medical administrator within the hospital.<sup>388</sup>

In the event that abortion was decriminalised in Queensland, Professor Ellwood speculated that much of the review process currently undertaken in relation to a proposed late termination of pregnancy due to foetal abnormality would continue. Termination committees still exist in public hospitals in jurisdictions where abortion has been decriminalised.<sup>389</sup> The Royal Women's Hospital in Victoria has maintained a termination review panel for assessment of termination cases with gestation above 20 weeks. In the Australian Capital Territory, the process of review by an ethics committee has continued in public hospitals after provisions for termination of pregnancy were removed from that jurisdiction's Criminal Code.<sup>390</sup> Professor Ellwood stated:

*The reason for retaining [the review process] was to ensure that there was some collective ownership of the decisions that were being made around termination of pregnancy and that the entire department was comfortable with the decisions that were being made.*<sup>391</sup>

### 12.2.6 Late term abortion and stakeholder views

A number of submitters providing care and assistance with late terminations supported decriminalising abortion to improve the circumstances under which a termination is provided. The submission from a clinician at the Centre of Advanced Prenatal Care at the Royal Brisbane and Women's Hospital stated:

*Decriminalising the abortion law would provide a safe and supportive environment where the provider and the patient are comfortable without the element of pressure that they can be penalised for practicing what in other states is routine.*<sup>392</sup>

The RANZCOG agreed, noting that the availability of late termination would allow a 'multidisciplinary approach' to support women in such circumstances.<sup>393</sup>

In considering whether current assessment and decision making about late term abortion in hospitals would benefit from decriminalisation, Professor Ellwood affirmed that benefits could include: greater clarity about what the law permitted; a psychiatric opinion would not be required in order to make the

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<sup>388</sup> Public hearing transcript, Brisbane, 4 August 2016, pp 12, 14.

<sup>389</sup> Kirsten Black, Heather Douglas and Caroline de Costa, 'Women's access to abortion after 20 weeks' gestation for fetal chromosomal abnormalities: view and experiences of doctors in New South Wales and Queensland', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 55, 2015, p 147.

<sup>390</sup> Public hearing transcript, Brisbane, 4 August 2016, p 15

<sup>391</sup> Public hearing transcript, Brisbane, 4 August 2016, p 14

<sup>392</sup> Submission 850.

<sup>393</sup> Submission 845, p 2.

process lawful; and there would be a collegial, collaborative process to ensure that clinical decision-making was appropriate.<sup>394</sup>

Some submitters suggested that babies had been delivered alive after a 'failed termination' and had not given medical or palliative care, and that this number may increase if abortions are decriminalised.<sup>395</sup> The committee asked clinicians about late-gestation abortions and live deliveries. Professor Ellwood explained that Queensland Health policy<sup>396</sup> requires discussion of foeticide with parents above 22 weeks gestation,

*...but not all women will accept that as part of the process and there is no requirement for them to accept that. Somebody may choose to terminate a pregnancy for what is essentially a lethal foetal abnormality such as anencephaly or trisomy 18 or trisomy 13 and choose not to have a foeticide procedure done and following induction of labour that baby is very likely to be born alive... It is not failed termination of pregnancy, it is just the way that the process was carried out and the choice that that woman made.<sup>397</sup>*

Several witnesses noted that any sign of life must be recorded as a live birth in Queensland. In response to committee questions about Queensland Health's procedure to assist when there is a live birth following a late-gestation termination, Professor Kimble said that compassionate palliation would be provided.

*The paediatricians, our neonatal colleagues, would be there to provide care and, generally speaking, would provide pain relief for the baby and stay with it. It depends on gestation and whether it is one gasp or whether it is a baby that might demise in 30 minutes. Whatever the situation may be, the neonatologists generally tend to be there to provide what we would call palliative care, and that is reducing pain and suffering for the baby.<sup>398</sup>*

Professor Kimble clarified that following a termination there is generally no resuscitation, but pain relief is provided.

### 12.3 Impact on professional training

The RANZCOG stated that the cornerstone of providing good health care is the availability of well-trained health professionals. Issues relating to termination of pregnancy should be included in the education of all health professionals, particularly those who are primarily involved in women's health care.<sup>399</sup>

Children by Choice stated that the scarcity of trained providers in Queensland was 'a by-product of both continued criminalisation of abortion and the stigma that criminalisation helps perpetuate'. It has resulted in several doctors providing terminations in private clinics in more than one location. Clinics in Rockhampton and Townsville operate one day a week with clinicians flown from Brisbane and interstate. This adds considerably to the cost of procedures in these locations and can cause delays for women accessing services, as they may need to wait for an available appointment.<sup>400</sup> Representatives from Marie Stopes International confirmed this evidence, stating that the cost of a termination is greater in Rockhampton and Townsville due to the shortage of locally based, qualified providers:

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<sup>394</sup> Public hearing transcript, Brisbane, 4 August 2016, p 14.

<sup>395</sup> See for example submissions 495, 535, 777, 810, 1176, 551, 832.

<sup>396</sup> Clinical Guideline, Therapeutic termination of pregnancy

<sup>397</sup> Public hearing transcript, Brisbane, 4 August 2016, p 16

<sup>398</sup> Public briefing transcript, 12 July 2016, p 20

<sup>399</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *College Statement: Termination of pregnancy*, C-Gyn 17, March 2013.

<sup>400</sup> Submission 794, p 19.

*... we run clinics in Rockhampton and Townsville. We need to fly doctors to those clinics to provide those services because local doctors are not capable of doing the procedure in Rocky and Townsville.*<sup>401</sup>

One submitter suggested that decriminalising abortion would open up more options for medical practitioners, particularly in the provision of medical abortions. This would have beneficial effects by improving access:

*If abortion was no longer a criminal offence I believe more doctors would do the additional training required and become prescribers of this essential medication. This would relieve the burden of expensive travel to a major centre for desperate and vulnerable rural & remote women.*<sup>402</sup>

The PHAA stated that in decriminalising abortion, governments have a responsibility to adequately fund research, training and workforce development as for other areas of health practice, to promote evidence based quality care, adequacy of and access to service provision and service improvement.<sup>403</sup>

#### **12.4 Unplanned pregnancy after sexual assault**

There was acknowledgement among stakeholders that unplanned pregnancies can result from sexual assault and can occur in violent relationships.<sup>404</sup> Many submitters considered that abortion in these circumstances was justified and sought decriminalisation of abortion.<sup>405</sup> Other witnesses argued that abortion was never justifiable, including when a pregnancy resulted from sexual assault.<sup>406</sup>

Sexual assault such as rape and incest are not grounds for a lawful abortion – only their impact on a woman's health is able to be taken into account.<sup>407</sup> Many submitters expressed concern that serious sexual assault was currently not sufficient grounds for a lawful abortion in Queensland.<sup>408</sup>

One submission suggested that if decriminalisation was not possible, legislation could be drafted to provide for lawful pregnancy termination in certain circumstances, such as rape, incest or where there is a risk to the patient's physical or mental health.<sup>409</sup>

An audit conducted in 2006–2007 of clients using the Pregnancy Advisory Service in the Melbourne Royal Women's Hospital found that one per cent of women using the service cited pregnancy as a result of rape as their primary reason seeking an abortion.<sup>410</sup> While sexual assault, including rape and incest, is not a common reason for women seeking abortion, it should not be considered insignificant. The number of submissions that drew attention to this issue attests to this.<sup>411</sup>

The committee heard that providing funding and appropriate specialist services to address rape-related pregnancy is essential. Trauma counselling, especially for young women, should also be available.<sup>412</sup> The Brisbane Rape and Incest Support Centre advised the committee that restricted access to abortion services compounds an already distressing situation:

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<sup>401</sup> Public hearing transcript, Brisbane, 2 August 2016, p 20.

<sup>402</sup> Submission 841.

<sup>403</sup> Submission 763, p 10.

<sup>404</sup> See for example submissions 647, 553, 749, 764, 812.

<sup>405</sup> See for example submissions 354, 405.

<sup>406</sup> See for example submissions 553, 735.

<sup>407</sup> Submission 768, p 2.

<sup>408</sup> See for example submissions 647, 760, 768, 771, 783, 784, 785, 793, 799, 823, 838.

<sup>409</sup> Submission 851.

<sup>410</sup> Doreen Rosenthal, *et al*, *Understanding women's experiences of unplanned pregnancy and abortion*, University of Melbourne, Melbourne School of Population Health, 2009, p 15.

<sup>411</sup> See for example submissions 647, 760, 768, 771, 783, 784, 785, 793, 799, 823, 838.

<sup>412</sup> Submission 647.



*Sexual violence, incest and rape are violations of a person's bodily integrity, leading many survivors to feel out of control and powerless. One of the most significant steps towards healing from sexual violence is regaining agency and control, particularly over one's body. Thus, no or limited access to pregnancy termination compounds the trauma and powerlessness survivors are already experiencing.*<sup>413</sup>

In contrast, a number of submitters argued that, based on the premise that the welfare of the foetus should be considered as well as the mother, one violent act should not absolve another violent act, namely terminating the pregnancy.<sup>414</sup> The committee heard that, following a sexual assault, 'two wrongs don't make a right',<sup>415</sup> and that abortion will not necessarily improve the woman's situation.<sup>416</sup>

While acknowledging the abhorrent circumstances surrounding sexual violence, a submitter stated that 'pregnancy is not a death sentence, but abortion is', and noted that, as a society, 'we need to look at why that violence is occurring and address that issue, not kill the unborn child'.<sup>417</sup> In a similar vein, the Unborn Children's Advocacy Network stated that pregnancy in these circumstances did not justify taking another human life:

*Such offenses are the result of a criminal act and it is the perpetrator that deserves retribution, not the child. We as a society need to focus more on eliminating such heinous acts rather than simply 'curing' them with abortion.*<sup>418</sup>

## 12.5 Unplanned pregnancy and domestic violence

There is a well-established link between domestic violence and poor reproductive health outcomes, including unplanned pregnancy.<sup>419</sup> An audit conducted in 2006–2007 of clients using the Pregnancy Advisory Service in the Melbourne Royal Women's Hospital identified 16 per cent of all women accessing the service had experienced violence in some form.<sup>420</sup> Children by Choice reported for the 2014–15 year that 30 per cent of all women who contacted their service reported at least one form of violence and 7.5 per cent stated they had experienced both domestic and sexual violence.<sup>421</sup> An international study released in 2014 found that 25 per cent of women who had undergone a termination of pregnancy had experienced physical, sexual or emotional violence, and were more likely as a population group to access additional terminations in their lifetime.<sup>422</sup> The results indicate that violence is often present in the lives of women who have unplanned pregnancies and abortions.

Reproductive coercion may be associated with intimate partner violence and unintended pregnancy<sup>423</sup> and may include the following male partner behaviours:

- birth control sabotage
- forced sex

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<sup>413</sup> Submission 823, p 2

<sup>414</sup> Public hearing transcript, Brisbane, 1 August 2016, p 10

<sup>415</sup> Public hearing transcript, Brisbane, 1 August 2016, p 49

<sup>416</sup> Submission 553, p 6

<sup>417</sup> Public hearing transcript, Cairns, 15 July 2016, p 38

<sup>418</sup> Submission 735, p 11

<sup>419</sup> Submission 838, p 2

<sup>420</sup> Doreen Rosenthal *et al*, *Understanding women's experiences of unplanned pregnancy and abortion*, University of Melbourne, Melbourne School of Population Health, 2009, p 14

<sup>421</sup> Children by Choice, *Annual Report 2014-15*, pp 6-7

<sup>422</sup> Megan Hall *et al*, 'Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis', *PLOS Medicine*, 7 January 2014; referred to at Emerald public hearing, 14 July 2016, pp 18-19.

<sup>423</sup> Elizabeth Miller *et al*, 'Pregnancy coercion, intimate partner violence, and unintended pregnancy', *Contraception*, 81(4), April 2010, p 316

- refusal to use condoms
- threats of consequences if the woman uses birth control, and
- prevention from obtaining birth control.<sup>424</sup>

Violent relationships may also involve control over a woman through physical violence, emotional manipulation, threats of reprisals, social isolation, or financial control.<sup>425</sup> A pregnancy may become another reason to continue the violent behaviour and control over the woman.<sup>426</sup>

The current limited access to abortion in public hospitals was seen as particularly burdensome on women in violent relationships. Women experiencing domestic violence and financial control or heavy financial scrutiny may not be able to access funds for an abortion procedure through a private health facility.<sup>427</sup>

Recent studies indicate that women seeking an abortion and reporting intimate partner violence are concerned that continuing the pregnancy will tie them to a violent partner and expose their children to violence.<sup>428</sup>

A number of submitters took a different view. The Australian Family Association and others noted that the existing law is a safeguard for women under pressure from their partners or family to not continue with a pregnancy.<sup>429</sup> The committee heard that the Bill is 'really irresponsible' in the context of domestic violence because it removes the current protections that might prevent a women from obtaining an abortion as a result of pressure from her partner or family.<sup>430</sup>

## 12.6 Access to termination – public and private services

Citing the estimated 10,000 to 14,000 abortions performed in 2015 in Queensland, a number of submitters argued that many women successfully access abortions in Queensland, despite sections 224 to 226 of the Criminal Code. It was submitted that as women have accessed abortion services in Queensland for many years without prosecution, change to the law is not necessary.<sup>431</sup>

Conversely, some clinicians reported that the availability of termination services in Queensland, from both public and private sector providers, is adversely affected by the current law.<sup>432</sup>

### 12.6.1 Public hospitals

As discussed previously, the Queensland Health Clinical Guideline provides for hospitals to assess women presenting for termination to determine their eligibility for a procedure, recognising that termination of pregnancy is lawful where there is a serious risk to the woman's physical and/or mental health if the pregnancy continues.<sup>433</sup>

A number of submitters reasoned that the current laws prevented or limited ready access to abortion services within the public health system.<sup>434</sup> According to Queensland Health, 'for the most part, our

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<sup>424</sup> Submission 838, p 2, see also submissions 759, 847

<sup>425</sup> Submission 838, p 2

<sup>426</sup> See for example submissions 759, 1178

<sup>427</sup> Submission 759, p 3

<sup>428</sup> Chibber *et al*, 'The role of intimate partners in women's reasons for seeking abortion', *Women's Health Issues*, 24(1), January 2014, p 136.

<sup>429</sup> Submissions 831, p 2; 833, p 1

<sup>430</sup> Public hearing transcript, Brisbane, 1 August 2016, p 13; see also pp 18, 56

<sup>431</sup> Submission 775, 848

<sup>432</sup> See for example submissions 116, 835

<sup>433</sup> Submission 763

<sup>434</sup> See for example submissions 523, 533

provision of service in the public hospital setting pertains to foetal abnormalities and/or maternal illness, for example, or complications'.<sup>435</sup>

The Clinical Guideline was considered insufficient by health professionals and does not allay the fears of hospital administrators of the legal implications of providing abortion services.<sup>436</sup> The committee heard that section 282 of the Criminal Code provides inadequate protection for clinicians and health services. This is evidenced by the limited and inconsistent provision of abortion services in public hospitals.<sup>437</sup>

According to Health Consumers Queensland, there is an unacceptable inconsistency in how the Clinical Guideline is applied across Queensland's 16 HHSs. Anecdotally, this is due to continued fear of legal repercussions against health professionals as well as the personal or religious beliefs of health professionals.<sup>438</sup> In most circumstances, women must have a medical referral from a doctor and live within a hospital district prepared to accept the referral, or be able to otherwise access a 'sympathetic' hospital.<sup>439</sup>

*Access to abortion services for Queensland women should not be dependent on the personal values / beliefs of the doctor the woman presents to, or to how much money or other resources she has.*<sup>440</sup>

Children by Choice submitted that several of their clients had been denied financial reimbursement under the Patient Travel Subsidy Scheme due to concerns by hospital administration that, as the procedure is currently illegal under Queensland law, travel assistance should not be available for the purposes of an abortion.<sup>441</sup>

### 12.6.2 Private services

Most terminations are performed in private health facilities.

Children by Choice listed the Queensland private providers that offer either surgical or medical abortion, or both. The private abortion services are located in the following regions: eight in Brisbane; two on the Gold Coast; one on the Sunshine Coast; one in Rockhampton; one in Mackay; one in Townsville, and two in Cairns.<sup>442</sup>

### 12.6.3 Geographic considerations – regional and rural areas

Women in rural and remote areas are currently at a disadvantage in accessing termination services.<sup>443</sup> Access for these women is largely influenced by where they live and therefore limited to those who can travel to urban and regional private providers.<sup>444</sup> Women accessing these services must consider travel and accommodation costs, and arrange for time away from work and family.<sup>445</sup> The committee heard some of the difficulties women face accessing health services in rural and regional areas:

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<sup>435</sup> Public hearing transcript, Brisbane, 12 July 2016, p 13

<sup>436</sup> Submission 804, p 1

<sup>437</sup> Submission 804, p 1

<sup>438</sup> Submission 830, p 6

<sup>439</sup> Submission 835

<sup>440</sup> Submission 533

<sup>441</sup> Submission 794, p 19

<sup>442</sup> Children by Choice, 'How much will an abortion cost?', < <http://childrenbychoice.org.au/forwomen/abortion/abortioncosts>>.

<sup>443</sup> See for example submissions 498, 527, 533, 771, 804, 835, 848

<sup>444</sup> Submission 775, 804, 835

<sup>445</sup> See for example submissions 523, 746, 799, 802, 804, 848

*In many small towns, there are only a very few number of services or perhaps services are only outreach on certain days in that town and in certain places, whereby anyone and everyone knows who is going where and for what.*<sup>446</sup>

Many Aboriginal and Torres Strait Islander women, who experience health and socio-economic disadvantage as a population group, may be further disadvantaged in accessing termination services because of their geographic location and the associated costs of travelling to available services.<sup>447</sup>

#### 12.6.4 Cost considerations

Estimates of the cost of an abortion at a private clinic or GP generally ranged from \$400 (including pharmaceuticals for a medical abortion) to \$4,000, depending on the method of termination and gestation stage.<sup>448</sup> One submitter reported that the cost of surgical termination procedures has more than quadrupled since 2000.<sup>449</sup> Then, a termination prior to 11 weeks gestation and provided in Brisbane, had an out-of-pocket cost of approximately \$120.<sup>450</sup>

Despite the drug Mifepristone being listed on the Pharmaceutical Benefits Scheme, a medical abortion can cost as much as an early gestation surgical abortion. Access to medical abortion through a general practitioner may cost between \$350 and \$580, including initial and follow-up consultations.<sup>451</sup> The additional cost to purchase Mifepristone and Misoprostol may be up to \$50.<sup>452</sup>

The Royal Australian College of General Practitioners (RACGP) advised that some GPs provide medical termination of pregnancy and where necessary will bulk-bill a woman. If the woman has a healthcare card, Mifepristone and Misoprostol would cost \$6.10; otherwise the cost is closer to \$40.<sup>453</sup> Only a small number of GPs provide medical termination services.

A small number of telehealth medical abortion services are available. As at June 2016, the Tabbot Foundation had provided 850 abortions Australia-wide since commencing operation in September 2015. The Tabbot Foundation submitted that a medical abortion service costs \$250 for Medicare Card holders. Women using the service incur additional expenses, including for ultrasound and a blood test.<sup>454</sup> The Dr Marie clinics offer a similar service for \$290, excluding medications and postage.<sup>455</sup>

Second trimester abortions typically cost more than those during the first trimester.<sup>456</sup> A termination at 14 to 15 weeks gestation may cost between \$800 and \$1,500.<sup>457</sup> Only a small number of clinics (all in the south-east corner of Queensland) provide termination of pregnancy at or after 16 weeks gestation. A termination between 16 and 19 weeks gestation may cost \$2,000 to \$3,950 for Medicare Card holders.<sup>458</sup>

Children by Choice reported providing financial assistance to 281 women for terminations in 2014-15, amounting to almost \$90,000. Assistance consisted of grants, no interest loans and discounts

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<sup>446</sup> Public hearing transcript, Emerald, 14 July 2016, p 16

<sup>447</sup> See for example submissions 738, 857

<sup>448</sup> Submission 775, p 2

<sup>449</sup> Submission 838, p 4.

<sup>450</sup> Submission 838, p 4.

<sup>451</sup> Submission 763, p 4.

<sup>452</sup> Children by Choice, 'How much will an abortion cost?', < <http://childrenbychoice.org.au/forwomen/abortion/abortioncosts>>.

<sup>453</sup> Dr Burton, RACGP, Public briefing transcript, 12 July 2016, p 18

<sup>454</sup> Submission 856.

<sup>455</sup> Dr Marie, 'Prices: abortion', < <https://www.drmarie.org.au/bookings/prices/>>.

<sup>456</sup> Submission 773, p 1.

<sup>457</sup> Children by Choice, 'How much will an abortion cost?', < <http://childrenbychoice.org.au/forwomen/abortion/abortioncosts>>.

<sup>458</sup> Children by Choice, 'How much will an abortion cost?', < <http://childrenbychoice.org.au/forwomen/abortion/abortioncosts>>.

negotiated with private providers.<sup>459</sup> Children by Choice reported that during 2014-15, 64 per cent of women accessing their services had confirmed that the cost of abortion was a barrier to access.<sup>460</sup> It was of concern to those providing financial assistance that the same service may be accessed freely in Victoria and South Australia through the public hospital system in those states.<sup>461</sup>

The Royal Women's Hospital in Melbourne submitted that there were challenges in providing women who have travelled long distances with comprehensive and integrated health care over time, especially after care services. Such care would be 'better met by locally provided abortion services'.<sup>462</sup>

#### **12.6.5 Other barriers to access – non-Medicare Card holders**

Children by Choice reported that women studying or travelling in Australia, or those living in the community on temporary protection visas, often have no access to Medicare and will encounter high out-of-pocket costs for healthcare. Terminations through private clinics may cost as much as \$4,500 for non-Medicare Card holders, depending on gestation and location, while public hospitals may charge fees even if they deem a woman to be eligible for a termination.<sup>463</sup>

True Relationships and Reproductive Health submitted that they were aware of women living in Queensland on residency visas who had to travel overseas to access abortion services. They had travelled to locations such as China, Thailand and New Zealand in search of affordable - and potentially unsafe - access to abortion.<sup>464</sup>

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<sup>459</sup> Submission 794.

<sup>460</sup> Submission 794.

<sup>461</sup> Submission 798.

<sup>462</sup> Submission 826, p 3.

<sup>463</sup> Children by Choice, Development of a Queensland Women's Strategy: submission, December 2015, p 13.

<sup>464</sup> Submission 775, p 2.



## **PART 3: OPTIONS FOR ABORTION LAW**

### **13 Options to clarify the law**

The committee's terms of reference require it to report to the Legislative Assembly on the Private Member's Bill. The committee's recommendation about the Bill is contained in Chapter 6.

In addition to considering the Bill, the committee was required to consider and report on aspects of the law governing termination of pregnancy in Queensland, and options regarding matters in the terms of reference. Each of the elements of the committee's terms of reference have been discussed in preceding chapters. Some of the options to clarify the law are below.

#### **Option 1: No change to the law**

One option would be for the Criminal Code, and associated case law, to remain the law regulating abortion in Queensland.

#### **Option 2: Amendment of the Criminal Code**

The Criminal Code could be amended to remove section 225, so that it would no longer be an offence for a woman to procure her own abortion.

#### **Option 3: Further consideration by another body**

The committee is aware of strong and divergent community views about abortion, and the complexities of preparing legislation that achieves precisely what is intended and does not have unanticipated consequences. On that basis, another option is for government to ask a body such as the Queensland Law Reform Commission to undertake further work on appropriate legislation.

#### **Option 4: Decriminalisation**

The Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, if passed, would decriminalise abortion. The committee's reasons for not supporting this approach to decriminalisation are discussed in Chapter 6. The committee considers that simply removing offences from the Criminal Code, without some level of regulation, is inconsistent with community expectations. While professional standards and guidelines provide some protections, further regulation would be consistent with community expectations.

#### **Option 5: Regulation of abortion in health legislation**

If abortion was decriminalised, health legislation could create a framework for decision making about late-term abortion and reflect community views and current medical practice that recognises that late-term abortion is a more serious matter than early gestation abortion.

Health legislation could address conscientious objection to ensure that health professionals are not obliged to provide treatment to which they object except in an emergency. Also, health legislation could provide for safe access zones to ensure that patients and health professionals are not subject to obstruction or harassment. Health legislation could also promote a consistent approach to data collection and the provision of appropriate counselling services for women.

Concerns raised during the inquiry about the effect of the decision in *Central Queensland Hospital and Health Service v 'Q'* (see Chapter 11 for discussion of the case) need careful consideration. The committee has heard arguments that the legal position following this case could create significant delay in a decision about termination of a pregnancy of a girl who is not considered to be Gillick-competent. Such a delay could result in termination occurring at a later gestation, with the potential

of greater risks. Any reform of the law needs to be carefully considered in the context of the common law of consent to medical treatment, and the best interests of a girl with an unplanned pregnancy.

**Option 6: Abortion performed by person other than medical practitioner a crime**

While abortion performed by someone other than a medical practitioner has not been discussed in this report, there is a community expectation that unqualified abortion is dangerous and should be subject to the criminal law.



## 14 Legal principles - what principles should apply to regulation of abortion?

### 14.1 Values currently underpinning abortion in the criminal law

Criminal law generally serves two purposes, one symbolic and one utilitarian.

The symbolic purpose is oriented on creating policies based on collective understandings of right and wrong behaviour. What is and is not a crime will largely be determined by the law's symbolic purpose: what the community collectively holds to be wrong behaviour. Thus, what constitutes a crime varies between jurisdictions and across time.<sup>465</sup>

The utilitarian purpose of criminal law is future oriented and pragmatic, creating policies based on their intended consequences, such as preventing crime or reforming people.<sup>466</sup> The law's utilitarian purpose will largely determine the penalty imposed for a criminal act. The penalty may act to deter an individual or the broader community from committing the crime, to rehabilitate and change the behaviour or attitudes of the offenders, or to punish the offender and protect the community.<sup>467</sup>

The values underpinning the abortion provisions of the Criminal Code seem to be based on a belief that procuring an abortion, or providing drugs or instruments, is collectively understood as wrong behaviour that should be discouraged, and people should be punished if they engage in either procuring or providing drugs or instruments for an abortion.

However, the Criminal Code refers to 'unlawful' abortion; it implies that there are circumstances where abortion is considered lawful, and a statutory defence provision and case law have been successfully relied upon to avoid criminal responsibility.<sup>468</sup> The use of common law to supplement and explain legislation raised questions of whether the values underpinning the abortion offences in the Criminal Code align with the general purposes of criminal law.

### 14.2 Potential values to underpin abortion law

Professor Lindy Willmott of the ACHLR suggested six key values that should underpin the law governing abortion:

- clarity and certainty
- enforcement
- promotion of the wellbeing and, to the extent possible, ensuring citizens are not harmed
- autonomy
- justice and equity, and
- reflection of contemporary community attitudes and standards, as well as contemporary medical practice.<sup>469</sup>

Professor Eleanor Milligan, of Griffith University's School of Medicine, agreed and said that

*... legislation should be drafted in the public interest to minimise individual and public harm. If we accept the premise that termination of pregnancy is harmful to women, to the medical*

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<sup>465</sup> Marinella Marmo et al, 'Aims of the Criminal Justice System' in *Crime and Justice: A Guide to Criminology*, 2012, p 4.

<sup>466</sup> Marinella Marmo et al, 'Aims of the Criminal Justice System' in *Crime and Justice: A Guide to Criminology*, 2012, p 2.

<sup>467</sup> Marinella Marmo et al, 'Aims of the Criminal Justice System' in *Crime and Justice: A Guide to Criminology*, 2012, p 7-8.

<sup>468</sup> Section 282 was intended to be a defence to the offence of child destruction under section 313: cited in Ben White and Lindy Willmott 'Termination of a minor's pregnancy: Critical issues for consent and the criminal law', (2009) 17 *Journal of Law and Medicine*, p 255, attached to Submission No 1221.

<sup>469</sup> Hansard transcript, public hearing, 13 July 2016, pp 6-7.

*professionals and to the unborn foetus and that erodes community values, we need to consider how legislation can best reduce these harms.*<sup>470</sup>

### 14.2.1 Clarity and certainty

The ACHLR stated that under the rule of law 'society should be governed by the law, obey it and be able to be guided by it', and argued that the current laws do not meet this requirement as they are complex and unclear.<sup>471</sup>

*As a result, they [the laws] generate confusion and anxiety, both for women who are pregnant and are seeking to know their options about termination and also for health professionals seeking to provide advice to women. As such, the current laws on abortion do not satisfy the value of clarity and certainty of our laws.*

*It is difficult to be guided by the law if that law is unclear...*<sup>472</sup>

Professor Eleanor Milligan, in response to committee questions, suggested that consideration of harm reduction and honesty and transparency in clinical practice was important:

*..there is a lot of obfuscation and there are a lot of people operating outside of the law. That is preventing any of us knowing what is happening in this state. There is a level of dishonesty that is permeating clinical practice in this area. That is a consequence of the current law.*<sup>473</sup>

### 14.2.2 Enforcement

ACHLR stated that enforcement is an important component of the principle of the rule of law, as if 'laws are flouted and not enforced, our legal system is at risk of being brought into disrepute'.<sup>474</sup>

The ACHLR identified two important issues regarding the criminalising of abortion and enforcement. Firstly, that charges are rarely brought for abortion-related offences, and secondly whether the Director of Public Prosecutions will prosecute, even if a charge is laid.<sup>475</sup>

*If these actions are offences under the code, which is clearly the case, charges should be laid when an offence occurs. If this does not happen, the law is brought into disrepute. We know that many thousands of women receive abortions each year yet how many are charged.*<sup>476</sup>

*It is rare for prosecutions to be brought. Is this because the DPP believes that pursuing these charges would not be in the public interest? If breaches of the relevant code provisions are not prosecuted, again this has the potential to bring the law into disrepute.*<sup>477</sup>

### 14.2.3 Promotion of the wellbeing of citizens

The ACHLR stated that 'laws should promote the wellbeing of its citizens and to the extent that is possible ensure its citizens are not harmed'.<sup>478</sup> In its view, the current laws do not promote the wellbeing of citizens and, to the extent that is possible, ensure citizens are not harmed.

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<sup>470</sup> Public hearing transcript, Brisbane, 13 July 2016, p 31

<sup>471</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>472</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>473</sup> Public hearing transcript, Brisbane, 13 July 2016, p 38.

<sup>474</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>475</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>476</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>477</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>478</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

*The law does not currently 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. That criteria 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. The law fails the value of promoting her health.*<sup>479</sup>

Potential harm arises because if 'it is not lawful for a woman to obtain a termination from a doctor, she may have to resort to obtaining an abortion in unsafe circumstances'.<sup>480</sup> The ACHLR concluded that the law does not promote an individual's wellbeing, and, '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 ... health and avoidance of harm'.<sup>481</sup>

Professor Eleanor Milligan argued that 'legislation should be drafted in the public interest to minimise individual and public harm' and noted that 'criminalising termination of pregnancy is not protective of the rights of the foetus, nor is it protective of the rights of the mother'.<sup>482</sup>

#### **14.2.4 Autonomy**

Autonomy and the importance of deciding what happens to one's body is currently recognised in the legal system by the requirement that informed consent must be given for medical treatment. However, ACHLR argued that that the current abortion laws do not promote the autonomy of women to decide what happens to their body.

*...this principle of autonomy is an important value in deciding the law that should govern the termination of pregnancy. ...for the most part a woman should be able to decide what should be able to be done to her body. Women are responsible decision makers so should be afforded this right. The current laws on abortion do not promote the value of autonomy.*<sup>483</sup>

#### **14.2.5 Justice and equity**

The ACHLR asserted that justice and equity should underpin abortion laws, with access to abortion not dictated by 'economic circumstances, place of residence or other personal circumstances'.<sup>484</sup>

ACHLR argued that the current laws criminalising abortion adversely impact on women's just and equitable access to abortion.

*The fact that an abortion is unlawful necessarily affects the availability of the procedure. It is our understanding that the bulk of terminations are performed in private not public facilities. 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. Increasing accessibility should reduce these costs.*

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<sup>479</sup> Hansard transcript, public hearing, 13 July 2016, p 6.

<sup>480</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>481</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>482</sup> Public hearing transcript, Brisbane, 13 July 2016, p 31.

<sup>483</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>484</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

*Women who do not have the funds to source a termination in a private facility are disadvantaged under the current legal framework'.<sup>485</sup>*

Professor Eleanor Milligan concurred with the view that the current laws create inequity:

*The prospect of criminal prosecution has created a clinical culture in which workarounds around the law ensure the best clinical outcomes for patients. Practitioner anxiety and uncertainty can create access barriers for Queenslanders who seek advice and support.<sup>486</sup>*

#### **14.2.6 Law that reflects community attitudes and medical practice**

The ACHLR suggested that laws should reflect contemporary community attitudes and standards, as well as contemporary medical practice.<sup>487</sup> ACHLR argued that the current laws, creating offences under the Criminal Code, are 'archaic and do not reflect community standards'.<sup>488</sup> This view was echoed by many of the submitters who supported reform of the law.

*The offences about abortion are contained within chapter 22 of the code, which is entitled 'Offences against morality'. This chapter also contains offences including bestiality and indecent dealings with children.*

*...the offence provisions have not been revisited in more than a century. Since that time there has been a shift in community views. There is evidence of widespread support for reform of the law by both members of the public and also obstetricians and gynecologists. There is available peer reviewed literature to support this claim.<sup>489</sup>*

Professor Milligan noted while it cannot be stated with certainty what the community views are regarding abortion, in her view:

*.. the interests of the foetus are better served through decriminalisation and the implementation of appropriate medical care within a culture of transparency and reflective practice. I would also point out ... that a number of Queensland and Australian laws consistently confirm that the foetus has no rights before birth, so we need to think about how the Criminal Code aligns with those other pieces of legislation that do not recognise the rights of the foetus.<sup>490</sup>*

Current medical practice includes the provision of abortion, most in the first trimester of pregnancy. It is appears that the current law does not reflect current medical practice.

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<sup>485</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>486</sup> Public hearing transcript, Brisbane, 13 July 2016, p 31.

<sup>487</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>488</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>489</sup> Hansard transcript, public hearing, 13 July 2016, p 7.

<sup>490</sup> Public hearing transcript, Brisbane, 13 July 2016, p 32.

## 15 Counselling and support services for women

### 15.1 Introduction

There is broad consensus that access to counselling and support are important for women considering their options in relation to an unintended pregnancy, or faced with a diagnosis of a significant foetal abnormality or serious maternal illness.<sup>491</sup>

Counselling services relevant to abortion fall into three categories:

- decision-making counselling
- informed consent counselling, and
- post-abortion counselling.

Specialist counselling or psychiatric support may also be provided for women who have a pre-existing mental illness.

### 15.2 Decision making counselling

Generally, decision-making counselling involves providing information about, and discussing, the three available options - continuing the pregnancy to parent, continuing the pregnancy to adoption, and abortion - to support women in their decision making. There is no obligation for women to undertake decision making counselling; they may choose to make their decision independently with the support of significant others in their lives.

The importance of having access to comprehensive information and counselling to support a woman in making decisions about her pregnancy was acknowledged during the inquiry. For example, Priceless Life stated that 'counselling with an unbiased professional is key to the wellbeing of all parties'.<sup>492</sup> Children by Choice stated that a 'woman has the right to have information available to her and she has the right to have counselling support services available to her'.<sup>493</sup>

#### 15.2.1 Service providers

Information and counselling about pregnancy options are currently offered by a range of service providers including community organisations, not-for-profit organisations, family planning centres, and health professionals linked to medical facilities. These services are offered face to face and via telephone, which increases access for regional and remote women to counselling services; however inequity in access across Queensland was raised during the inquiry.

It must be noted that the provision of pregnancy counselling services is not regulated and providers are not bound to comply with any professional standards, guidelines, or codes of ethics unless they choose to become a member of a professional organisation or association (such as the Psychotherapy and Counselling Federation of Australia, or the Australian Association of Social Workers). 'In effect any person may purport to be a counsellor, regardless of whether they have attained any training or professional experience in counselling.'<sup>494</sup> The lack of transparency in advertising and notification of pregnancy counselling services was raised by the Victorian Law Reform Commission in its review of

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<sup>491</sup> See for example submissions 1393, 794.

<sup>492</sup> Submission 1393, p 7.

<sup>493</sup> Public hearing transcript, Brisbane, 2 August 2016, p, 29.

<sup>494</sup> Senate Community Affairs Legislation Committee, Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005, 17 August 2006, p 39.

abortion law<sup>495</sup> and was considered by the Commonwealth Community Affairs Legislation Committee.<sup>496</sup>

A number of submitters and witnesses raised concerns regarding a perception of bias in counselling services and the absence of a legal requirement to disclose any preconceived preferences or interests that may influence the advice provided to women. For example, the Australian Association of Social Workers expressed a concern that the absence of transparency in the philosophies of counselling services 'denies women the right to access non-judgemental and objective counselling services,'<sup>497</sup> while Cherish Life Queensland raised concerns about a potential conflict if the facility providing counselling would gain financially from the woman's decision.<sup>498</sup>

### 15.2.2 Guidelines

The Queensland Health Clinical Guideline establishes the framework for providing care to women requesting abortion services.<sup>499</sup> The Clinical Guideline emphasises the importance of providing information and counselling, outlining good practice points to include:

- supporting decision making by providing accurate, impartial and easy to understand information including options to continue the pregnancy and parent or place the child for foster care/adoption, or to terminate the pregnancy
- offering confidential, non-judgemental support and counselling by an appropriately qualified and/or trained person, who is familiar with the issues surrounding abortion, and has no vested interest in the pregnancy outcome.
- offering counselling 'close to home', where feasible, to aid the establishment of longer term support, and
- considering the need for a formal mental health referral especially if there is a history of mental illness.<sup>500</sup>

Health professionals are also advised to provide information and access to appropriate referral pathways whether or not a woman proceeds with an abortion.<sup>501</sup>

RANZCOG also recognises the importance of counselling and support for women to make decisions and in any post-abortion issues as best practice for providing abortion services.

### 15.3 Informed consent counselling

Consistent with all medical treatments or surgeries the patient must give informed consent before an abortion is performed. Informed consent counselling involves ensuring the patient:

- has the requisite capacity to consent to the procedure
- understands the nature and method of the procedure and the alternative options

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<sup>495</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, March 2008.

<sup>496</sup> Senate Community Affairs Legislation Committee, *Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005*, 17 August 2006.

<sup>497</sup> Public hearing transcript, Brisbane, 2 August 2016, p. 29.

<sup>498</sup> Submission 773, p 7.

<sup>499</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013; Queensland Health, *Private practice in the Queensland public health sector framework*, 2015, p 19.

<sup>500</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 13.

<sup>501</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8-13.

- is making the decision to have the procedure voluntarily, and
- understands the possible risks or complications associated with the procedure and the likelihood of them occurring.<sup>502</sup>

The discussion must be balanced, transparent, and sensitive to the situation, and the patient must have sufficient time to consider and clarify any information to make a decision and give their informed consent.<sup>503</sup>

There was general consensus that counselling to ensure fully informed consent was of critical importance for women considering an abortion.<sup>504</sup>

#### 15.4 Post-abortion counselling

Post-abortion counselling involves supporting women who need help 'with the consequence of their decision' or to 'resolve problems which may arise as a result'.<sup>505</sup> While evidence suggests that most women do not need post-abortion counselling, and that rates of mental health problems are largely unaffected by whether a woman has an abortion,<sup>506</sup> each woman's experience is unique and post-abortion counselling provides support to those who need it. Post-abortion counselling and support from specialist counsellors may be particularly beneficial in circumstances where the abortion occurred due to a diagnosis of a serious or fatal foetal abnormality.<sup>507</sup>

Post-abortion counselling is currently offered by a range of service providers including volunteer-based organisations, not-for-profit organisations, and health professionals linked to medical facilities. Counselling services are offered face-to-face and by telephone. Telephone counselling improves access for regional and remote women; however, inequity of access to services was raised during the inquiry.

##### 15.4.1 Guidelines

The Clinical Guideline emphasises the importance of post-abortion counselling and support, recommending that the need for support be considered for all women requesting an abortion, as the risk of mental health problems increases whatever the pregnancy outcome. Confidential, non-judgemental support and counselling by an appropriately qualified or trained person who is familiar with the issues surrounding abortion should be offered.<sup>508</sup>

RANZCOG also recognises that making post-abortion counselling available is best practice for providing abortion services, acknowledging that women may need ongoing support.<sup>509</sup>

##### 15.4.2 Specialist counselling and disability

Specialist counselling services are available for women faced with a diagnosis of a significant foetal abnormality to support them in their decision making and with any negative psychological reactions they may encounter post-abortion. Specialist counselling and support services are provided by genetic

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<sup>502</sup> Queensland Health, Guide to informed decision making in healthcare, 2012, p 2; *Rogers v Whittaker* (1992) 175 CLR 479.

<sup>503</sup> Queensland Health, Guide to informed decision making in healthcare, 2012, p 2.

<sup>504</sup> See for example submission 1222, p 4; submission 535, p 2; public hearing transcript, Brisbane, 2 August 2016, p 10.

<sup>505</sup> Royal College of Obstetricians and Gynaecologists (UK), *The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline No 7*, 2011, p 37.

<sup>506</sup> National Collaborating Centre for Mental Health (UK), *Induced abortion and mental health: a systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors*, 2011.

<sup>507</sup> Submission 778, p 6

<sup>508</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 13.

<sup>509</sup> Royal College of Obstetricians and Gynaecologists (UK), *The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline No 7*, 2011, p 37.

counsellors and maternal medicine specialists, and by organisations such as Support after Fetal Diagnosis of Abnormality.<sup>510</sup>

The Anti-Discrimination Commission Queensland noted the importance of 'providing support for women who wish to carry an impaired foetus to term'. Counselling and support must be professional and impartial to avoid being discriminatory.<sup>511</sup>

### **15.4.3 Specialist mental health counselling**

Specialist counselling services are also available from mental health services in circumstances where the woman has a pre-existing mental health problem. Mental health services support the woman both in the decision making about her options and in post-abortion counselling if the woman chooses to have an abortion.<sup>512</sup>

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<sup>510</sup> National Alliance of Abortion and Pregnancy Options Counsellors, submission 778, pp 5-6.

<sup>511</sup> Submission 769, p 6.

<sup>512</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 13.



## 16 Conscientious objection by health professionals

### 16.1 Conscientious objection

The committee heard from submitters and witnesses about issues relating to health practitioners who have a conscientious objection to abortion. A conscientious objection is when a health practitioner 'refuses to provide, or participate in, a legally-recognised treatment or procedure because it conflicts with his or her own personal beliefs and values'.<sup>513</sup>

### 16.2 Current law and practice

Laws covering freedom of conscience, or the right to claim conscientious objection, to permit health practitioners to refuse to perform, or participate in the performance of, an abortion are found in most Australian states and territories.<sup>514</sup>

In Victoria, South Australia, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory, the law provides that no person is under a duty to participate in an abortion if they have a conscientious objection.<sup>515</sup> In New South Wales and Queensland, the issue of conscientious objection to abortion is dealt with in policy directives or clinical guidelines, which permit a health practitioner to decline to abortion services on the basis of conscientious objection.<sup>516</sup>

#### 16.2.1 Emergency

In Victoria, Tasmania and South Australia conscientious objection does not apply to emergencies where the woman's life is at risk. If an abortion is necessary to save the woman's life or prevent her from suffering serious injury, the health practitioner has a duty to perform, or participate in the performance of, an abortion and cannot refuse on the grounds of conscientious objection.<sup>517</sup>

In NSW the policy directive provides that health practitioners must, notwithstanding their conscientious objections, perform, or participate in the performance of, an abortion in emergency cases where it is necessary to preserve the life of the pregnant woman.<sup>518</sup>

### 16.3 Referral to another health practitioner

Some jurisdictions, including Queensland, ACT and NSW, have policies or guidelines which state that health practitioners with a conscientious objection to abortion are to refer, or take reasonable steps to refer, a pregnant woman seeking an abortion to another practitioner who does not have a conscientious objection.<sup>519</sup>

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<sup>513</sup> Australian Medical Association, *Position Statement – Conscientious Objection*, 2013, p 1.

<sup>514</sup> Anne O'Rourke, *et al*, 'Abortion and Conscientious Objection: The New Battleground', *Monash University Law Review*, 2012, 38(3).

<sup>515</sup> Criminal Law Consolidation Act 1935 (SA), s 82A(5); Health Act 1911 (WA), s 334(2); Health Act 1993 (ACT), s 84; Medical Services Act (NT), s 11(6); Reproductive Health (Access to Terminations) Act 2013 (Tas), s 6.

<sup>516</sup> Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8; New South Wales Health, *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*, 2 July 2014, p 7.

<sup>517</sup> Criminal Law Consolidated Act 1935 (SA), s 82A(6); Reproductive Health (Access to Terminations) Act 2013 (Tas), s 6; and Abortion Law Reform Act 2008 (Vic), ss 6 - 7.

<sup>518</sup> New South Wales Health, *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*, 2 July 2014, p 7.

<sup>519</sup> ACT Government Health, Canberra Hospital and Health Services Clinical Guideline – Management of Termination of Pregnancy, Miscarriage or Fetal Death, Issued 4 August 2016, p.4; New South Wales Health, *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*, 2 July 2014; Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8.

Victoria has gone further and legislated to provide that health practitioners who have a conscientious objection are under a statutory duty to refer a patient to another health practitioner who does not have a conscientious objection.<sup>520</sup> Tasmania has similarly legislated that a practitioner with a conscientious objection must provide a woman seeking an abortion with a list of prescribed health services that provide information or counselling on the full range of pregnancy options.<sup>521</sup> Legislation similar to Victoria is currently before the New South Wales Legislative Council.<sup>522</sup>

#### 16.4 National codes of conduct, guidelines and policies

The Medical Board of Australia's *Good medical practice: A code of conduct for doctors in Australia*, which describes what is expected of all doctors registered to practise medicine in Australia, outlines what good medical practice is for those medical practitioners with a conscientious objection. The code states that 'decisions about patients' access to medical care need to be free from bias and discrimination', with good practice involving health practitioners:

*Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.*

*Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.*<sup>523</sup>

Consistent with the Medical Board of Australia's Code of Conduct, the AMA's Code of Ethics states:

*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.*

*Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.*

*Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.*<sup>524</sup>

The *Code of Ethics for Nurses* in Australia and Royal College of Nursing Australia's *Conscientious Objection: Position Statement* include similar guidelines for nurses and midwives.

The issue of conscientious objection is also covered by the RANZCOG's College Statement on the Termination of Pregnancy, which states that:

*No member of the health team should be expected to perform termination of pregnancy against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained.*<sup>525</sup>

The AMA has published a position statement outlining the following steps that a doctor should take if they have a conscientious objection to providing, or participating, in certain procedures:

- inform your patient of your objection, preferably in advance or as soon as practicable

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<sup>520</sup> Abortion Law Reform Act 2008 (Vic), s 5(2).

<sup>521</sup> Reproductive Health (Access to Terminations) Act 2013 (Tas), s 7.

<sup>522</sup> Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW).

<sup>523</sup> Medical Board of Australia, *Good medical practice: A code of conduct for doctors in Australia*, March 2014, p 7.

<sup>524</sup> Australian Medical Association, *Code of Ethics*, 2004 – Editorial Revised 2006, p 1-2.

<sup>525</sup> RANZCOG, *College Statement: Termination of pregnancy*, C-Gyn 17, March 2013, p 2.

- inform your patient that they have the right to see another doctor. You must be satisfied the patient has sufficient information to enable them to exercise that right. You need to take whatever steps are necessary to ensure your patient's access to care is not impeded
- continue to treat your patient with dignity and respect, even if you object to the treatment or procedure they are seeking
- continue to provide other care to your patient if they wish, and
- refrain from expressing your own personal beliefs to your patient in a way that may cause them distress.<sup>526</sup>

### 16.5 Stakeholders' views about conscientious objection

During the inquiry there appeared to be a general consensus that health practitioners should have a right to conscientious objection allowing them to decline to perform, or participate in the performance of, an abortion.<sup>527</sup> For example, Mr Averill of Nexus Church stated:

*With regard to the welfare of those administering an abortion, we ask that provision be made for conscientious objection for those who would seek it, for to deny it could be to deny them the wholeness of soul that gives meaning to their participation in the medical profession in the first place.*<sup>528</sup>

Numerous submissions supported provision for a conscientious objection by health practitioners.<sup>529</sup> However, a number of submissions also noted that in a medical emergency health practitioners with a conscientious objection should be compelled to perform, or participate in the performance of, an abortion, in the absence of an alternative practitioner being available.<sup>530</sup>

However, views appeared to be divided regarding whether health practitioners who have a conscientious objection should be required to refer the woman to a practitioner who does not share the objection.

Ms Lindel, Manager, Women's Health Centre, Rockhampton stated that:

*We support conscientious objections. Health professionals who hold a conscientious objection to abortion need to make a woman aware of their objection to abortion and make a referral to a doctor who does not have this objection thus providing the woman with the information and support she is seeking.*<sup>531</sup>

Similarly Professor Permezal of RANZCOG stated:

*Conscientious objection is something we feel strongly about. We absolutely respect the right of all practitioners to have a conscientious objection, but it is extremely unfair to women for them to be placed on a roulette wheel where they cruise around a circle of practitioners and cannot access the service, and by the time they find someone who can provide the service the gestation is advanced and the issue of termination becomes a lot more complex than it would have been had the first practitioner directed her to somebody without such a conscientious objection.*<sup>532</sup>

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<sup>526</sup> Australian Medical Association, *Position Statement – Conscientious Objection*, 2013, p 1.

<sup>527</sup> See for example submissions 779, 803, 773, 809.

<sup>528</sup> Murray Averill, public hearing transcript, Brisbane, 1 August 2016, p 55.

<sup>529</sup> See for example submissions 535, 785, 788, 773, 796; Angela Duff, public hearing transcript, Brisbane, 1 August 2016, p 18.

<sup>530</sup> See for example submissions 501, 775.

<sup>531</sup> Belinda Lindel, public hearing transcript, Emerald, 14 July 2016, p 23.

<sup>532</sup> Michael Permezal, public hearing transcript, Brisbane, 2 August 2016, p 2.

Conversely, Dr David van Gend, World Federation of Doctors Who Respect Human Life, commented on a case in Victoria and expressed the view that mandating the referral of the patient to another practitioner meant that:

*...you must participate in the machinery of this appalling act even though you consider it to be so wrong and if you do not participate in that machinery you are the target of the law.*<sup>533</sup>

Cherish Life Queensland also submitted that:

*If a GP doesn't believe abortion is in the best interests of the patient, he/she should actually not refer as a matter of medical ethics.*<sup>534</sup>

In relation to existing arrangements for conscientious objections, Dr Heather McNamee stated that:

*It is already enshrined in AHPRA's regulation and there is a section in the AHPRA regulation around conscientious objection. It states very clearly that if the doctor has a personal or a conscientious objection to termination they do not need to be involved in the provision of that termination. It also makes quite clear that they must offer an alternate healthcare professional in a timely manner, and that can be as simple as having some cards on your desk for the family planning clinic or the Sexual Health Clinic or for my clinic, and AHPRA is very clear on that point.*

*I know in Victoria that that was enshrined in law and it may surprise you to hear that I do not actually agree with putting it in as a law or a Criminal Code. I do not think doctors need [to] be prosecuted for not following AHPRA's regulations. I think they need discipline by AHPRA, warning by AHPRA or notes made on their registration on the website by AHPRA that they have broken AHPRA's regulations and AHPRA has plenty of ways of disciplining us and encouraging us to live up to our responsibilities.*<sup>535</sup>

Dr Carol Portmann's submission described the pathway for a pregnant woman with a diagnosis of a medical condition or foetal abnormality to access an abortion in a Queensland public hospitals.

*In most circumstances, they must have a medical referral and live in a hospital district prepared to accept the referral, or be able to otherwise access a 'sympathetic' hospital. For women in remote areas with only one available GP who is a conscientious objector, even the first step of referral may be difficult.*<sup>536</sup>

In response to committee questions in a public hearing, Dr Portmann said:

*In general an obstetrician will see a patient, a second obstetrician will support that, but then it goes to the hospital administration that also needs to support the decision. You do need those levels of support. You also need to have nursing staff and, if it is occurring in theatre, you need anaesthetists and nursing staff or midwives who are all supportive of providing that service. If you do not have all of that then you will not have a hospital that will readily provide that type of care.*<sup>537</sup>

Dr Portmann also stated that in circumstances where a health facility does not provide abortion services due to conscientious objection:

*We are going to put something in place to ensure that if there is conscientious objection that stops an entire hospital from providing a service that an additional mechanism of referral to an appropriate place can be done, and can be done with minimal delay.*<sup>538</sup>

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<sup>533</sup> Public hearing transcript, Brisbane, 1 August 2016, p 30

<sup>534</sup> Submission 773, p 9.

<sup>535</sup> Heather McNamee, public hearing transcript, Cairns, 15 July 2016, p 16.

<sup>536</sup> Submission 835

<sup>537</sup> Dr Portmann, Public hearing transcript, Brisbane 4 August 2016, p 4

<sup>538</sup> Dr Portmann, Public hearing transcript, Brisbane 4 August 2016, p 5

## 17 Safe access zones around health facilities

The committee heard from submitters and witnesses about safe access zones around health facilities that provide abortions. Abortion is a highly emotive and value driven issue within the Queensland community, with strongly held views on both sides of the public debate. Those who oppose abortion sometimes demonstrate outside health facilities that provide abortion services; safe access zones prohibit demonstrations within a defined zone around the health facilities.

### 17.1 Freedom of speech considerations

The concept of safe access zones raises the question as to whether demonstrations outside facilities that provide abortion services are protected as a form of freedom of speech. It is important to note that the Australian Constitution does not explicitly protect freedom of speech; however, the High Court has held that an implied right to freedom of political communication exists as a necessary part of the Australia's system of representative and responsible government. This right to freedom of political communication operates not as a personal right to freedom of speech but as a right to freedom from government restraint about political matters.<sup>539</sup> Thus regulations may place some restriction on speech providing any limitations do not impinge on the system of representative government.

The objective of safe access zones is to protect the safety, and respect the privacy, of people accessing abortion services and employees who work at the facilities by prohibiting protest activities in the immediate vicinity. While safe access zones likely restrict speech that arguably falls within the ambit of political communication by limiting the area in which people may demonstrate, it is unlikely that safe access zones would be seen as impinging on the system of representative government.<sup>540</sup>

### 17.2 Current regulation of safe access zones in other jurisdictions

#### Australia

The three Australian jurisdictions that have decriminalised abortion, Victoria, Tasmania and the Australian Capital Territory, have all legislated safe access zones around health facilities where abortions are provided. There are no known legal challenges to these laws.

#### 17.2.1 Victoria

In Victoria a safe access zone is an area within a radius of 150 metres of a facility providing abortions.<sup>541</sup> Within this zone it is an offence for a person to:

- beset, harass, intimidate, interfere with, threaten, hinder, obstruct or impede a person accessing, attempting to access, or leaving the facility
- communicate by any means in relation to abortions in a manner that can be seen or heard by a person accessing, attempting to access, or leaving the facility and that is reasonably likely to cause distress or anxiety
- interfere with or impede a footpath, road or vehicle, without reasonable excuse, in relation to the facility

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<sup>539</sup> Lang v Australian Broadcasting Corporation (1997) 189 CLR 520, p 560.

<sup>540</sup> Mitchell Landrigan, 'Protests outside abortion clinics: Constitutionally protected speech?', *Alternative Law Journal*, 41(1), pp 8-12; Department of Parliamentary Services Parliament of Victoria, *Research Note on Exclusion Zones in Australia*, September 2015.

<sup>541</sup> Public Health and Wellbeing Act 2008 (Vic), s 185B(1).

- intentionally record a person accessing, attempting to access, or leaving the facility, without their consent.<sup>542</sup>

The penalty for engaging in prohibited behaviour in a safe access zone is 120 penalty units (\$18,655.20) or imprisonment for a term not exceeding 12 months.<sup>543</sup>

### 17.2.2 Tasmania

In Tasmania a safe access zone is an area within a radius of 150 metres of a facility providing abortions. Within this zone it is an offence for a person to engage in threatening or harassing behaviour, protest, interfere with a footpath or record persons entering an abortion facility.<sup>544</sup>

The penalty for engaging in prohibited behaviour in a safe access zone is 75 penalty units (\$11,775) or imprisonment for a term not exceeding 12 months, or both.<sup>545</sup>

### 17.2.3 Australian Capital Territory

In the Australian Capital Territory a safe access zone is a declared area of at least 50 metres from a facility providing abortions, that is sufficient to ensure privacy and unimpeded access for anyone accessing, attempting to access, or leaving the facility.<sup>546</sup>

Within this zone it is an offence, between 7am and 6pm on the days the facility is open, for a person to:

- harass, hinder, intimidate, interfere with, threaten, obstruct or record a person with the intention of stopping them from entering the facility or having an abortion
- perform an act that can be seen or heard by anyone in the safe access zone, that is intended to stop a person from entering the facility or having an abortion
- protest in relation to the provision of abortions.<sup>547</sup>

The penalty for engaging in prohibited behaviour within the safe access zone is 25 penalty units (\$3,750),<sup>548</sup> and the penalty for publishing recorded information of a accessing, attempting to access, or leaving the facility is 50 penalty units (\$7,500) or imprisonment for 12 months, or both.

### 17.2.4 International

In British Columbia, Canada, safe access zones are created around facilities that provide abortion services, residences and offices of doctors who provide abortion services, and residences of other employees of facilities that provide abortion services. Within this zone, it is an offence to engage in footpath interference, protest, beset, intimidate, or attempt to intimidate, physically interfere, or record patients or employees of facility.<sup>549</sup> There have been several legal challenges to the law on the basis of freedom of speech; however, no challenge has been successful.<sup>550</sup>

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<sup>542</sup> Public Health and Wellbeing Act 2008 (Vic), ss 185D and 185B(1)

<sup>543</sup> *Public Health and Wellbeing Act 2008* (Vic), ss 185D and 185B(1). The value of a penalty unit is \$155.46: *Sentencing Act 1991* (Vic), s 110; *Monetary Units Act 2004* (Vic), s 5; *Victorian Government Gazette GG15*, 14 April 2016, p 639

<sup>544</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 9.

<sup>545</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 9. The value of a penalty unit is \$157: *Penalty Units and Other Penalties Act 1987* (Tas) s 4A; *Tasmanian Government Gazette GG21*, 1 June 2016, p 892

<sup>546</sup> *Health Act 1993* (ACT), s 86

<sup>547</sup> *Health Act 1993* (ACT), ss 85 and 87

<sup>548</sup> *Health Act 1993* (ACT), s 85. The value of a penalty unit is \$150: *Legislation Act 1987* (ACT) s 133(2)

<sup>549</sup> *Access to Abortion Services Act 1995* (BC) s 2

<sup>550</sup> See *R v Lewis* [1997] 1 WLR 496; *R v Demers* 2002 BCCA 28

There is no safe access zone legislation in the United Kingdom and Northern Ireland, however other methods, such as deterring protestors under harassment laws, are commonly used.

### 17.3 Stakeholders views about regulation of safe access zones

The majority of submitters and witnesses who made representations about safe access zones supported their introduction to protect patients and employees of health facilities from offensive and obstructive behaviour.<sup>551</sup> The Australian Centre for Health Law Research expressed the view that:

*...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.*<sup>552</sup>

RANZCOG supported the view that women and employees involved with abortion services have the right to some degree of privacy, stating that '[a]n exclusion zone unfortunately seems to be necessary'.<sup>553</sup>

A number of submissions and witnesses considered safe access zones in three Australian jurisdictions to be successful.<sup>554</sup> They expressed support for similar legislation 'to ensure that women in Queensland can receive health service free from judgement, harassment, intimidation and harm'.<sup>555</sup>

The impact that safe access zones may have on freedom of speech and the perceived right to object to abortion outside health facilities was also raised, with one submitter stating:

*...legislation should promote freedom of speech (including allowance of promotional material for both sides) outside abortion clinics and that this information permits the morality or immorality of abortion to be explained.*<sup>556</sup>

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<sup>551</sup> See for example submissions 794, p 5; 501, p 2; 647, p 3; 1222, p 6; Brooke Calo, public hearing transcript, Brisbane, 2 August 2016, p 26; Olivier King, public hearing transcript, Brisbane, 2 August 2016, p, 51.

<sup>552</sup> Submission 1221, p 12.

<sup>553</sup> Public hearing transcript, Brisbane, 2 August 2016, p 2.

<sup>554</sup> See for example submissions 537, p 2; 837, p 3; 848, p 3; 501, p 2; Alexis Apostolellis, public hearing transcript, Brisbane, 2 August 2016, p 18.

<sup>555</sup> True Relationships and Reproductive Health, submission 775, pp 2-3.

<sup>556</sup> Spencer Gear, submission 455, p 14.

## Appendix A - Legislation and regulation in other jurisdictions

### Introduction

This Appendix outlines the law that regulates abortion in other Australian jurisdictions. Chapter 3 contains a short summary of the law in other states and territories.

### Victoria

#### Background

Until 2008, abortion in Victoria was prohibited under sections 65 and 66 of the *Crimes Act 1958* (Vic), which were virtually identical to sections 224 and 225 of the Criminal Code.<sup>557</sup> Abortion was only an offence if performed 'unlawfully'. There were no specific exemptions from criminal liability similar to section 282 of the Criminal Code and the circumstances in which an abortion was considered lawful were not defined.

#### Cases

In the 1969 Supreme Court case of *R v Davidson*,<sup>558</sup> Justice Menhennitt ruled that an abortion is 'lawful' if the accused honestly believed on reasonable grounds that the act done was:

- necessary to preserve the woman from a serious danger to her life or physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of pregnancy would entail
- in the circumstances not out of proportion to the danger to be averted.

#### Legislation

In October 2008, the *Abortion Law Reform Act 2008* (Vic) was passed by Parliament. It repealed the provisions relating to abortion from the *Crimes Act 1958* and removed all common law offences, effectively decriminalising abortion.

Under the Act, a registered medical practitioner may perform an abortion on a woman who is not more than 24 weeks pregnant upon request.<sup>559</sup> The legislation specifically includes abortion by administration of a drug.<sup>560</sup> After 24 weeks, a registered medical practitioner may only perform an abortion where the practitioner:

- reasonably believes that the abortion is appropriate in all the circumstances
- has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances.<sup>561</sup>

In considering whether the abortion is appropriate in all the circumstances, a registered medical practitioner must have regard to:

- all relevant medical circumstances
- the woman's current and future physical, psychological and social circumstances.<sup>562</sup>

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<sup>557</sup> Nicolee Dixon, *Abortion Law Reform: An Overview of Current Issues*, Queensland Parliamentary Library, 2003, p 21.

<sup>558</sup> *R v Davidson* [1969] VR 667.

<sup>559</sup> *Abortion Law Reform Act 2008* (Vic), s 4.

<sup>560</sup> *Abortion Law Reform Act 2008* (Vic), ss 6, 7.

<sup>561</sup> *Abortion Law Reform Act 2008* (Vic), s 5(1).

<sup>562</sup> *Abortion Law Reform Act 2008* (Vic), s 5(2).



### **Conscientious objection**

The *Abortion Law Reform Act 2008* (Vic) provides that medical practitioners who have a conscientious objection to performing or advising on abortions must:

- advise the patient that they have a conscientious objection to abortions, and
- refer the patient to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.<sup>563</sup>

Despite any conscientious objection to abortion, a registered medical practitioner has a duty to perform an abortion in an emergency where it is necessary to preserve the life of the pregnant woman.<sup>564</sup>

### **Penalties**

While there are no longer criminal penalties for procuring an abortion in the *Crimes Act*, according to the Explanatory Memoranda for the Abortion Law Reform Bill 2008:

*A registered medical practitioner who performed an abortion on a woman who was more than 24 weeks pregnant without considering the relevant circumstances, or without seeking the opinion of a second registered medical practitioner will be liable to be found to have engaged in professional misconduct under the Health Professions Registration Act 2005.*

### **Access zones around abortion clinics**

The *Public Health and Wellbeing Act 2008* (Vic) was amended in 2015 to provide for safe access zones around premises at which abortions are provided, and to prohibit publication and distribution of certain recordings. Those amendments have not yet come into force.<sup>565</sup>

## **New South Wales**

### **Legislation**

Sections 82-84 of the *Crimes Act 1900* (NSW) creates similar offences relating to procuring an abortion to those in the Criminal Code. Abortion is only an offence if performed 'unlawfully' and those circumstances are not specified. Under the Crimes Act, if a woman or other person procures an abortion the maximum penalty is ten years imprisonment. Supplying or procuring drugs or instruments has a maximum penalty of five years.

### **Cases**

The 1972 NSW District Court decision of *R v Wald* by Judge Levine established the grounds on which an abortion may be performed lawfully in New South Wales:<sup>566</sup>

*[a]n abortion should be considered to be lawful if the doctor honestly believed on reasonable grounds that "the operation was necessary to preserve the woman involved from serious danger to her life or physical or mental health which the continuance of the pregnancy would entail" and that in regard to mental health the doctor may take into account "the effects of economic or social stress that may be pertaining to the time".*

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<sup>563</sup> Abortion Law Reform Act 2008 (Vic), s 8(1).

<sup>564</sup> Abortion Law Reform Act 2008 (Vic), s 8(3).

<sup>565</sup> Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015 (Vic), s 2.

<sup>566</sup> (1971) 3 DCR (NSW) 25.

*Levine also specified that two doctors' opinions are not necessary and that the abortion does not have to be performed in a public hospital.*<sup>567</sup>

The 1995 New South Wales Supreme Court case, *CES and Anor v Superclinics*, affirmed this decision and held that a threat to the woman's mental health which may occur after the birth can be taken into account, including social and economic considerations.<sup>568</sup>

### South Australia

The *Criminal Law Consolidation Act 1935* (SA) creates offences similar to those in Queensland.<sup>569</sup> The Act was amended in 1969 to include section 82A which sets out circumstances where the procurement of an abortion will be lawful.<sup>570</sup>

The effect of s 82A is as follows:

*In essence, s 82A permits an abortion in two types of situations.*

*The **first** situation applies in the period before the foetus has become 'a child capable of being born alive' (which s 82A(8) sets at **28 weeks**). That is, if a qualified medical practitioner and one other qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman, that –*

- *the continuation of the pregnancy involves greater risk to the woman's life or of injury to physical or mental health than if the pregnancy were terminated; or*
- *there is a substantial risk that, if the pregnancy were not terminated, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.*

*The **second** situation is where, at any stage of the pregnancy (including **over 28 weeks**), the termination is immediately necessary to save the woman's life, or prevent grave injury to her physical or mental health. The abovementioned procedural requirements do not apply in these circumstances.*

*The provision also makes it clear that no person is under a duty to participate in any such termination operation to which he or she has a conscientious objection.*<sup>571</sup>

Under the *Criminal Law Consolidation Act 1935* (SA), procuring an abortion has a maximum penalty of life imprisonment. Supplying or procuring drugs or instruments has a maximum penalty of three years.

### Western Australia

Under s 199(1) of the Western Australian *Criminal Code*, the procurement of an abortion is unlawful unless:

- (a) the abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and*
- (b) the performance of the abortion is justified under section 334 of the Health Act 1911.*

Section 334 of the *Health Act 1911* (WA) provides that the performance of an abortion is justified under the *Criminal Code* only if:

- (a) the woman concerned has given informed consent; or*

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<sup>567</sup> Children by Choice, *Australian Abortion Law and Practice*, 2015, <  
<http://childrenbychoice.org.au/factsandfigures/australianabortionlawandpractice>>.

<sup>568</sup> (1995) 38 NSWLR 47.

<sup>569</sup> *Criminal Law Consolidation Act 1935* (SA), ss 81 and 82.

<sup>570</sup> Nicolee Dixon, *Abortion Law Reform: An Overview of Current Issues*, Queensland Parliamentary Library, 2003, p 22.

<sup>571</sup> Nicolee Dixon, *Abortion Law Reform: An Overview of Current Issues*, Queensland Parliamentary Library, 2003, p 23.

- (b) *the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or*
- (c) *serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or*
- (d) *the pregnancy of the woman concerned is causing serious danger to her physical or mental health.*

Informed consent is also required under section 334(b)-(d) of the *Health Act* where practicable. The availability of abortion after giving informed consent means that abortion is effectively available on request up to 20 weeks of pregnancy.

Under section 334(7), if 20 weeks of the pregnancy have been completed, the performance of the abortion is not justified unless:

- (a) *2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and*
- (b) *the abortion is performed in a facility approved by the Minister for the purposes of this section.*

Provisions regarding the nature of informed consent apply where the woman is a dependant minor.<sup>572</sup> No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion.<sup>573</sup>

A person who unlawfully performs an abortion is guilty of an offence with a penalty of \$50,000. A person who performs an abortion who is not a medical practitioner is guilty of a crime and is liable to imprisonment for five years.

## **Tasmania**

### **Legislation**

In November 2013 the *Reproductive Health (Access to Terminations) Act 2013* (Tas) removed the crime of abortion from the *Criminal Code Act 1924* (Tas). The legislation provides that a pregnancy of not more than 16 weeks may be terminated by a medical practitioner with the woman's consent.<sup>574</sup>

Under section 5(1), a pregnancy after 16 weeks may be terminated by a medical practitioner with the woman's consent if the medical practitioner:

- (a) *reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and*
- (b) *has consulted with another medical practitioner who reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.*

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<sup>572</sup> *Health Act 1911* (WA), s 334(8).

<sup>573</sup> *Health Act 1911* (WA), s 334(2).

<sup>574</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 4. See also, the *Reproductive Health (Access to Terminations) Regulations 2014* (Tas) which prescribe various health services which a medical practitioner must provide to a woman if the practitioner is aware that the woman is seeking a termination or advice regarding a full range of pregnancy options.

In assessing the risk, the medical practitioners must have regard to the woman's physical, psychological, economic and social circumstances and at least one of the medical practitioners is to be a medical practitioner who specialises in obstetrics or gynaecology.<sup>575</sup>

The legislation specifically provides that a woman who consents to, assists in or performs a termination on herself is not guilty of a crime or any other offence.<sup>576</sup>

It remains a criminal offence under the Tasmanian *Criminal Code* for a termination that is performed other than by a medical practitioner or without a woman's consent.

### **Conscientious objection**

Under section 6 of the *Reproductive Health (Access to Terminations) Act 2013* (Tas), an individual who has a conscientious objection to abortion does not have a duty to participate in an abortion. However, a medical practitioner has a duty to perform a termination in an emergency if it is necessary to save a pregnant woman's life or to prevent her serious physical injury. A nurse or midwife has a duty to assist a medical practitioner with an abortion in an emergency, if it is necessary to save the life of a pregnant woman or prevent her serious physical injury.<sup>577</sup>

### **Access zones**

The *Reproductive Health (Access to Terminations) Act 2013* (Tas) also provides that a person must not engage in prohibited behaviour within an access zone, that is within 150 metres of a premises providing abortion. Prohibited behaviour includes: threatening or harassing behaviour, protesting, footpath interference, and the recording of persons entering an abortion facility.<sup>578</sup>

## **Australian Capital Territory**

### **Legislation**

Prior to 2002, it was an offence under sections 42-44 of the *Crimes Act 1900* (ACT) for a doctor or woman to procure an abortion. Abortion was decriminalised in 2002 when the *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT) was passed, removing the offence of abortion from the *Crimes Act*. Abortion is therefore available upon request.

The *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT) also amended the *Health Act 1993* (ACT) to require abortions to be performed by a registered medical practitioner in a medical facility approved by the Minister.

### **Privacy zones**

The *Health (Patient Privacy) Amendment Act 2015* (ACT) amended the *Health Act 1993* (ACT) to insert provisions that allow the creation of 'privacy zones' around approved medical facilities. It is an offence to:

- conduct protests or other public displays about abortion
- to harass, hinder, intimidate, interfere with, threaten, obstruct or film a person, with the intention of preventing a person from entering the facility or accessing its services.

## **Northern Territory**

Sections 208B and 208C of the *Criminal Code Act* (NT) make the procurement of an abortion a criminal offence. No specific exemptions from criminal responsibility are provided for under *Criminal Code*.

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<sup>575</sup> Reproductive Health (Access to Terminations) Act 2013 (Tas), s 5(2)(3).

<sup>576</sup> Reproductive Health (Access to Terminations) Act 2013 (Tas), s 8.

<sup>577</sup> Reproductive Health (Access to Terminations) Act 2013 (Tas), s 6.

<sup>578</sup> Reproductive Health (Access to Terminations) Act 2013 (Tas), s 9.

Section 11 of the *Medical Services Act* (NT) sets out circumstances where the procurement of an abortion is lawful. It is lawful where:

- a medical practitioner reasonably believes a woman has been pregnant for not more than 14 weeks
- two medical practitioners (where possible, one practitioner must be an obstetrician or gynaecologist) are of the opinion that:
  - the continuance of the pregnancy would involve greater risk to her life or greater risk of harm to her physical or mental health than if the pregnancy were terminated, or
  - there is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities
- the treatment is given in hospital
- at the time the treatment is given the practitioner reasonably believes the woman has been pregnant for not more than 14 weeks, and
- the appropriate person consents to the treatment.

Women under 16 years of age or who lack capacity cannot give consent.<sup>579</sup>

An abortion is also lawful where:

- a medical practitioner reasonably believes that a woman has been pregnant for not more than 23 weeks
- is of the opinion termination of the pregnancy is immediately necessary to prevent serious harm to her physical or mental health, and
- the appropriate person consents to the giving of the treatment.<sup>580</sup>

An abortion is also lawful where:

- the treatment is given or carried out in good faith for the sole purpose of preserving her life, and
- the appropriate person consents to the giving of the treatment.<sup>581</sup>

A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so.<sup>582</sup>

The penalties for procuring an abortion on another are a maximum seven years imprisonment. Procuring a substance or instrument also has a maximum penalty of seven years imprisonment.

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<sup>579</sup> Medical Services Act (NT), s 11(1)(c).

<sup>580</sup> Medical Services Act (NT), s 11(3).

<sup>581</sup> Medical Services Act (NT), s 11(4).

<sup>582</sup> Medical Services Act (NT), s 11(6).

## **Appendix B – Submissions**

The committee received 1,445 submissions to this Inquiry. Copies of submissions can be accessed from the Inquiry webpage at:

[http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDVPC/  
inquiries/current-inquiries/AbortionLR-WRC-AB2016](http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDVPC/inquiries/current-inquiries/AbortionLR-WRC-AB2016)

## Appendix C – Briefings and Public Hearings

<b>Public briefing on the Private Members Bill – 15 June 2016</b>
Mr Rob Pyne MP, Member for Cairns

<b>Public briefing, Brisbane 12 July 2016</b>
<b>Australian Psychological Society</b> <ul style="list-style-type: none"><li>• Heather Gridley</li></ul>
<b>Australian Association of Social Workers, Queensland Branch</b> <ul style="list-style-type: none"><li>• Dr Fotina Hardy</li><li>• Jacklyn Whybrow</li></ul>
<b>Queensland Health</b> <ul style="list-style-type: none"><li>• Associate Professor Rebecca Kimble, Chair, Statewide Maternity and Neonatal Clinical Network</li><li>• Dr John Wakefield, Deputy Director-General, Clinical Excellence Division</li></ul>
<b>Royal Australian and New Zealand College of Psychiatrists</b> <ul style="list-style-type: none"><li>• Dr Lyndall White</li></ul>
<b>Royal Australian College of General Practice</b> <ul style="list-style-type: none"><li>• Dr Wendy Burton</li></ul>

<b>Public briefing Brisbane 13 July 2016</b>
<b>Australian Catholic University and Australian Centre for Christianity and Culture</b> <ul style="list-style-type: none"><li>• Father Frank S J Brennan</li></ul>
<b>Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology</b> <ul style="list-style-type: none"><li>• Professor Lindy Willmott</li><li>• Professor Ben White</li></ul>
<b>School of Medicine, Griffith University</b> <ul style="list-style-type: none"><li>• Professor Eleanor Milligan, Professor of Ethics and Professional Practice</li></ul>
<b>TC Beirne School of Law, The University of Queensland</b> <ul style="list-style-type: none"><li>• Professor Heather Douglas</li></ul>

**Public Hearing Emerald 14 July 2016**

**Private Capacity**

- Noela Grierson
- Robert Grierson
- Susan Kirk
- Olga Kirk
- Wesley Stott

**Women's Health Centre, Rockhampton**

- Belinda Lindel, Manager
- Selina Utting, Board Member

**Public Hearing Cairns 15 July 2016**

**Private Capacity**

- Rodney Byl
- Dr Michael Carette
- Dr Tim Coyle
- Professor Caroline de Costa
- Dr Paul Hyland
- Dr Heather McNamee
- Lyn Shumack
- William Tento
- Stuart Withrington



<b>Public hearing, Brisbane 1 August 2016</b>
<b>Australian Christian Lobby</b>
<ul style="list-style-type: none"> <li>• Wendy Francis, Queensland Director</li> </ul>
<b>Australian Family Association</b>
<ul style="list-style-type: none"> <li>• Angela Duff, Vice President</li> <li>• Alan Baker</li> </ul>
<b>Canberra Declaration Team and Community</b>
<ul style="list-style-type: none"> <li>• David Rowsome</li> <li>• Teresa Martin</li> </ul>
<b>Cherish Life Queensland</b>
<ul style="list-style-type: none"> <li>• Julie Borger, President</li> <li>• Dr Donna Purcell, Vice President</li> </ul>
<b>Family Voice Australia</b>
<ul style="list-style-type: none"> <li>• Ros Phillips, National Research Officer</li> </ul>
<b>Nexus Church</b>
<ul style="list-style-type: none"> <li>• Murray Averill</li> </ul>
<b>Priceless Life</b>
<ul style="list-style-type: none"> <li>• Catherine Toomey, Managing Director</li> <li>• Luz Miranda, Counsellor</li> </ul>
<b>Queensland Baptists</b>
<ul style="list-style-type: none"> <li>• Dr Anne Klose, Board Member</li> <li>• Dr Neil Parker, Board Member</li> </ul>
<b>Queensland Bioethics Centre (representing The Catholic Archdiocese of Brisbane)</b>
<ul style="list-style-type: none"> <li>• Dr Ray Campbell, Director</li> </ul>
<b>Uniting Church in Australia, Queensland Synod</b>
<ul style="list-style-type: none"> <li>• Rev David Baker</li> <li>• Sue Hutchinson</li> </ul>
<b>St Vincent de Paul Society – Social Justice Committee</b>
<ul style="list-style-type: none"> <li>• Dr Nerida Smith</li> </ul>
<b>Women’s Forum Australia</b>
<ul style="list-style-type: none"> <li>• Kristan Dooley, Managing Director</li> </ul>
<b>World Federation of Doctors who Respect Human Life</b>
<ul style="list-style-type: none"> <li>• Dr David van Gend, Queensland Secretary</li> </ul>

<b>Public hearing, Brisbane 2 August 2016</b>
<b>Children by Choice</b> <ul style="list-style-type: none"><li>• Kate Marsh, Communications Co-ordinator</li><li>• Sian Tooker, Counsellor</li></ul>
<b>Institute of Urban Indigenous Health</b> <ul style="list-style-type: none"><li>• Dr Caroline Harvey</li><li>• Jody Currie</li></ul>
<b>Marie Stopes International in Australia</b> <ul style="list-style-type: none"><li>• Alexis Apostolellis, Chief Executive Officer</li><li>• Natalie de Vos, Director of Clinical Services</li></ul>
<b>Maternity Choices Queensland</b> <ul style="list-style-type: none"><li>• Leah Hardimann</li></ul>
<b>National Alliance of Abortion and Pregnancy Options Counsellors</b> <ul style="list-style-type: none"><li>• Brook Calo</li><li>• Trish Hayes</li></ul>
<b>Pro-Choice Queensland</b> <ul style="list-style-type: none"><li>• Carla Gorton</li><li>• Amanda Bradley</li></ul>
<b>Public Health Association of Australia</b> <ul style="list-style-type: none"><li>• Professor Angela Taft</li></ul>
<b>Queensland Nurses' Union</b> <ul style="list-style-type: none"><li>• Beth Mohle, Secretary</li><li>• Liz Todhunter, Research and Policy Officer</li></ul>
<b>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</b> <ul style="list-style-type: none"><li>• Professor Michael Permezel, President</li></ul>
<b>True Relationships and Reproductive Health</b> <ul style="list-style-type: none"><li>• Dr Fiona Mack</li></ul>
<b>Women's Legal Service</b> <ul style="list-style-type: none"><li>• Katherine Kerr, Social Worker</li><li>• Angela Lynch, Acting Co-ordinator</li></ul>
<b>Young Queenslanders for the Right to Choose</b> <ul style="list-style-type: none"><li>• Kate Marchesi, President</li><li>• Olivia King, Vice-President</li></ul>

<b>Public hearing, Brisbane 4 August 2016</b>
<b>Private capacity</b> <ul style="list-style-type: none"><li>• Professor David Ellwood</li><li>• Dr Glenn Gardener</li><li>• Dr Carol Portmann</li></ul>

## Appendix D - Community attitude surveys

Chapter 8 of this report summarises the analysis, by ANU, of the reliability of seven community attitude surveys about abortion. Below is the ANU's detailed analysis, including tables of some of the survey results.

### 1 Galaxy Research 'What Queenslanders Really Think about Abortion' 2016

#### Background

The 'What Queenslanders Really Think about Abortion' study is a single-instance survey, commissioned by the Australian Family Association in 2016. The Australian Family Association is a not-for-profit organisation formed in 1980. It has a publicly stated position opposing legal abortion.

The survey was conducted by Galaxy Research in May 2016. It sampled 400 Queensland residents: 200 living in Brisbane, and 200 living in rural and regional areas. The sample was drawn from 'telephone lists'. The survey was conducted via telephone.

The collected data have been weighted to reflect the age, gender, and geographic characteristics of the Queensland population, based on Australian Bureau of Statistics benchmarks.

#### Content

This survey consisted of 13 questions on attitudes to abortion, as well as additional demographic questions. Two questions directly asked about the acceptability of abortion:

*Research shows that the vast majority of abortions in Australia are performed for social or financial reasons. Do you support abortion in cases where a healthy mother is carrying a healthy unborn baby?*

*Response options: Yes/No/Don't know*

*Up to what stage of pregnancy would you allow abortion? Would it be...?*

*Response options: Not at all/At any time up to 13 weeks, that is, 3 months/ At any time up to 20 weeks, that is, halfway through the pregnancy, or/At any time during the pregnancy up to birth*

#### Results

In total, 38 per cent of respondents said they supported abortion where a healthy mother is carrying a healthy unborn baby. A further 45 per cent said they did not support it and a sizable 17 per cent responded 'don't know'.

Half of all respondents (50 per cent) would allow abortion in the first 13 weeks of pregnancy (Table 2). Thirteen per cent would allow it in the first 20 weeks, while six per cent would allow it at any stage of the pregnancy. Almost one quarter (22 per cent) would not allow abortion at all. The remaining nine per cent of the sample 'don't know'.

#### Survey strengths and limitations

The design of the questionnaire limits the ability to the survey to collect reliable information on community attitudes about abortion.

The first three questions about abortion<sup>583</sup> ask respondents if they believe that abortion involves taking a human life, whether unborn babies have human rights, and whether abortion can harm the physical

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<sup>583</sup> [http://www.family.org.au/reports/May\\_2016\\_Abortion\\_Galaxy\\_poll.pdf](http://www.family.org.au/reports/May_2016_Abortion_Galaxy_poll.pdf)

and/or mental health of a woman. Best practice survey design would not ask emotive questions such as these so early in a survey, for fear they will 'prime' the respondents' answers to subsequent questions.<sup>584</sup>

Similarly, the preamble in the question *Research shows that the vast majority of abortions in Australia are performed for social or financial reasons. Do you support abortion in cases where a healthy mother is carrying a healthy unborn baby?* is likely to produce lower rates of support for abortion than the same question asked without the leading preamble.

Other questions are similarly loaded to maximise the chances of eliciting negative attitudes towards abortion. The wording for one of the questions includes the misleading statement that a baby born at 20 weeks can survive out of the womb.<sup>585</sup>

We have been able to locate only very limited information about how the sample was selected. It is not clear if the telephone list used to randomly select respondents included landline phones only or also mobile phones. A landline-only sampling frame would substantially limit the representativeness of the sample; one third of the Australian adult population is estimated to have a mobile phone but no landline.<sup>586</sup> The response rate is also not provided, further limiting our ability to assess the representativeness of the data.

The leading nature of the questions, relatively small sample size and lack of information on how the sample was selected and response rates means that the data from this survey should not be considered a reliable source of information on community attitudes towards abortion.

## 2 Australian Election Studies 2010 and 2013

### Background

The 2010 Australian Election Study and 2013 Australian Election Study are part of a series of social surveys conducted since 1987. Each Australian Election study collects information about the attitudes of Australians on a range of political and social issues in the weeks following a federal election. The Australian Election Study is currently directed by a team of researchers from The Australian National University, Queensland University of Technology and University of Manchester.<sup>587</sup>

The Australian Election Study is designed to be representative of Australians aged 18 or over who were enrolled and eligible to vote in the election. The survey is administered via a hard-copy questionnaire mailed to randomly selected individuals (with an online completion option). In the 2013 survey, 12,200 surveys were mailed out and 3,955 completed returns were received (including 576 online returns). Excluding out of scope addresses (deceased, incapable, return to sender, 530 cases), the response rate was 34.2 per cent. In the 2010 survey 4,999 surveys were mailed out and 2,003 completed returns were received (including 165 online returns). Excluding out of scope addresses (deceased, incapable, return to sender, 530 cases), the response rate was 42.5 per cent.

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<sup>584</sup> See for example Carlson, C. S. (2006), 'Context Effects on Abortion Questions: Who is Inconsistent', Dissertation, Georgia State University, [http://scholarworks.gsu.edu/political\\_science\\_diss/1/](http://scholarworks.gsu.edu/political_science_diss/1/)

<sup>585</sup> See for example Rysavy, M.A. et al. (2015), 'Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants', *The New England Journal of Medicine* 2015;372:1801-11., DOI: 10.1056/NEJMoa1410689, <http://www.nejm.org/doi/pdf/10.1056/NEJMoa1410689>.

<sup>586</sup> <http://www.acma.gov.au/theACMA/engage-blogs/engage-blogs/Research-snapshots/Australians-get-mobile>

<sup>587</sup> Australian Election Study <http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/australian-election-studies> at 21 July 2016

Data are weighted by sex, age and state, and party vote based on Australian Electoral Commission and Australian Bureau of Statistics benchmarks.<sup>588</sup>

## Content

The Australian Election Study series contains one question on abortion attitudes:

*Which one of these statements comes closest to how you feel about abortion in Australia?*

*Response options: Women should be able to obtain an abortion readily when they want one/Abortion should be allowed only in special circumstances/Abortion should not be allowed under any circumstances/Don't know*

## Results

In the 2013 survey, 60 per cent of respondents selected the option 'women should be able to obtain an abortion readily when they want one' (see Table 1, Appendix D). Twenty-seven per cent selected 'abortion should be allowed only in special circumstances'; four per cent selected 'abortion should not be allowed under any circumstances'; and four per cent of respondents selected 'don't know'.

The results for the 2010 survey are very similar, with 58 per cent of respondents selecting 'women should be able to obtain an abortion readily when they want one', 31 per cent selecting abortion 'should only be allowed in special circumstances', four per cent selecting 'abortion should not be allowed under any circumstances' and seven per cent of respondents selecting 'don't know'.

Responses from Queensland residents were broadly similar with national community attitudes in both 2010 and 2013.

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<sup>588</sup> Australian Election Study 2013 Methodology.

<http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/australian-election-study/aes-2013> at 21  
July 2016.

**Table 4 Abortion support, Australian Election Study 2013, by State (column percentage)**  
*'Which one of these statements comes closest to how you feel about abortion in Australia?'*

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT <sup>a</sup>	Total
	%	%	%	%	%	%	%	%	%
<i>Women should be able to obtain an abortion readily when they want one</i>	59	63	58	55	59	55	78	56	60
<i>Abortion should be allowed only in special circumstances</i>	27	26	30	32	25	36	15	29	27
<i>Abortion should not be allowed under any circumstances</i>	4	3	3	4	6	3	3	0	4
<i>Don't know</i>	8	6	6	7	7	6	3	8	7
<i>No response</i>	2	2	3	2	3	1	2	6	2
<i>Total</i>	100	100	100	100	100	100	100	100	100
<i>Number of observations</i>	1,264	977	743	299	379	96	70	33	3,862

Notes: <sup>a</sup> Responses for ACT should be interpreted with caution due to the low sample size (30 cases)

Source: 2013 Australian Election Study. Weighted percentages.

### Survey strengths and limitations

The response rate to the 2013 Australian Election Study was 34 per cent, and the response rate to the 2010 Australian Election study was 42 per cent. These response rates are in line with those achieved by high quality postal surveys. The fall in response rate between 2010 and 2013 is consistent with generally falling response rates to surveys, although some of that decline can likely be attributed to the fact that the 2013 Australian Election Study targeted a disproportionately large sample of first-generation migrant Australians.

The question on abortion is not negatively or positively loaded and presented in a simple and factual way.

A limitation is that the general nature of the question does not allow insight on the exact limits of when respondents think abortion acceptable or not; that is, 'special circumstances' probably measures quite a broad spectrum of different positions on abortion but categorises them all as one.

The Australian Election Study is a high quality survey of community attitudes and the results provide reliable estimates of community attitudes to abortion.

### 3 Second Australian Study of Health and Relationships 2013

#### Background

The second 'Australian Study of Health and Relationships' is a large-scale survey conducted in 2013 by CSIRO on behalf of research partners at the University of New South Wales, University of Sydney, University of Sussex, and La Trobe University.<sup>589</sup>

<sup>589</sup> World Values Survey (Australian component)

<http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/world-values-survey>

The survey is designed to be representative of Australian adults aged between 16 and 69 years. The survey was conducted via a combination of random-digit dialling landline and mobile phone numbers. A total of 20,094 surveys were completed, with a response rate of 24.5 per cent to 28.9 per cent depending upon how it is calculated. This response rate is in line with common response rates in a high quality random digit dial telephone survey. The data are weighted by sex, age, and location, based on Australian Bureau of Statistics benchmarks.<sup>590</sup>

## Content

The Second Australian Study of Health and Relationships 2013 asked respondents a series of statement about attitudes towards sex and relationships including one on abortion:

*I'm now going to read several statements and I'd like you to tell me whether you: ... abortion is always wrong.*

*Response options: Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree/Don't know/Refused*

Embedding the question about abortion in a series of statements a number of which related to sex may have had an impact upon the responses provided, although the direction of any impact is unclear.

## Results

Responses to this question have only been reported publicly by gender subgroup, not as total percentages of the population. Women (74 per cent) are slightly more likely to disagree that abortion is always wrong (Table 2, Appendix D). Slightly fewer men (67 per cent) disagree that abortion is always wrong.

**Table 5 Abortion support, Australian Study of Health and Relationships 2013**

*'I'm now going to read several statements and I'd like you to tell me whether you: ... abortion is always wrong.'*

	Men	Women
	%	%
<i>Agree</i>	20	15
<i>Neither</i>	13	11
<i>Disagree</i>	67	74
<i>Total %</i>	100	100
<i>Number of observations</i>	9,947	9,989

Source: Visser et al (2014). Attitudes towards sex and relationships: the Second Australian Study of Health and Relationships. *Sexual Health*, 11, 397–405.

## Survey strengths and limitations

The reported response rate of around 25 per cent is in line with those achieved by high quality random digit dial surveys. The sample was selected using a probability sample and so are likely to be generally representative of the Australian population.

<sup>590</sup> Australian Study of Health and Relationships 2  
<http://www.publish.csiro.au.virtual.anu.edu.au/?paper=SH14115> accessed 21 July 2016

The question is clear in what is asking respondents, but it does not measure respondents' attitudes to different forms or contexts of abortion.

The reporting of responses in available sources does not break down responses by 'strong' agreement or disagreement', instead combining 'strongly agree' and 'agree' into 'agree', and 'strongly disagree' and 'disagree' into 'disagree'.

The Second Australian Study of Health and Relationships 2013 is a high quality survey of community attitudes and the results provide reliable estimates of community attitudes to abortion.

#### **4 World Values Survey (Australian component) 2012**

##### **Background**

The 2012 World Values Survey is part of a series of surveys started in 1981, used to gauge citizens' attitudes on a range of social issues. The survey is conducted internationally by investigators in each participating country. The Australian component of the survey is directed by researchers at ANU.<sup>591</sup> The 2012 Australian survey contributed data to Wave 6 of the World Values Survey series.

The survey is designed to be representative of Australian adults aged 18 or over, enrolled and eligible to vote in federal elections. The survey was conducted as a postal survey with an option to complete the survey online. Of 5,000 surveys mailed out, 1,477 completed returns were received, including 191 completed online. Excluding out of scope addresses (deceased, incapable, return to sender, 206 cases), the response rate was 29.5 per cent.

Data are weighted by sex, age, state/territory, and educational attainment, based on Australian Bureau of Statistics benchmarks.<sup>592</sup>

##### **Content**

The 2012 World Values Survey asks respondents whether abortion is justifiable, as part of a battery of questions on moral and sexual health issues.

*Please tell me for each of the following actions whether you think it can always be justified, never be justified, or something in between: abortion.*

*Response options: Never justifiable = 1/2/3/4/5/6/7/8/9/Always justifiable =10*

##### **Results**

On the 1 to 10 response scale, respondents' mean answer was 5.8. Sixteen per cent responded that abortion is never justifiable, and 15 per cent responded that abortion is always justifiable. Twenty-two per cent responded with '5', halfway between 'always' and 'never' justifiable.

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<sup>591</sup> World Values Survey (Australian component) <http://politicsir.cass.anu.edu.au/research/projects/electoral-surveys/world-values-survey>

<sup>592</sup> Australian Survey of Social Attitudes 2009 Methodology <http://www.ada.edu.au/ADADData/notes/ADA.NOTE.01189-UG.pdf> at 21 July 2016



**Table 6 Abortion support, World Values Survey (Australian component) 2012**

*'Please tell me for each of the following actions whether you think it can always be justified, never be justified, or something in between: abortion.'*

	%
<i>Never justifiable</i>	16
2	3
3	4
4	3
5	22
6	9
7	9
8	12
9	6
<i>Always justifiable</i>	15
<i>Total</i>	100
<i>Number of observations</i>	1,477

- Source: 2012 World Values Survey (Australian component). Weighted percentages.

### Survey strengths and limitations

The response rate of 29.5 per cent is in line with those achieved by high quality postal surveys. The data are weighted so are likely to be generally representative of the Australian population.

The question allows respondent to express a more nuanced view than questions in similar surveys: if respondents hold a position between 'never allow' and 'always allow', they have the opportunity to express the strength of their attitude with this question.

A limitation however is that asking respondents to provide such a nuanced response can lead them to 'satisficing', that is, providing a 'good enough' response. This often manifests in a high number of 'middle of the road' (i.e. '5' on the scale) responses.

The 2012 World Values Survey is a high quality survey of community attitudes and the results provide reliable estimates of community attitudes to abortion.

## 5 Auspoll 'Queensland Voters' Views on Abortion' 2009

### Background

The 'Queensland Voters' Views on Abortion' is a single-instance survey, commissioned by Children by Choice in 2009. Children by Choice is a Queensland based advocacy group that provides counselling, information and education services relating to unplanned pregnancies, abortion, adoption and parenting. The group is strongly pro-choice.<sup>593</sup>

<sup>593</sup> Children By Choice <http://childrenbychoice.org.au/> at 22 July 2016

The survey was conducted by Auspoll in May 2009. It sampled 1016 Queensland residents via an online questionnaire. No information regarding response rates or the sampling process has been made publicly available.

The data have been weighted to reflect the age, gender, and geographic characteristics of the Queensland population. The benchmarks used for weighting the data are not publicly available.

## Content

We have been unable to locate a copy of the questionnaire, but some question wording is included in a report released by Children by Choice<sup>594</sup>. The three questions detailed in that report focus primarily on the legal aspects of abortion:

*Are you aware that abortion is a crime in Queensland, for which a woman can be jailed for up to seven years?*

*Response options: Yes/No*

*In Queensland abortion is still on the law books as a serious crime for which a woman can be jailed for up to seven years. A Queensland woman has been charged this year for an abortion offence, and faces time in jail. Which is closest to your view?*

*Response options: The law should be changed so abortion is no longer a crime/Abortion should remain a criminal offence*

*The decision about abortion should be a matter for a woman and her doctor - it is not something the government should be involved in.*

*Response options: Agree/Disagree*

## Results

According to the Children by Choice report, 35 per cent of respondents said that they were aware that abortion was a criminal offence in Queensland.

About eight of ten respondents (79 per cent) believed the law should be changed so that abortion was no longer a crime, and an overwhelming majority (85 per cent) agreed that the decision about abortion 'should be a matter for a woman and her doctor', rather than 'something for the government to be involved in'.

## Survey strengths and limitations

The survey was conducted online. The published report does not provide information about how the sample was selected.

The language used in the question wording is emotive and likely to influence how respondents answer the questions (particularly regarding decriminalisation).

The lack of information on how survey was selected and response rates, the leading nature of the questions, and the limited representativeness of the sample mean that the data from this survey should not be considered a reliable source of information on community attitudes towards abortion.

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<sup>594</sup> Children by Choice and Auspoll (2009), Queensland Voters' Views on Abortion.  
<https://prochoiceqld.files.wordpress.com/2013/07/auspoll-attitudes-to-abortion-report-queensland-2009.pdf>

## 6 Australian Survey of Social Attitudes 2009

### Background

The 2009 Australian Survey of Social Attitudes (AUSSA) is part of a series of surveys used to measure the Australians' attitudes on social issues. The 2009 survey was directed by researchers from the ANU.<sup>595</sup> The target sample was Australian adults aged 18 or over. The survey was run as a postal survey. Of 5,002 surveys mailed out, 1,718 completed returns were received. Excluding out of scope addresses (deceased, incapable, return to sender, 325 cases), the response rate was 37 per cent. Data were weighted by sex, age and educational attainment, based on Australian Bureau of Statistics benchmarks.<sup>596</sup>

### Content

The two questions on abortion in the 2009 AUSSA focused on moral and economic aspects of abortion law:

*Do you personally think it is wrong or not wrong for a woman to have an abortion... If there is a strong chance of serious defect in the baby.*

*Response options: Almost wrong/Almost always wrong/Wrong only sometimes/Not wrong at all/Don't know*

*Do you personally think it is wrong or not wrong for a woman to have an abortion..... If the family has a very low income and cannot afford any more children.*

*Response options: Always wrong/Almost always wrong/Wrong only sometimes/Not wrong at all/Don't know*

### Results

About two-thirds of respondents (67 per cent) said it is not wrong for a woman to have an abortion if there is a strong chance of serious defect in the baby. Eight per cent said it is always wrong for a woman to have an abortion if there is a strong chance of serious defect in the baby.

Comparing the responses across the states, the responses from Queensland are in line with views from the other states and similar to those from New South Wales and Victoria in particular.

Just less than half the respondents (45 per cent) said it is not wrong for a woman to have an abortion if the family has a very low income and cannot afford to have further children. Twenty-three per cent said it is always wrong for a woman to have an abortion if the family has a very low income and cannot afford to have further children.

Again, comparing responses across states, the responses from Queensland are in line with views from the other states and similar to those from New South Wales and Victoria in particular.

### Survey strengths and limitations

The response rate of 37 per cent is in line with those achieved by high quality postal surveys. The data is weighted so is likely to be broadly representative of the Australian population.

The question on abortion is not negatively or positively loaded and presented in a simple and factual way, although the context of the questions – moral and economic – should be considered when interpreting the responses.

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<sup>595</sup> Australian Survey of Social Attitudes <http://aussa.anu.edu.au/about.php>

<sup>596</sup> Australian Survey of Social Attitudes 2009 Methodology <http://www.ada.edu.au/ADADData/notes/ADA.NOTE.01189-UG.pdf> at 21 July 2016

A limitation however is that the specific contexts of the questions obscures any 'general' views on abortion, however these results can complement existing surveys using similar methodologies, such as the 2010 and 2013 Australian Election Studies.

The Australian Survey of Social Attitudes 2009 is a high quality survey of community attitudes and the results provide reliable estimates of community attitudes to abortion.

**Table 7 Abortion support, Australian Survey of Social Attitudes 2009, by State (column percentages)**

*'Do you personally think it is wrong or not wrong for a woman to have an abortion... If there is a strong chance of serious defect in the baby.'*

	NSW	VIC	QLD	SA	WA	TAS <sup>a</sup>	NT <sup>a</sup>	ACT <sup>a</sup>	Total
	%	%	%	%	%	%	%	%	%
<i>Always wrong</i>	12	6	8	9	9	12	8	7	8
<i>Almost always wrong</i>	6	11	7	7	12	3	0	1	8
<i>Wrong only sometimes</i>	14	18	21	18	16	15	37	2	17
<i>Not wrong at all</i>	68	65	64	71	64	71	55	91	67
<i>Total %</i>	100	100	100	100	100	100	100	100	100
<i>Number of observations</i>	387	426	285	155	185	58	21	35	1,552

Notes: <sup>a</sup> Responses for Tasmania, Northern Territory, and ACT should be interpreted with caution due to the low sample sizes.

Source: 2009 Australian Survey of Social Attitudes. Weighted percentages.

**Table 8 Abortion support, Australian Survey of Social Attitudes 2009, by State (column percentages)**

*'Do you personally think it is wrong or not wrong for a woman to have an abortion... If the family has a very low income and cannot afford any more children.'*

	NSW	VIC	QLD	SA	WA	TAS <sup>a</sup>	NT <sup>a</sup>	ACT <sup>a</sup>	Total
	%	%	%	%	%	%	%	%	%
<i>Always wrong</i>	24	22	28	17	24	19	8	15	23
<i>Almost always wrong</i>	13	17	13	10	13	6	35	1	13
<i>Wrong only sometimes</i>	18	14	20	24	24	21	10	8	18
<i>Not wrong at all</i>	44	47	40	51	39	55	47	76	45
<i>Total %</i>	100	100	100	100	100	100	100	100	100
<i>Number of observations</i>	387	426	285	155	185	58	21	35	1,552

Notes: <sup>a</sup> Responses for Tasmania, Northern Territory, and ACT should be interpreted with caution due to the low sample size.

Source: 2009 Australian Survey of Social Attitudes. Weighted percentages.

## 7 Crosby Textor 'Australian attitudes to early and late abortion' survey 2008

### Background

The project was conducted by a team of researchers, including medical ethicists and the managing director of the social research company Crosby Textor.

The survey was conducted by Crosby Textor in July 2008. The survey sampled 1,050 Australians aged 18 and over via the internet. The initial sample frame consisted of an online rewards-based panel of 500,000. From this panel a random selection of these members was chosen, stratified by age, sex and location. Four per cent of individuals invited to participate declined, and 15 per cent started the survey but did not complete it.<sup>597</sup> Residents in Victoria were over-sampled, but the data were subsequently weighted based on sex, age and location, with a resulting effective national sample size of 798.

### Content

This survey asked respondents a range of questions regarding the legal, moral, and political dimensions of abortion in Australia.

Four substantive questions relate directly to attitudes towards abortion:

*Thinking now about your own personal views on abortion, do you think abortion should be lawful or unlawful during each of the following stages of pregnancy: In the first three months of pregnancy/In the second three months of pregnancy/In the final three months of pregnancy?*

*Response options: Lawful/Unlawful/Depends on the circumstances/Can't say/Don't know.*

*[Respondents provided with balanced information on each of the Victorian Law Reform Commission's three models of abortion law reform.] Regardless of what you know or guess about current abortion laws, please indicate which one of these models comes closest to your own personal view of what the laws should be governing abortion in Victoria and possibly elsewhere in Australia.*

*Response options: Model A/Model B/Model C/None of the above models, abortion should remain a crime/None of the above models, but abortion should not be a crime/Don't know/Can't say/Confused by the above models.*

*Following are some circumstances under which an abortion after 24 weeks gestation might be considered. Thinking specifically about a situation where either you or someone else close to you such as a partner, sister, daughter or close friend was facing such circumstances, please indicate whether or not you think that a doctor should face professional sanctions including possible deregistration for performing an abortion after 24 weeks for you or the woman close to you.*

*Scenarios were presented to respondents in random order and response options were: Should face professional sanctions including possible de-registration/Should not face professional sanctions including possible de-registration/Can't say.*

### Results

The authors of this survey subsequently published the results in a peer-reviewed journal article, but not all the data collected were reported there. The article does report that a majority (61 per cent) of respondents support the legality of abortion during the first trimester of pregnancy, but there is a clear decline in support for abortion being lawful as pregnancy progresses.

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<sup>597</sup> de Crespigny, L. J., Wilkinson, D. J., Douglas, T., Textor, M., & Savulescu, J. (2010). Australian attitudes to early and late abortion. *Medical Journal of Australia*, 193(1), 9-12.

The study authors have also publicly released additional tables of results from the survey.<sup>598</sup> Based on those tables, respondents’ support for doctors who perform abortions after 24 weeks gestation appears contingent on the circumstances of the abortion. Nearly 80 per cent of all respondents believe a doctor who performs a post-24 week abortion when continuing the pregnancy would involve greater risk to the life of the woman than termination should not face professional sanctions. Only approximately 30 per cent believe performing an abortion at the same stage of pregnancy because the woman or family cannot afford to raise the child should not incur professional sanction. Attitudes are fairly stable between male and female respondents.

As the initial sample frame was not based upon a probability sample its representativeness of the Australian population and the extent to which the results can be generalised to the population is not known.

This survey includes clearly worded questions on many varied scenarios regarding abortion, measuring a range of attitudes that other similar studies do not. The questions are – for the most part – neutrally worded. The one question that asks respondents to think ‘specifically about a situation where either you or someone else close to you such as a partner, sister, daughter or close friend was facing such circumstances’ may induce a pro-choice bias, but not strongly enough to discard the results.

Despite some potential lack of representativeness of the data, the more nuanced survey questions as compared to some of the other studies makes the results of this survey of value in assessing community attitudes towards abortion.

**Table 9 Attitudes regarding whether abortion should be lawful during each trimester (column percentages)**

*‘Thinking now about your own personal views on abortion, do you think abortion should be lawful or unlawful during each of the following stages of pregnancy: In the first three months of pregnancy/In the second three months of pregnancy/In the final three months of pregnancy?’*

	<i>First trimester</i>	<i>Second trimester</i>	<i>Third trimester</i>
	%	%	%
<i>Lawful</i>	61	12	6
<i>Depend on circumstances</i>	26	57	42
<i>Unlawful</i>	12	28	48
<i>Can’t say or don’t know</i>	1	3	5
<i>Total %</i>	100	100	100

Source: de Crespigny, L. J., Wilkinson, D. J., Douglas, T., Textor, M., & Savulescu, J. (2010). Australian attitudes to early and late abortion. *Medical Journal of Australia*, 193(1), 9-12.

<sup>598</sup> [http://www.practicaethics.ox.ac.uk/\\_data/assets/pdf\\_file/0009/29916/WebDataSurveyFinal.pdf](http://www.practicaethics.ox.ac.uk/_data/assets/pdf_file/0009/29916/WebDataSurveyFinal.pdf)

**Table 10 Attitudes towards whether doctors should face sanctions for performing abortion after 24 weeks gestation in difference scenarios (column percentages)**

Following are some circumstances under which an abortion after 24 weeks gestation might be considered. Thinking specifically about a situation where either you or someone else close to you such as a partner, sister, daughter or close friend was facing such circumstances, please indicate whether or not you think that a doctor should face professional sanctions including possible deregistration for performing an abortion after 24 weeks for you or the woman close to you.

	Respondents believing doctor <b>should not face sanctions</b>	
	<b>Male</b>	<b>Female</b>
<i>When continuing the pregnancy would involve greater risk to the life of the woman than termination</i>	76	80
<i>When there is evidence that the baby is suffering such severe abnormalities that it would be unlikely to survive long after birth and that medical treatment would be unlikely to prolong its life</i>	77	79
<i>When continuing the pregnancy would involve greater risk of injury to the physical health of the woman than termination</i>	74	78
<i>When the pregnancy was caused by rape or incest</i>	71	74
<i>When there is evidence the baby is suffering severe abnormalities that would result in a very serious intellectual or physical impairment</i>	71	73
<i>When continuing the pregnancy would involve greater risk of injury to the mental health of the woman than termination</i>	67	68
<i>When there is evidence that the baby may be mentally impaired</i>	61	61
<i>When there is evidence that the baby may be physically impaired</i>	58	60
<i>When the woman has a major drug addiction</i>	57	58
<i>When the woman is a minor, that is, aged 15 or under, and did not realise or admit earlier that she was pregnant</i>	53	52
<i>When the woman is a minor, that is, aged 15 or under</i>	52	50
<i>The woman's partner is abusive and is likely to be abusive to the partner</i>	39	40
<i>When the woman did not realise or admit earlier that she was pregnant</i>	40	35
<i>When the woman's partner died or left her during pregnancy</i>	33	28
<i>If, for any reason, the woman decides that she does not wish to have a child at that point in her life</i>	33	29
<i>When the woman or family cannot afford to raise the child</i>	32	28

Source: de Crespigny, L. J., Wilkinson, D. J., Douglas, T., Textor, M., & Savulescu, J. (2010). Australian attitudes to early and late abortion. *Medical Journal of Australia*, 193(1), 9-12.