

REVIEW OF TERMINATION OF PREGNANCY LAWS

**Children by Choice Submission to the
Queensland Law Reform Commission
January 2018**



ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, offer financial assistance for contraceptive and abortion access, deliver sexual and reproductive health education sessions in schools and youth centres, and offer training for GPs and other health and community professionals on unplanned pregnancy options.

We also advocate for improvements to law and policy that would increase women's access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to reproductive and sexual health.

In 2016-17 we received a total of 4039 contacts with or regarding 1678 clients, ranging in age from under 14 to over 50, and provided almost \$130,000 in financial assistance for contraceptive and abortion access. Our Annual Reports are available on our website at www.childrenbychoice.org.au.

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WHO SHOULD BE PERMITTED TO PERFORM OR ASSIST IN PERFORMING TERMINATIONS

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Registered health and medical practitioners with appropriate qualifications and training should be permitted to perform, and assist in performing, lawful terminations of pregnancy in Queensland.

It should remain an offence for an unqualified person to provide a termination.

RATIONALE

Excepting Queensland and New South Wales, legislation in every other Australian state or territory exempts medical practitioners from criminal offences for performing terminations of pregnancy.

As the Commission states in the consultation paper for this review, ‘as a matter of clinical practice, other health practitioners, such as nurses and midwives, Aboriginal and Torres Strait Islander health practitioners, and pharmacists, may also assist in performing terminations of pregnancy’.

Legislating for registered medical practitioners to provide, and health practitioners to assist in providing, lawful terminations of pregnancy, therefore seems reasonable.

This approach would also support the principles of providing clarity and certainty, consistency with modern clinical practice, and national harmonisation, provided by the Commission as guiding this review into termination of pregnancy laws.

We would, however, encourage the Commission to consider the longevity of any new legislation proposed as a result of this review. Permitting registered health practitioners with appropriate qualifications and training to provide, as well as assist in providing, terminations of pregnancy, may help future-proof the legislation for changes in the delivery of medication abortion in particular.

In some overseas jurisdictions, mid-level providers of medication abortion are lawfully permitted and appropriately trained to offer terminations of pregnancy. Evidence exists to support the safety and efficacy of these services when provided by health practitioners, including Nurse Practitioners or pharmacists, without direct supervision by a medical practitioner, and the willingness of these mid-level service providers to provide medication abortion in this way.^{1, 2, 3}

¹ Berer M “Provision of abortion by mid-level providers: international policy, practice and perspectives” *Reproductive Health Matters* 2008, cited in *Bulletin of the World Health Organization* 2009;87:58-63. Online at <http://www.who.int/bulletin/volumes/87/1/07-050138/en/>.

² Kishen M, Stedman Y “The role of Advanced Nurse Practitioners in the availability of abortion services” *Best Practice and Research: Clinical Obstetrics and Gynaecology* 2010 Oct;24(5):569-78. Online at <https://www.ncbi.nlm.nih.gov/pubmed/20385513>.

³ Lyons E *Provision Of Reproductive Health Care Services By Nurse Practitioners And Certified Nurse Midwives: Unintended Pregnancy Prevention And Management In Vermont* (2014). University of Vermont: Graduate College Dissertations and Theses. Paper 375. Online at <https://scholarworks.uvm.edu/cgi/viewcontent.cgi?referer=https://www.google.com.au/&httpsredir=1&article=1374&context=graddis>.

At present the clinical guidelines on the provision of medication abortion require them to be prescribed by a registered medical practitioner;⁴ were this to change, the legislation would also have to be updated in future to reflect this.

In 2009, the advent of the availability of medication abortion and a subsequent criminal charge involving its use in Queensland necessitated an adjustment to s282 of the 1899 Criminal Code, in order to add the words ‘medical treatment’ and thus place medical and surgical terminations of pregnancy on the same legal footing – albeit an unclear one – as medical termination of pregnancy had been an unforeseen development when the legislation was originally inculcated in 1899.⁵

In order to prevent similar discrepancies between law and practice arising due to the impossibility of predicting developments in access, future-proofing termination of pregnancy legislation as far as is possible for future developments seems reasonable and rational, although we recognise that other Australian jurisdictions have not progressed this far as yet.

Permitting registered health practitioners to provide lawful terminations of pregnancy could also help address workforce shortages and geographic isolation as barriers to accessing terminations of pregnancy for Queenslanders, particularly those in rural and remote parts of the state; however we recognise that this aspect of provision is outside the terms of reference for this review.

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

No. It should not be possible for a woman or pregnant person in Queensland to be charged for accessing a termination of pregnancy or consenting to someone else providing them with a termination of pregnancy.

RATIONALE

Queensland is one of only three jurisdictions in Australia where it is still possible for women to be charged for procuring a termination of pregnancy.⁶ That is, in every jurisdiction where the law has been modernised since the 1970s, this statute has been removed as an offence. Removing it from Queensland legislation would align with the Commission’s stated goal of national legislative consistency as one of the guiding principles underpinning this review.⁷

The Victorian Law Reform Commission recommended as part of their report into termination of pregnancy in that jurisdiction in 2007 that it should not be an offence for a woman to perform or attempt to perform an abortion on herself, or to allow someone else (qualified or otherwise) to

⁴ Guidelines for the approved indications and availability of termination medications in Australia are available on the Therapeutic Goods Administration website at <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

⁵ A summary of the *R v Leach and Brennan* case and the subsequent changes to s282 of the Criminal Code is available on our website at <https://www.childrenbychoice.org.au/factsandfigures/queenslandabortionlaw>.

⁶ Overview of termination of pregnancy law by jurisdiction on the Children by Choice website at <https://www.childrenbychoice.org.au/factsandfigures/australianabortionlawandpractice>.

⁷ *Review into termination of pregnancy laws: Consultation Paper* Queensland Law Reform Commission. December 2017; WP No 76; 30. Online at http://www qlrc qld gov au/_data/assets/pdf_file/0010/547165/qlrc-wp-no-76-2017 pdf

perform one (lawful or unlawful) upon her.⁸ There is no reason this same principle would not apply in a different Australian jurisdiction.

The argument that termination of pregnancy should remain an offence for women and pregnant people in order to deter ‘backyard’ or ‘self-administered’ procedures is a fallacy. Until the advent of safe clinical procedures in the 1970s, unsafe and unlawful termination was one of the main causes of maternal mortality in Queensland (and indeed the rest of Australia).⁹ The legal status of termination of pregnancy was the same then as it is now.

International research shows conclusively that ‘legal restrictions on abortion do not result in fewer abortions nor do they result in significant increases in birth rates’,¹⁰ that countries where terminations of pregnancy are highly restricted by law have slightly higher rates of termination than those with more liberal lawful access,¹¹ and that restrictive law often leads to worse health outcomes for women and pregnant people seeking termination.¹²

We note that the Queensland Parliamentary Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, despite finding itself unable to recommend the passing of the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016, noted in their 2016 report that “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”.¹³

We also support the Commission’s statement that removing the offence of a woman or pregnant person causing their own termination would be “appropriate for consistency with the removal of criminal responsibility for medical practitioners”.¹⁴

⁸ *Law of Abortion: Final Report* Victorian Law Reform Commission, Melbourne, 2008: 8. Online at <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>

⁹ De Costa C (2010) Never, Ever, Again: Why Australian Abortion Law Needs Reform. Boolarong Press; 39.

¹⁰ Sedgh G, et al. “Induced abortion: incidence and trends worldwide from 1995 to 2008.” *Lancet*. 2012;379:625–632; Levine PB, Staiger D “Abortion policy and fertility outcomes: the Eastern European experience.” *Journal of Law and Economics*. 2004;XLVII:223–243. Quoted in [2].

¹¹ Cohen SA (2009) “Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide” *Guttmacher Policy Review* New York: Guttmacher Institute. Online at <https://www.guttmacher.org/gpr/2009/11/facts-and-consequences-legality-incidence-and-safety-abortion-worldwide>.

¹² *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd ed; 2012. Geneva: World Health Organization. Available to view online at <https://www.ncbi.nlm.nih.gov/books/NBK138197/>.

¹³ Parliamentary Committee Report 24 (2016) Brisbane: Queensland Parliament; 33. Online at <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2016/5516T1337.pdf>

¹⁴ *Review into termination of pregnancy laws: Consultation Paper* Queensland Law Reform Commission. December 2017; WP No 76; 34. Online at http://www qlrc.qld.gov.au/_data/assets/pdf_file/0010/547165/qlrc-wp-no-76-2017.pdf

GESTATIONAL LIMITS AND GROUNDS

Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?

Children by Choice does not believe a legislated gestational limit for lawful termination of pregnancy is necessary, and would note that this view aligns with that of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists¹⁵ and other peak medical and legal groups. However, we recognise that significant community concern exists in regards to later gestation termination. We would therefore support the introduction of a staged approach to decriminalisation as per the law in Victoria.

Q-4 If yes to Q-3, what should the gestational limit or limits be? For example:

- (a) an early gestational limit, related to the first trimester of pregnancy;**
- (b) a later gestational limit, related to viability;**
- (c) another gestational limit or limits?**

Any limit on lawful termination on request set down in legislation should not be less than 24 weeks, as per Victorian law.

RATIONALE

Although the lack of mandatory data collection means we must rely on estimates for termination statistics,¹⁶ all available information strongly suggests that the vast majority of terminations in Australia occur within the first trimester of pregnancy.

In South Australia, one of the few jurisdictions to collect and publish termination of pregnancy data, 92% of pregnancy terminations in 2015 were performed within the first trimester of pregnancy (under 14 weeks gestation), and 2% after 20 weeks gestation.¹⁷

The only private clinic in Australia to provide terminations of pregnancy between 20 and 24 weeks gestation is located in Melbourne and is one of 17 clinics operated by Marie Stopes Australia nationally. Then CEO of Marie Stopes Australia Alexis Apostolellis told a parliamentary hearing in 2016 that “termination or pregnancy procedures of 20- to 24-week gestations comprise 0.5 per cent of all the terminations MSI did in Australia in 2015. Almost half of the women accessing post 20-week terminations at MSI travel interstate to Victoria.”¹⁸

¹⁵ Submission 845 to the Inquiry into the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland. 2016: 2. Online at <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/AbortionLR-WRC-AB2016/submissions/845.pdf>.

¹⁶ More information on abortion statistics and estimates is available on our website at <https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>.

¹⁷ Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R. *Pregnancy Outcome in South Australia 2015*. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2017: 55. Online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>.

¹⁸ Public Hearing – Inquiry into the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland. Transcript of proceedings, 2 August 2016;

Given the limitations in second trimester termination access in Queensland¹⁹ it is reasonable to assume some of the number travelling from interstate to Victoria for later gestation procedures come from Queensland. We provide over 100 referrals interstate for our clients each year. Around half of these referrals are due to gestational access issues.²⁰

Although women presenting into the second trimester make up a minority of those seeking termination of pregnancy, they are more likely to be experiencing disadvantage or distress. Their circumstances are more likely to include maternal and fetal health concerns, violence and coercion, financial or other disadvantage, dramatic and unforeseen changes in life circumstances, and obstructed access to earlier termination through geographic isolation and/or unsupportive health practitioners.^{21, 22} Later recognition and diagnosis of pregnancy can also be more common in younger women and in those whose pregnancies have resulted from contraceptive failure, as some contraceptives can mask the symptoms of early pregnancy.^{21, 22}

Our service data from the 2016-17 financial year shows that of the 12% of our contacts presenting with pregnancies of 16 weeks gestation or higher, over 60% reported domestic violence, sexual assault, and/or fetal anomaly.²³ Over half the terminations provided after 20 weeks gestation in South Australia are due to negative fetal diagnoses.²⁴

Ultrasound screening for fetal health is routinely recommended around midway through pregnancy, at 18-21 weeks gestation, and many anomalies are not diagnosed until this time.²⁵ Implicit in this practice is that if those tests return an unexpected or negative diagnosis, women and couples will be supported to make a decision regarding the pregnancy given the knowledge that testing has afforded to them. Many Queensland women and pregnant people are shocked to discover that this decision is not legally theirs to make.

A legislated gestational limit of less than 24 weeks would impact significantly and unfairly on vulnerable pregnant people and their families and should not be considered by the Committee as part of this review.

15. Brisbane: Parliament of Queensland. Online at <http://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/AbortionLR-WRC-AB2016/14-trns-2Aug%202016.pdf>.

¹⁹ Information on gestational limits for Queensland providers are listed on our website at <https://www.childrenbychoice.org.au/forwomen/abortion/clinicsqld>.

²⁰ *Children by Choice Submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee – Inquiry into the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland*. Brisbane; 2016: 38.

²¹ Who has second trimester abortions? 2TRIFS-E15. Ipas: NC, USA: 2015. Online at <http://www.ipas.org/en/Resources/Ipas%20Publications/Who-has-second-trimester-abortions.aspx>.

²² Rice K (2007) *Termination of Pregnancy Post 20 Weeks: Background Paper*. Melbourne: Women’s Health Victoria. Online at <http://whv.org.au/>.

²³ *Children by Choice Annual Report 2016-17* Brisbane: Children by Choice; 10. Online at <https://www.childrenbychoice.org.au/aboutus/annualreports>.

²⁴ Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2015. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2017: 55. Online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>.

²⁵ Todros T, Capuzzo E, Gaglioti P “Prenatal diagnosis of congenital anomalies” *Images in Paediatric Cardiology* 2001 Apr-Jun; 3(2): 3-18. Online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3232499/>.

Q-5 Should there be a specific ground or grounds for a lawful termination of pregnancy?

Should a staged gestational approach to law reform be pursued, the only requirement for a lawful termination before 24 weeks gestation should be the woman or pregnant person's informed consent.

Should a staged gestational approach to law reform be pursued, additional grounds would be acceptable after 24 weeks gestation (as at Q-7) provided they do not impose an undue burden on distressed or disadvantaged women, pregnant people, and their doctors.

Q-6 If yes to Q-5, what should the specific ground or grounds be? For example:

(a) a single ground to the effect that termination is appropriate in all the circumstances, having regard to:

- (i) all relevant medical circumstances;**
- (ii) the woman's current and future physical, psychological and social circumstances; and**
- (iii) professional standards and guidelines;**

Should a staged gestational approach to law reform be pursued, this should be the ground to be met for a termination after 24 weeks. No grounds should apply for terminations sought prior to this gestation other than the pregnant person's informed consent.

(b) one or more of the following grounds:

- (i) that it is necessary to preserve the life or the physical or mental health of the woman;**
- (ii) that it is necessary or appropriate having regard to the woman's social or economic circumstances;**
- (iii) that the pregnancy is the result of rape or another coerced or unlawful act;**
- (iv) that there is a risk of serious or fatal fetal abnormality?**

Children by Choice strongly opposes the introduction of specific legislated grounds to be met for a termination of pregnancy to be considered lawful, for the following reasons:

- autonomy of decision making is removed from the pregnant person and placed in the hands of others;
- specific grounds along the lines of those listed above do not align with other Australian jurisdictions where termination of pregnancy legislation has undergone relatively recent reform (ie Victoria (2008), Tasmania (2013), Northern Territory(2017));

- (i) is in line with current case law and creates barriers to access due to the lack of an accepted medical definition over what constitutes a serious risk to health and who is responsible for deciding this;²⁶
- (ii) again relies on someone other than the pregnant person to deem a procedure ‘necessary or appropriate’;
- (iii) presumably requires an evidentiary criteria to be met in order to satisfy the grounds of rape, coercion or unlawful acts, which places the burden on the survivor of these acts to prove their case and carries a significant risk of re-traumatising survivors. In international jurisdictions, criteria for satisfying these grounds can be onerous and may include the necessity of the survivor reporting to the police; evidence on sexual assault reporting in Australia suggests that fewer than 15% of offences are reported to the police;²⁷ and
- (iv) fetal anomaly, or risk of disability, as a grounds in and of itself for termination of pregnancy, is offensive to people living with a disability and their family, as stated by many submitters to the Queensland parliamentary inquiries in 2016, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.²⁸

We strongly support RANZCOG’s assertion that ‘[n]o specific clinical circumstance should qualify or not qualify a woman for termination’ as the ‘impact of any particular condition is highly individual and often complex’.²⁹

Q-7 If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

Should a staged gestational approach be pursued, prior to 24 weeks gestation, the only grounds to be satisfied for a termination to be lawful should be the informed consent of the pregnant person.

Should a staged gestational approach be pursued, after 24 weeks gestation, the only grounds to be satisfied should be that termination is appropriate in all the circumstances, having regard to:

- (i) all relevant medical circumstances;
- (ii) the woman’s current and future physical, psychological and social circumstances; and
- (iii) professional standards and guidelines.

²⁶ *Children by Choice Submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee – Inquiry into the Abortion Law Reform (Woman’s Right to Choose)* Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland. Brisbane; 2016: 14, 18-19. Online at https://www.childrenbychoice.org.au/images/downloads/ChildrenbyChoiceSubmission_HealthCommittee_AbortionLawReform_June2016.pdf.

²⁷ *The law and sexual offences against adults in Australia* Australian Institute of Family Studies ACSSA Issues No. 4 – June 2005, at <https://aifs.gov.au/publications/law-and-sexual-offences-against-adults-australia/reporting-and-conviction-rates>.

²⁸ Parliamentary Committee Report No 33a (2017), quoting Evidence to the Parliamentary Committee, Oct 2016 (Prof M Permezel, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

²⁹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016), cited in *Review into termination of pregnancy laws: Consultation Paper* Queensland Law Reform Commission. December 2017; WP No 76; 48. Online at http://www.qlrc.qld.gov.au/_data/assets/pdf_file/0010/547165/qlrc-wp-no-76-2017.pdf

CONSULTATION BY THE MEDICAL PRACTITIONER

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

Should a staged gestational approach to law reform be pursued, no consultation should be required for a termination of pregnancy at less than 24 weeks gestation.

Should a staged gestational approach to law reform be pursued, consultation would be acceptable in the case of terminations sought after 24 weeks gestation.

If yes to Q-8:

Q-9 What should the requirement be? For example:

(a) consultation by the medical practitioner who is to perform the termination with:

- (i) another medical practitioner; or**
- (ii) a specialist obstetrician or gynaecologist; or**
- (iii) a health practitioner whose specialty is relevant to the circumstances of the case; or**

(b) referral to a multi-disciplinary committee?

Should a staged gestational approach to law reform be pursued, consultation with another medical practitioner should be required after 24 weeks gestation before a termination of pregnancy is provided.

RATIONALE

This requirement would align most closely with legislation in most other jurisdictions which take a staged approach to termination of pregnancy, albeit at differing gestations.

It is also the option which provides the pregnant person with the most autonomy and creates the least burdensome and intrusive process in order for a termination to be accessed.

Requirements for specialist consultation would impact far more heavily on rural and remote women and pregnant people and their medical practitioners, potentially further delaying access, as the Commission points out in the consultation paper for this review.³⁰ These are the patients already most heavily impacted by access barriers to termination.

Professional standards and guidelines as well as current practice will ensure specialist involvement where this is clinically indicated and appropriate, as pointed out by multiple submitters to the

³⁰ *Review into termination of pregnancy laws: Consultation Paper* Queensland Law Reform Commission. December 2017; WP No 76; 55. Online at http://www.qlrc.qld.gov.au/_data/assets/pdf_file/0010/547165/qlrc-wp-no-76-2017.pdf

Queensland parliamentary inquiries in 2016, including the Australian Clinical Psychology Association and practising maternal fetal medicine specialists from several Queensland hospitals.

Children by Choice strongly opposes the introduction of a legislated requirement for consultation or approval via a committee.

In Western Australia, two medical practitioners from a panel of six appointed by the Minister for Health have to approve a termination after 20 weeks gestation, on the grounds that the pregnant woman or her fetus has a severe enough medical condition to justify the procedure. These decisions are final and no appeal process exists. Only one hospital in the state has been approved by the Minister to provide these procedures.³¹

In addition, a 2002 review conducted and published by the WA Department of Health into the impact of that state's post-20 week legislative requirements reported that (a) the requirement for a panel to meet and discuss cases seeking approval after 20 weeks has created further delays in accessing services where approved; and (b) that pregnant women felt that decisions on whether to continue or terminate a pregnancy were more highly pressurised and had to be made in haste or with incomplete information, where negative or inconclusive diagnoses were received not long before the 20 week limit, fearing that their options would be significantly limited once the limit was passed.³¹

Q-10 When should the requirement apply? For example:

- (a) for all terminations, except in an emergency;**
- (b) for terminations to be performed after a relevant gestational limit or on specific grounds?**

For terminations after 24 weeks only, should a staged gestational approach to law reform be pursued.

³¹ Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion, as introduced by the Acts Amendment (Abortion) Act 1998. Western Australian Department of Health, June 2002. Online at <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>.

CONSCIENTIOUS OBJECTION

Q-11 Should there be provision for conscientious objection?

Yes. Individual clinical practitioners should be legally able to conscientiously object to involvement in terminations of pregnancy. This provision should not be applicable to administrative staff, services, facilities, organisations, or corporate entities.

Q-12 If yes to Q-11:

- (a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?**

Conscientious objection should not apply in an emergency. One person's life should always take precedence over another's personal values or beliefs, no matter how firmly held.

In all other situations, health services should ensure that their patients' access to lawful procedures is not limited or removed due to conscientious objection. It is the position of Children by Choice that these matters are best dealt with using policies and clinical guidelines; however, administrative staff and facilities should be exempt from being lawfully able to conscientiously object, in order to minimise barriers to access for women and pregnant people living in rural and remote parts of the state, for example.

- (b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?**

A practitioner with a conscientious objection to termination of pregnancy should be legally obligated to refer a pregnant person to another practitioner who does not hold a conscientious objection, in a timely manner, without discrimination or delay.

RATIONALE

This legislative requirement, though heavily protested by anti-abortion groups as being 'coercive', would align with the advice the Australian Medical Association provides to its members around conscientious objection,³² as well as that provided in the Queensland Maternity and Neonatal Clinical Guideline on the Therapeutic Termination of Pregnancy.³³

Legislation should also require conscientious objectors to publicly disclose this position (for example, on their clinic website and/or via signs on their premises), to allow them to practice as they choose while at the same time prioritising women's right to timely and supportive information and care.

³² *Conscientious Objection Policy Statement*, Australian Medical Association, 2013. Online at <https://ama.com.au/position-statement/conscientious-objection-2013>.

³³ *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy*. Queensland Health, 2013. Available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

COUNSELLING

Q-13 Should there be any requirements in relation to offering counselling for the woman?

No.

RATIONALE

We support the availability of genuine, professionally provided, unbiased all options pregnancy counselling for anyone who wishes to access it.

We also take this opportunity to state our strong opposition to any mandatory requirement for counselling before or after a termination of pregnancy. Professional counselling should always be freely available for those who choose to access it, but should not be mandatory.

We have concerns about legislating the requirement to offer counselling due to the lack of clarity in what this requirement would mean (for example, what sort of counselling and by whom), the lack of legislative requirements for transparency in pregnancy counselling, and the lack of necessity for the offer of counselling to be a legislative provision.

A survey of Australian GPs in 2004 found that 26% of Queensland GPs self-identify as being anti-abortion.³⁴ Some doctors are quite open about using their consultations with pregnant women to attempt to convince them to continue pregnancies despite their patient's express wish for termination: see for example the website of the Victorian group 'Doctors Conscience', who refuse to comply with the legislative requirement for referral.³⁵ We are concerned a legal obligation to offer counselling would provide a loophole for these practitioners to use their position to offer this counselling themselves, at cost to their patients.

Pregnancy counselling services in Australia are not legally required to disclose if they are run on an anti-abortion basis, and are not subject to the trade practices legislation that regulates misinformation and false advertising.³⁶ This allows services to provide inaccurate and sometimes intentionally misleading information on abortion and its availability to women experiencing an unplanned or unwanted pregnancy, and can make it extraordinarily difficult for women and pregnant people to know that they are accessing a genuine all options service, or for medical professionals to be confident that is what they are referring patients to, particularly when the names of such services provide no hint of their position.³⁷

³⁴ *General Practitioners: Attitudes to Abortion* Prepared by Quantum Market Research and Marie Stopes International Australia, November 2004.

³⁵ The Doctors Conscience website is available at <http://www.doctorsconscience.org/>.

³⁶ *Transparent advertising and notification of pregnancy counselling services Bill 2005*: overview of the Inquiry by the Senate Community Affairs Legislation Committee is available on the federal parliament website at http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pregnancy_counselling/report/c01.

³⁷ For example, Pregnancy Counselling Link is a service funded by the Queensland Government which offers 'counselling by qualified professionals' and support with 'difficult decisions' and 'unplanned pregnancy' according to their website (<http://wwwpcl.org.au/>). Their 'abortion information brochure' contains in small print at the bottom of the second page that 'Pregnancy Counselling Link does not provide referrals for abortion.' The brochure must be downloaded from their website as a pdf (<http://wwwpcl.org.au/assets/PCL-AbortionBrochure.pdf>) and is not otherwise accessible. The information about refusal to refer is not stated in any other place on their website.

Informed consent counselling seeks to ensure that the patient understands the nature and the purpose of a medical procedure, its alternatives, the possible complications, and the likelihood of these complications occurring. It also ascertains that the patient is making the decision to proceed with the treatment voluntarily. As with other medical procedures (arguably more so under our current legislative framework), informed consent counselling is a standard part of public and private termination of pregnancy services in Queensland, and is additionally addressed in the Queensland Maternity and Neonatal Clinical Guideline on the Therapeutic Termination of Pregnancy³⁸, the Clinical Services Capability Framework (CSCF) for Licensed Private Health Facilities and the relevant companion modules for terminations of pregnancy and day surgeries,³⁹ and the licensing and distribution conditions for medical abortion determined by the Therapeutic Goods Administration.⁴⁰

Any uncertainty, ambivalence, or distress regarding the decision would be identified and dealt with appropriately by termination providers as part of gaining informed consent, and it is therefore unnecessary for a mandatory offer of counselling to be included in any proposed legislative amendments.

³⁸ *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy*. Queensland Health, 2013. Available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

³⁹ ‘About the CSCF’, available on the Queensland Health website at <https://www.health.qld.gov.au/clinicalpractice/guidelines-procedures/service-delivery/cscf/about/default.asp>.

⁴⁰ Australian Register of Therapeutic Goods ID 210574 (MS-2 Step composition pack) product information available online at the Therapeutic Goods Administration website: [https://www.ebs.tga.gov.au/servlet/xmlmillr6?dbid=ebs/PublicHTML/pdfStore.nsf&docid=77FFC395C0EC491DCA257E5F004236DF&agid=\(PrintDetailsPublic\)&actionid=1](https://www.ebs.tga.gov.au/servlet/xmlmillr6?dbid=ebs/PublicHTML/pdfStore.nsf&docid=77FFC395C0EC491DCA257E5F004236DF&agid=(PrintDetailsPublic)&actionid=1).

PROTECTION OF WOMEN AND SERVICE PROVIDERS AND SAFE ACCESS ZONES

Q-14 Should it be unlawful to harass, intimidate or obstruct:

- (a) a woman who is considering, or who has undergone, a termination of pregnancy; or
- (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Yes.

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

Yes. Creating safe access zones to protect patients and employees of pregnancy termination services from offensive and obstructive behaviour by opponents of abortion is an important and necessary initiative.

RATIONALE

This would align Queensland legislation with four other Australian jurisdictions which already have legislated safe access zones in place.

We are strongly supportive of the principle of safe access zones and agree with the statement by Victorian Health Minister Jill Hennessy that they are necessary “in order to prevent the harm and not just to respond to inappropriate conduct when it occurs.”

Human rights law experts support the introduction of safe access zones around abortion provider premises, and state that enacting this legislation does not impose a burden on the implied right to freedom of political communication.⁴¹

Most providers of pregnancy termination services have extensive experience with opponents of abortion being obstructive, abusive and violent toward patients, their support people, staff and passers-by, as this 2016 article from The Age on the Victorian access zone legislation illustrates:

Laws passed last year making it illegal to harass people within 150-metres of abortion providers came into effect on Monday.

For the first time in 25 years, the group of anti-abortion protesters who have picketed the Wellington Parade abortion clinic six days a week were absent and women were able to enter the building without first being forced to run the gauntlet.

⁴¹ See for example ‘Safe Access Zones’ presentation by Dr Ronli Sifris, Deputy Director of Castan Centre for Human Rights, at the second national Unplanned Pregnancy and Abortion in Australia Conference, August 2017, online at <https://www.childrenbychoice.org.au/images/downloads/2017conference/Ronli-Sifris-Safe-access-zones.pdf>; also the Human Rights Law Centre submission to the Health (Abortion Law Reform) Amendment Bill 2016 at <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/18-HealthAbortion/submissions/894.pdf>.

*"Usually we have patients coming in who are crying, we may have partners who are angry, we might have children who are upset," clinical psychologist Susie Allanson said on Monday. "Today has been delightfully uneventful."*⁴²

The Guardian reported in 2014 that the patients of one regional NSW abortion provider had 'ended up self harming or even attempted suicide because of harassment from [the] protesters' who have gathered every day the clinic operates for more than ten years.⁴³ Many clients of Children by Choice anecdotally report concerns about their safety and privacy due to harassment by abortion opponents outside clinics. One Queensland woman who shared her story anonymously in 2016 wrote:

*The day I went in I was harassed and bullied by protesters outside. They yelled at me if I was sure I was doing the right thing? Did I know that I would be a murderer? I walked past them and flung myself into the clinic. My partner arrived after I did and they must have yelled at him too. He was red faced and possibly more traumatised than me by them.*⁴⁴

Another, pregnant after a sexual assault during a home invasion, wrote:

*My husband took me to the clinic that day and acted as a human shield from the protesters who were outside the clinic yelling things like 'baby killer' and facts about what the pain level of an embryo. It was humiliating. I wanted to yell at them and scream 'You don't know why I'm here.' 'You have no idea. I wish I could be anywhere else.'*⁴⁵

Opponents of abortion occasionally protest outside our own premises; despite the fact we are not a provider of pregnancy termination, this can still have a negative impact on our staff and clients.

If yes to Q-15:

Q-16 Should the provision:

- (a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or**
- (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?**

The provision should automatically establish an area of 150m around premises providing termination of pregnancy, as a safe access zone.

⁴² Donnelly B 'Women avoid pro-life protesters for the first time in decades' *The Age*, 2 May 2016. Online at <http://www.theage.com.au/victoria/women-avoid-prolife-protesters-for-the-first-time-in-decades-20160502-gok1gl.html>

⁴³ Davey M 'Albury's only abortion clinic: protests 'push women to point of self-harm' *The Guardian Australia*, 9 December 2014. Online at <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortionharassed-by-protesters-to-point-of-suicide>.

⁴⁴ Online at <https://youngqldfortherighttochoose.weebly.com/myabortionstory/anonymous5736169>

⁴⁵ Online at <https://youngqldfortherighttochoose.weebly.com/myabortionstory/my-abortion-story5575096>

RATIONALE

A safe access zone of 150m which automatically applies around premises providing termination of pregnancy would align Queensland legislation most closely with the majority of other Australian jurisdictions with safe access zones already in place.

As the Commission is aware, Victoria, Tasmania, and the Northern Territory have a legislated 150m safe access zone which automatically applies around termination provider premises. The Australian Capital Territory is the only other Australian jurisdiction with legislated exclusion zones, and while theirs is a minimum of 50 metres authorities have already had to expand it as it proved insufficient to provide adequate protection to staff and patients.⁴⁶

Q-17 What behaviours should be prohibited in a safe access zone?

We favour the Victorian legislation as providing the clearest definition of behaviours prohibited within a safe access zone, particularly in relation to ‘a communication that relates to terminations and is reasonably likely to cause distress or anxiety.’

While it is our belief that the premises of termination providers are not the appropriate place to protest abortion, we do not believe that ‘protests’ should be included in the prohibited behaviours listed in legislation, as long as the Victorian provisions are adopted instead. This is due to (a) those provisions being broad enough to capture actions intended to harass or intimidate; and (b) the risk of the legislation’s constitutional validity being compromised by the inclusion of the word ‘protest’ in prohibited behaviours.

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

For the sake of simplicity and clarity we believe safe access zone prohibitions on behaviour should apply at all times.

This would also align Queensland legislation most closely with the majority of other Australian jurisdictions with safe access zones already in place.

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Yes.

RATIONALE

The single clinic providing terminations of pregnancy in the regional New South Wales town of Albury has been targeted for several years by a small group of abortion opponents whose actions

⁴⁶ Back A & Knaus C “Police extend abortion clinic exclusion zone as first fine withdrawn” *Canberra Times* 18 May 2016. Online at <http://www.canberratimes.com.au/act-news/police-extend-abortion-clinic-exclusionzone-as-first-fine-withdrawn-20160503-gol6mp.html>.

have, by their own admission, included filming those who enter and leave the clinic.⁴⁷ Clinicians and community members claim names and number plates are also being recorded, that the actions of this group are leading to trauma and self harm, and that privacy concerns are causing women to drive several hundred kilometres to access termination through another clinic.^{48,49}

Using surveillance to track car registration and other information about clinic staff and patients is becoming more common in the United States and now forms part of the training for future anti-abortion campaigners in some parts of the country.⁵⁰

If safe access zones are an acceptable method of protecting the rights of clinic staff and patients - which we would argue for strongly - then the right to privacy must be one of the rights included under these protections, and this necessitates a ban on making or distributing recordings of entry or exit to these facilities.

COLLECTION OF DATA ABOUT TERMINATIONS OF PREGNANCY

Q-20 Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

Yes.

RATIONALE

The lack of accurate data regarding the provision of pregnancy termination procedures creates significant difficulties in service delivery planning, addressing barriers to service access, and monitoring the success or otherwise of public health interventions in reducing the unplanned pregnancy and abortion rate, at both state and national levels.

⁴⁷ See for example Worrall B "Anti-abortionists secretly film clinic" *Border Mail* 6 May 2011, at <http://www.bordermail.com.au/story/58302/anti-abortionists-secretly-film-clinic/>; website of 'Abortion Hurts Albury' at <https://abortionhurtsalbury.org/>.

⁴⁸ Davey M "Albury's only abortion clinic: protests 'push women to point of self harm'" *The Guardian*, 9 December 2014, at <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide>.

⁴⁹ Norton S "The Australian town where anti-abortion protesters are pushing women to self-harm" *Mamamia*, 10 December 2014, at <https://www.mamamia.com.au/anti-abortion-protesters-albury/>

⁵⁰ See for example Dries K "Pro-life activists are tracking license plates of abortion patients" *Jezebel*, 13 August 2014, at <https://jezebel.com/pro-life-activists-are-tracking-license-plates-of-abort-1620983363>.