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**Queensland Law Reform Commission  
Review of Termination of Pregnancy Laws  
Consultation Paper**

**Submission of the Women's Electoral Lobby  
(NSW)**

**13 February 2018**

Women's Electoral Lobby, established in 1972, is an independent, non-party political lobby group dedicated to creating a society where women's participation and their ability to fulfill their potential are unrestricted, acknowledged and respected and where women and men share equally in society's responsibilities and rewards.

The Women's Electoral Lobby (WEL) is a national, independent, non-party political, feminist lobby group that has worked tirelessly for over 45 years to improve the position of women in society.

The Women's Electoral Lobby is dedicated to creating a society where women's participation and their ability to fulfil their potential are unrestricted, acknowledged and respected and where women and men share equally in society's responsibilities and rewards.

WEL applies a feminist approach to all its work from policy analysis and development to campaigning. WEL has developed a Feminist Policy Framework, which sets out the values, which we use to measure fairness for women and fairness for society. WEL believes that good policies should address these indicators and work with governments at all levels on achieving better and fairer policy outcomes.

Our current strategic focus areas include:

- Violence against women including securing crucial funding for women's refuges
- Financial security for women
- Women's reproductive rights

Women's Electoral Lobby NSW is pleased to respond to the Queensland Law Reform Commission's Consultation Paper 'Review of Termination of Pregnancy Laws.'

Since WEL's foundation in 1972, it has consistently advocated for women's right to make well informed and autonomous decisions and choices regarding their bodies, including their reproductive lives.

WEL's support for women's right and capacity to make these decisions is based on the principle that sees women as equal to men in their decision making powers and their right to privacy, integrity and autonomy in relation to health and medical treatment.

WEL also sees achievement of reproductive rights, including access to family planning advice, contraception and abortion, as fundamental to the ongoing transformations in Australian life occasioned by the movement for women to achieve social, economic and cultural equality.

Women's Electoral Lobby's national policy on abortion calls for:

1. The decriminalisation of abortion in all states and territories, with abortion regulated by health legislation;
2. Legislative reform to allow women control over their bodies and reproductive choices at all times rather than requiring the approval of one or two doctors as in some states and territories;
3. Funding to health services to ensure the increased availability and accessibility of abortion, with a particular focus on the affordability of abortion and access in rural areas;
4. Commitment to the principle of all women's right to control their reproductive choices in making policies on foreign aid, Medicare funding, counselling, and all other areas; and
5. Establishment of exclusion zones around providers of abortions, to ensure the safety of women seeking terminations and medical practitioners, and reduce the culture of harassment and stigmatisation;
6. Introduction of laws requiring truth in advertising for pregnancy counselling services.

## **PRINCIPLES**

The Queensland Attorney General's Terms of Reference ask the Commission to have regard to 'existing legal principles relating to termination practices in Queensland'.

WEL notes that the Commission's Consultation paper has set out the following principles to guide modernisation and clarification of the Queensland law in relation to terminations of pregnancy:

- the promotion of autonomy and health (including access to safe medical procedures);
- clarity and certainty;
- consistency with modern clinical practice;
- community expectations; and
- national harmonisation.

WEL proposes that the principles of 'autonomy and health' and 'national harmonisation' be understood to include consistency with Australia's international obligations. The Consultation Paper includes a detailed appendix (D) on this subject. WEL would like to congratulate the Commission on the scope of the canvassed agreements and the useful analysis in this section of the paper.

Australia's accession to these agreements is included in the rationales behind our support for reproductive health services in our international aid programs, where we remain a global leader, despite pressure from the United States in particular to follow the Global Gag Rule. We believe that they should inform all initiatives to modernise abortion laws on a state and territory basis, especially when taken with the principle of 'national harmonisation'.

Taken together, WEL considers these five principles to be relevant as guides to the modernisation of abortion laws in Queensland, NSW and indeed all remaining states and territories where abortion remains in whole or in part in the Criminal Codes.

## **A PRINCIPLED APPROACH TO MODERNISING THE LAW ON ABORTION**

### **Principle 1 The promotion of autonomy and health (including access to safe medical procedures)**

WEL's policy on abortion is founded on the belief that women must be the primary agents and decision makers in determining whether and when they will have children. Women must be supported in these decisions through unimpeded access to the full range of reproductive health services. The Consultation Paper quotes the International Covenant on Civil and Political Rights:

*Due to women's reproductive capacities, the realisation of the right of women to sexual and reproductive health is essential to the realisation of the full range of their human rights. The right of women to sexual and reproductive health is*

*indispensable to their autonomy and their right to make meaningful decisions about their lives and health. Gender equality requires that the health needs of women, different from those of men, be taken into account and appropriate services provided for women in accordance with their life cycles.*<sup>1</sup>

There is substantial evidence that criminalisation of abortion undermines women's health and their capacity to make autonomous decisions.<sup>2</sup> Moreover levels of abortion reduce where abortion is legal, accessible and affordable.<sup>3</sup>

As the Children by Choice submission to the Commission's current Consultation states: *'until the advent of safe clinical procedures in the 1970's unsafe and unlawful terminations were one of the main causes of maternal mortality in Queensland and in the rest of Australia'*<sup>4</sup>

## **Principle 2 Clarity and certainty**

### **Clarity and certainty for whom?**

It could be argued that a forceful and punitive level of 'clarity' and 'certainty' were originally established through the Queensland and the NSW Criminal codes, which criminalise any person, such as the doctors, nurses, midwives, pharmacists who undertake or assist with abortions, and the women who decide to terminate.

We are particularly conscious that Queensland and NSW are now the only states where abortion is still wholly criminalised under legislation, dating ultimately from the 19<sup>th</sup> century. So in these states modernisation is an urgent priority.

Practically, removal of abortion from Criminal Codes could assist in achievement of an alternative and person-centred clarity and certainty for medical and health practitioners and people seeking terminations. At the same time, aspirations for clarity and certainty need to be tempered by the practical reality that each woman's decision to seek termination arises from individual and sometimes complex circumstances. Statute law cannot easily codify and guide expert judgement and informed decision making in such a variety of circumstances.

### **Uncertainties alleviated but persist under common law decisions**

The Consultation Paper outlines the complex history of decisions under case law that have made abortion lawful in Queensland, if performed to prevent serious danger to the woman's physical or mental health. The Paper includes a detailed account of this history and of the current legal situation in Queensland.

WEL understands that the defence against unlawful abortions in Queensland relies on case law (RV Bayliss and Cullen and RV Leach and Brennan) and on Section 282 of the Criminal

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<sup>1</sup> Queensland Law Reform Commission 'Review of Termination of Pregnancy Laws' Consultation Paper December 2017 See P 99 of the QLRC Consultation Paper.

<sup>2</sup> Cohen, S 'Facts and Consequences: Legality and Safety of Abortion Worldwide' Guttmacher Policy Review, Fall 2009

<sup>3</sup> Cohen, S op.cit.

<sup>4</sup> See Children by Choice Submission:5. The submission cites a number of sources including De Costa, C *Never, Ever, Again: Why Australian Abortion Law Needs Reform* Boolarong Press:39

Code, which attempts to define a lawful abortion and is used as a defence to unlawful abortion. The wording was amended in September 2009 to include medication abortion following unsuccessful prosecutions. (R V Leach and Brennan 2009.)

As is well known, this involved a 19-year-old Cairns woman charged under section 225 in the Queensland Criminal Code, for procuring her own miscarriage. Her partner was charged under section 226 for assisting her. The case was heard in the Cairns District Court in October 2010, where the jury brought down not guilty verdicts in both charges.)

As in Queensland, the circumstances in which an abortion is 'lawful' in NSW were expanded by judicial decision to include medical considerations.

A 1971 decision by Justice Levine of the NSW District Court (the 'Levine judgement') said that an abortion was not unlawful if a 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 pregnancy would entail" (R v Wald [1971]). "Mental health" has since been interpreted to include "the effects of economic or social stress that may pertain either during pregnancy or after birth" (CES v Superclinics Australia Pty Ltd [1995] NSWLR 47).

Unlike the 1971 Levine ruling in NSW, economic and social issues are not able to be considered when determining legality in Queensland. They were not included in R V Bayliss and Cullen, the decision which determined the successful defence. This was the precedent setting Queensland equivalent of the Levine case in NSW.

In NSW, as in Queensland, reliance on judicial decision has created substantial areas of uncertainty. Several participants in the 2017 NSW Parliamentary debate on Mehreen Faruqi MLC's Bill to decriminalise abortion (the Law Reform (Miscellaneous Acts Amendment) Bill 2016) declared themselves in favour of decriminalisation, pointing to the lack of clarity and consistency inherent in reliance on judicial interpretation.<sup>5</sup>

Removal of abortion from the Criminal Code in both states would free medical and health professionals and women themselves from the possibility of prosecution. This threat may rarely materialise but that doesn't diminish the suffering it can bring when enacted. The inappropriateness of its recent application is highlighted through the 2008 Queensland case already cited, and more recently in NSW.

Uncertainty persists in the face of a history of admittedly rare but always unanticipated prosecutions. In 2017 NSW a woman was charged under the Crimes Act for self-administering a drug to procure a miscarriage and sentenced in the Local Court to a 2 year good behaviour bond. In what appears to have been a complex and possibly tragic case involving a vulnerable woman, the magistrate noted that "the ongoing debate regarding pro-

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<sup>5</sup> See Hansard NSW parliament 11 May 2017. Contributions from Hon J Graham and Hon Adam Searle. <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-73360/link/28>

and anti-abortion is a polarising issue within the community" and said it was his job to apply the law rather than "express views either way".<sup>6</sup>

### **Uncertain access via postcode**

People seeking abortions from rural and regional areas, as well as socially and economically marginalised women currently face the greatest uncertainties in terms of access and affordability. The Commission's Consultation Paper cites important research undertaken in the aftermath of the 2008 law reform in Victoria<sup>7</sup>. This concluded that while legalisation had improved clarity and safety for doctors, significant geographical and economic barriers remained in terms of access and affordability.

WEL notes that the Victorian Government recognises this challenge and in March 2017 released a women's sexual and reproductive health strategy. Three of the 14 priorities address termination with a focus on improving awareness of and access to medical abortion.

In our discussion on achievement of the principle of national harmonisation we propose that there is an important strategic role for the Commonwealth government in ensuring greater access and affordability.

In summary WEL's view is that the best way to achieve clarity and certainty is to remove abortion from the criminal code altogether so that medical and health practitioners and women are freed from any possibility of criminal prosecution.

In addition we propose that any replacement legislation accompanying repeal from the criminal code needs to scrupulously avoid circumscribing long established values underpinning women's rights and decision making capacities, as well as being consistent with current clinical research and practice, contemporary attitudes and developments in medical technology.

### **Principle 3 Consistency with modern clinical practice**

Specialist medical colleges act as arbiters and leaders of best clinical practice in their areas of specialisation. WEL notes that RANZCOG, the peak professional body of gynaecologists and obstetricians, strongly supports decriminalisation of abortion and opposes imposition of constraints, such as legislated gestation limits and approval committees, on the grounds that they hinder best clinical practice.

In its submission to the Queensland Parliamentary Inquiry on the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, RANZCOG sets support for decriminalisation within the broad context of reproductive health.

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<sup>6</sup> SMH 14/Aug 2017 'Sydney Woman Prosecuted for taking Abortion Drug' <http://www.smh.com.au/nsw/sydney-woman-prosecuted-for-taking-abortion-drug-20170814-gxvoqd.html>

<sup>7</sup> See QLRC Consultation Paper: 25 and footnote129.

*'The prevention of unintended pregnancy should be a priority. RANZCOG supports broad community education (including in schools), with regard to sexual and reproductive health including relationships, safe sex and contraception. RANZCOG specifically supports ready access to a wide a range of safe and reliable contraceptive measures.'*<sup>8</sup>

Some of those who argue against decriminalisation, or for increased constraints, such as early or staged gestational limits, specified and detailed grounds for approval or compulsory unaccredited counselling, choose to ignore the fact that, as a relatively common clinical practice, abortion is already highly regulated (as indeed are all medical procedures).

Institution of additional constraints via legislation often springs more from lingering moral and ideological attitudes, rather than having any sound basis in social, scientific or medical evidence.

The Consultation Paper sets out in considerable detail the tight and intricate regulatory frameworks, separate from abortion legislation - that already govern medical and health practitioners and facilities, including all aspects of the delivery of termination services in Queensland - and which are replicated in every other state and territory.

As the only Australian jurisdiction to have adopted the simple repeal model of abortion law reform, the ACT relies, apparently successfully, on such existing and evolving regulation of health practitioners and facilities.

The apparatus do so exists in every Australian state and territory, and through the intersections between state based and Commonwealth regulations and ethical and conduct codes of professional associations and colleges. For example the Consultation Paper notes Queensland Health's *Clinical Guideline for Health Professionals on Therapeutic Abortion*. This Guideline sets out detailed standards for access, referral, care setting and the workforce and identifies good practice points against each of these.<sup>9</sup>

This document suggests consultation with other medical health professionals in response to *'complex cases' in 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 termination of pregnancy. This may include (but is not automatically a requirement of or limited to) issues related to a woman's: • Medical, social or economic circumstances • Capacity to consent • Mental health • Age • Gestation of pregnancy at which termination of pregnancy is requested'*

Similarly the NSW Ministry of Health's *Policy Directive Framework for Terminations in NSW Public Health Organisations* broadly accords with the 'legal' position in NSW and, like its Queensland equivalent, exemplifies the cavernous gap between NSW statute law and

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<sup>8</sup> <https://www.parliament.qld.gov.au/documents/committees/HCDSDVPC/2016/AbortionLR-WRC-AB2016/submissions/845.pdf>

<sup>9</sup> [https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0018/140733/g-ttop.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0018/140733/g-ttop.pdf)

regulated medical practice<sup>10</sup>. Clause 2.1 of the *Policy Directive* states that abortions are lawfully available as a health service in NSW public hospitals on the basis of the legal test established in *Wald* (the Levine Judgement). It adopts a policy position on matters that have not been addressed by NSW abortion law, including requiring that:

- all women seeking an abortion be offered pre-termination counselling from an appropriately qualified health care professional counselling (clause 3.1);
- gestation period and foetal abnormality be considered as part of an assessment of need (clause 3.2); and
- doctors who conscientiously object inform the woman that they have a conscientious objection and take every reasonable step to direct the woman to another health practitioner, in the same profession, who does not have a conscientious objection to termination of pregnancy (clause 4.2)

Importantly no gestational limit is offered in the NSW. Rather, in the assessment of need, after 20 weeks the treating practitioner should 'seek appropriate consultation and advice as dictated by the individual clinical scenario.'

#### **Principle 4 Community Expectations**

There is strong and long standing public support for decriminalisation of abortion in Australia. Some reputable and impartial polling has identified pockets of concern regarding late term abortion, which do not however diminish the overall rate of support for people to access termination services without legal sanctions.

The Australian Survey of Social Attitudes (ASSA) and the Australian Election Study (AES), draw on very large sample sizes and are assessed as the most methodologically credible Australian surveys by the expert reviewers in the Queensland and Victorian reports. Both surveys include questions about attitudes to abortion.

Since their inception, both the ASA and the AES have used single questions to track consistently high levels of general support for women having the right to choose an abortion/ women being able to obtain an abortion readily if they want.

The most recent AES (conducted after the 2016 Federal election ) signals that 69% of people (the highest ever) support women being able to readily obtain an abortion, with a further 27% supporting access to abortion in special circumstances. The Australian Survey of Social Attitudes data from 2003 and 2005 indicate that around 80% of Australians strongly agree or agree that: 'A women should have the right to choose.' Both surveys also show a persistent, but very small minority – fluctuating since 1979 between 4 to 6% -who support banning abortion.

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<sup>10</sup> [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014\\_022.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_022.pdf)

The 2016 Health Committee report of the Queensland Parliament's Inquiry into laws governing termination of pregnancy in Queensland includes an expert assessment (from Professor Mathew Guy and colleagues from the ANU) of seven Australian community attitude surveys and opinion polls published since 2007<sup>11</sup>.

An expert overview, also from the ANU, and an analysis of the methodology, questions and reliability of the most frequently cited opinion polls is also provided in Chapter 4 of the Victorian Law Reform Commission's (VLRC) 2008 report on abortion law reform in that state<sup>12</sup>.

Women's Electoral Lobby understands that despite a large majority of Australians in each state and territory supporting decriminalisation and a 'woman's right to choose', there remain some pockets of community concern, especially in regard to gestational limits at the point of viability and to conscientious objection. These may justify legislation additional to repeal from the Criminal Code.<sup>13</sup>

To respond to this in a legislative context (and in consultation with legal and medical experts) WEL's NSW arm has recently developed a working policy position as a framework for the reform of abortion laws in NSW. The position recommends the Victorian legislative model as best fitting the need to balance concerns that would entail some legislative constraints (on top of existing regulations) with the community's strong preference for women to be able to exercise autonomy and choice and also to support established and evolving clinical practice as the bedrock which legislation does not presume to override.

We will discuss these issues in more detail in our responses to the Consultation questions.

### **Principle 5 National harmonisation**

In Australia, the conditions and constraints abortion laws place on women's access vary from state to state, with little apparent medical or legal rationale. The Commission's consultation paper sets out the many divergent variations in Australian legislation on a state by state basis and also in comparable countries internationally.<sup>14</sup>

WEL is very concerned that in 2018, for around half of Australian Women – those in NSW and Queensland - abortion is still criminalised under statute law. As we have seen, common law decisions in those states enable women to access abortions, but women and medical practitioners are still able to be charged under the crimes acts in these states. This the only common medical procedure to be classified as a crime.

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<sup>11</sup> Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, Report No 25:47-51* August 2016

<sup>12</sup> Victorian Law Reform Commission *The Law of Abortion: Final Report* :55-68, August 2008

<sup>13</sup> See De Crespigny, L; Wilkinson, D; Douglas, T; Textor, M; Savulescu, J 'Australian Attitudes to Early and Late Abortion' *Medical Journal of Australia* Vol 193, No1 July 2010:9-12

<sup>14</sup> See QLRC Consultation Paper :Appendix B

NSW now lags the nation in its short sighted refusal to contemplate modernising abortion laws to reflect current medical practice and community expectations in that state.

Northern Territory, Western Australia, Tasmania and Victoria have decriminalised abortion. South Australia allows abortion with the consent of two doctors and under specified conditions up to 28 weeks but retains abortion in the criminal code.

The Commission's Consultation paper details the range of constraints and conditions which vary in some cases radically across the states, and which include:

- The stage of pregnancy up to which a woman can have a right to access abortion upon request (the gestational limit);
- Whether any additional conditions should be placed on access to abortion up to the gestational limit (ie WA requires counselling and decision by a ministerial appointed committee, other states a second doctor's assessment, possibly at several stages as in NT).
- If abortion will be allowed after the gestational limit and if so, the manner in which abortion access will be granted:
  - Whether a decision of a doctor or doctors is required;
  - The test to be applied by those doctors:
    - preventing risk of injury to life or physical or mental health of the pregnant woman;
    - whether there is a severe foetal abnormality; or
    - cases of rape or incest.<sup>15</sup>

WEL is concerned that the recent decriminalisation in the Northern Territory has introduced new legislation which imposes, without apparent medical justification, two gestational limits –one at 12 weeks and another at 23 weeks and appears to make abortion illegal except where the mother's life is in danger, after 23 weeks.

While it is commendable that the Northern Territory has decriminalised abortion, the replacement legislation has added another complex variation to the 'checker board' and post-code lottery of state and territory provisions.

There is a problem in the temptation that exists for State Parliaments to attempt to assuage unrepresentative but influential opponents of abortion decriminalisation, by inserting statutory requirements or 'grounds,' which pre-empt or inhibit the decisions, especially in complex cases which may involve the possibility of a late term abortion – roughly in the period after 22 weeks. Any process of harmonisation should seek to remove such 'grounds' from state and territory statutes as they override a woman's agency and medical assessment and advice. These include those that are potentially discriminatory, such as

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<sup>15</sup> The QLRC Consultation Paper has a detailed discussion of the various 'grounds in state legislation. See pp 43-48.

‘foetal abnormality’, as well as grounds such as rape or incest that impose heavy evidentiary burdens on women.

We therefore urge the Queensland Law Reform Commission to consider invoking the principle of national harmonisation in its recommendations to the Queensland Government on the shape of legislation. In WEL’s view the Victorian model provides the most realistic way forward, with the ACT model as the ideal but, unlikely to assuage concerns in some sectors of the community.

WEL also sees a role for the Commonwealth in review of abortion laws leading to national harmonisation, both through COAG Health Ministers, through the Commonwealth’s role in supporting professional training and through health and hospital funding.

The most striking inequities in access to abortion in Australia derive from the very limited provision of abortion through the public health system and its confinement to generally excellent but ‘pay for service’ private clinics, to which most states in Australia –and especially NSW and Queensland - outsource the delivery of abortion, particularly in the first trimester. The anticipated potential of greatly enhanced access to medical abortion via a critical mass of certified GP’s, Nurses and Midwives, Aboriginal and Torres Strait Islander Health workers and dispensing Pharmacists, largely remains unrealised and needs Commonwealth leadership to kick start.

Finally, application of this principle needs to be made in the light of Australia’s obligations under international instruments, in particular as a signatory to the International Convention on the Elimination of all Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and the Convention on the Rights of Persons with Disabilities.

It is salient but disturbing to WEL that in its most recent Country Review of Australia the CEDAW Committee expressed concern that the ‘sexual and reproductive health needs of women are not equally met within all the States and Territories’ of Australia.<sup>11</sup>

In its concluding observations, the Committee stated that:

*[It] remains concerned about the lack of harmonisation or consistency in the way that the Convention is incorporated and implemented across the country, particularly when the primary competence to address a particular issue lies with the individual States and Territories. It notes, for example, that inconsistent approaches have arisen with regard to the imposition of criminal sanctions, for example with regard to abortion.<sup>16</sup>*

There is therefore a real opportunity through recommendations coming out of this consultation, for the Queensland Law Reform Commission to propose a legislative framework and principles that will set a new path for Queensland but for Australia’s approach to reproductive health and the further empowerment of Australian women.

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<sup>16</sup> QLRC Consultation Paper:97-98

## WEL RESPONSES TO THE CONSULTATION QUESTIONS

### 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 (and in NSW should a successful decriminalisation be replaced by legislation). This includes doctors, nurses and midwives, ATSI health workers and pharmacists.

There is a need to 'future proof' legislation in this area, as medical advances increasingly allow for supervised prescription of medication and where the pregnant person could safely rely on assessment and oversight by an accredited clinical nurse practitioner.

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

#### **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 to be charged for accessing a termination of pregnancy, or consenting to someone else providing them with a termination of pregnancy.

WEL sees this the one of the most pernicious aspects of the criminalisation of abortion. Recent cases in Queensland and NSW demonstrate the punitive cruelty that underpins the provision, where extremely vulnerable and even desperate women can be charged when they most need to access support and advice without fear.

Some opponents of abortion claim that retention of criminal responsibility will discourage 'backyard' or unsafe abortion. Submissions to the two Queensland Parliamentary Inquiries already undertaken on reform of abortion laws, as well as expert submissions to this current Consultation provide incontrovertible data to disprove this urban myth.

## **Gestational limits and grounds**

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

WEL 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 Gynaecologists and most other peak medical and legal groups.<sup>17</sup>

The Commission's Consultation Paper includes a section on 'Development and Moral Status of the Foetus'. Medical evidence assembled there indicates that there is no clear and certain consensus justifying establishment of a strict gestational limit. Rather there seems to be some agreement that 'viability' may emerge from around 20 to 24 weeks. The analysis also indicates that there is certainly no 'philosophical' consensus on the development of 'personhood', other than the normal legal definition of a person as beginning their existence at birth. The pregnant person is normally considered as the sole bearer of rights prior to this point. Modernisation of abortion laws should be careful about muddying this assumption as it is a critical foundation of women's reproductive autonomy.

However, WEL recognises significant pockets of concern regarding the rare occurrence of late termination. We would therefore support the introduction of a staged approach to decriminalisation, with one stage only at 24 weeks, after which the guidance would be that two doctors confer, as with 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. We strongly urge against multiple stages or gateways, as in the Northern Territory.

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

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<sup>17</sup> QLRC Consultation Paper:89-91

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 may be acceptable after 24 weeks gestation (as at Q-7). However we remain concerned that any such grounds would impose an undue burden on distressed or disadvantaged women, pregnant people, and their doctors who are likely at this stage to be dealing with complex cases..

**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, assessments arising from professional standards and guidelines 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 foetal abnormality?**

WEL 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;
- (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; and
- (iv) foetal 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 families, as stated by many submitters to the Queensland parliamentary inquiries in 2016, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Moreover a list of ‘grounds’ inevitably omits and pre-empt the multiple factors which can drive pregnant people’s decisions.

There is emerging recognition for example of the link between women’s reproductive rights and eliminating violence against women. Reproductive coercion from a partner is a form of violent abuse which attacks a woman’s right and capacity to make her own soundly based decisions regarding her reproductive health, contraception and pregnancy. It can involve pressuring a women to become pregnant as proof of fidelity, sabotaging access to birth control and pressuring a woman to continue or end a pregnancy.

WEL strongly supports 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’.

**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.

### **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, along the lines set out in the NSW and Queensland Clinical Directions and Guidelines.

**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?**

WEL opposes legislation of a staged gestational approach, as we have explained in relation to the need for any legislation to reflect the principle of current clinical practice. At the same time we recognise that late term terminations, after 20 - 24 weeks, are a significant area of community concern. Therefore we support adoption of the Victorian provision, where consultation with another medical practitioner should be recommended after 24 weeks gestation, before a termination of pregnancy is provided. This best captures the guidance in both the Queensland and the NSW Clinical Direction and Guidelines.

This requirement would also align most closely with legislation in most other jurisdictions which take a staged approach to termination of pregnancy.

We oppose any escalation of this requirement with multiple staged gestational limits and specialists required in later stage terminations. We believe that medical and health regulations, and the assessment of medical and health practitioners, in conjunction with the woman's decisions, adequately provide direction in these generally complex cases. It is

critical that the pregnant person faces the least burdensome and intrusive process to access a termination, which may be life threatening or is often urgent.

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. 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.

WEL strongly opposes the introduction of a legislated requirement for consultation or approval via a committee.

In Western Australia, we understand that 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 foetus 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.

In addition, WEL understands that 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) has placed great pressure on pregnant women already dealing with complex diagnoses and sometimes very difficult decisions regarding prognoses.

WEL understands that many women seek to travel to other states from Western Australia for late term abortions and that this has a major impact on women's access to safe late terminations where they are not able to afford to travel interstate.

**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 single staged gestational approach to law reform be pursued

### **Conscientious objection**

**Q-11 Should there be provision for conscientious objection?**

Yes. The provision should only apply to individuals, and then only to registered medical and health practitioners undertaking or directly participating in a clinical or medical termination. The provision should not apply to administrative staff or to institutions (as it does currently in Western Australia). There should be a requirement that conscientious objectors should identify themselves as such prior to participation in abortion procedures.

**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?**

As is the case with other states and territories which have already largely or decriminalised abortion and provide for conscientious objection, this provision should not apply in an emergency. The codes of conduct which to which members of Colleges and professional associations accede also require that conscientious objection not apply in an emergency.

**(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?**

Yes. This condition is specified in clinical guidelines in NSW and Queensland and in other regulatory provisions. It applies in Victoria, Northern Territory, Tasmania and in the ACT (via regulation).

**Counselling**

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

No state in Australia includes mandatory counselling as a legislated condition for a lawful abortion. Internationally, mandatory counselling is not a legislated requirement for lawful abortion in Canada, the UK or New Zealand. Mandatory counselling is typically a feature of legislation designed to restrict abortion access, such as in some US states and is often offered by unqualified providers who are in fact 'advocates' opposed to abortion.

In this context, "counselling services" are separate from the best clinical practice and knowledge provided by a woman's doctor and/or medical personnel, and refers to a service provided by someone (who may or may not be qualified in a relevant discipline) to a pregnant woman, prior to her being granted access to the abortion care she seeks.

The Victorian Law Reform Commission thoroughly examined the issue of mandatory counselling in Chapter 8 of its report, following an inquiry into the state's abortion laws in 2007 and found that mandated counselling would be unnecessary and ineffective. The Commission's report concluded that:

*"Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm. Mandating counselling may result in women having to travel long distances for multiple medical*

*assessments and counselling sessions before they can proceed. This would exacerbate existing inequities.*

*Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling."*<sup>18</sup>

Credible scientific studies conducted internationally and in Australia indicate that most women seek abortions as a routine medical procedure. This is especially so in the first trimester and up to the second. These studies confirm that that the vast majority do not wish to speak to a counsellor prior to making their decision.<sup>19</sup>

From a professional perspective, the option of offering and referring a patient to counselling from a qualified, registered and impartial psychologist is considered part of the provision of a suite of termination services.

RANZCOG's policy on termination recommends that counselling be available if desired, but not required. Similarly the NSW Health directive "Framework for Terminations in NSW Public Health Organisations" recommends that women be offered counselling<sup>20</sup>.

There is the added danger that there is no overall regulatory framework for counselling in Australia and no requirement for transparency for those who offer such services. Moreover, quality and impartial counselling services are few and far between in rural, regional and remote Australia. Mandatory counselling would further add to the delays and accessibility challenges faced by pregnant people in these geographical areas.

Law reform should not therefore provide for mandatory counselling in any circumstance. Women seeking termination should have the choice to seek counselling if they wish. Such counselling may or may not include information to assist decision making.

### **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?**

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<sup>18</sup> *Law of Abortion. Final report*, Melbourne 2008:126

<sup>19</sup> Billie Boneviski and Jane Adams *Psychological Effects of the Termination of Pregnancy: A Summary of the Literature 2001*; Trine Munk-Olsen, Ph.D., Thomas Munk Laursen, Ph.D., Carsten B. Pedersen, Dr.Med.Sc., Øjvind Lidgaard, Dr.Med.Sc., and Preben Bo Mortensen, Dr.Med.Sc. 'Induced First-Trimester Abortion and Risk of Mental Disorder' *New England Journal of Medicine* 2011; 364:332-339;

<sup>20</sup> RANZOG 'Termination of Pregnancy. A Resource for Health Professionals', 2005:4.

Yes in both cases. There is general support across the community for clients, patients, medical, health staff and other workers to be protected from abuse, unsolicited approaches, invasions of privacy and other types of harassment when entering or leaving a facility.

**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 already established through legislation in Victoria, ACT, Northern Territory and Tasmania, with a Bill to establish such zones in NSW currently before the NSW Parliament. Inclusion of Safe Access Zones in Queensland Legislation would also be another step towards national harmonisation.

**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**

As is the case in the Victorian, Tasmanian and Northern Territory legislation, any Queensland provision the Commission proposes should automatically establish an area of 150m around premises providing termination of pregnancy, as a safe access zone.

**(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?**

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

The Victorian legislation defines behaviours prohibited within a safe access zone, in relation to 'a communication that relates to terminations and is reasonably likely to cause distress or anxiety.'

We understand that the Victorian provisions are broad enough to capture actions intended to harass or intimidate; and avoid the risk of the legislation's constitutional validity being compromised by the inclusion of the word 'protest' in prohibited behaviours. They describe behaviours as '*Interfering, harassing, causing anxiety or distress or recording.*'

Nevertheless should the NSW Bill pass into law before the Commission reports we suggest that the wording presents an equally concise description of behaviours as is the case with Victoria's. The NSW Bill would forbid '*Harassing, interfering, obstructing, causing distress or anxiety or recording*'.

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

Most other jurisdictions that have legislated for Safe Access Zones apply the provisions at all times. This option avoids monitoring on site and protects clients and workers who may need to access facilities after hours or in emergencies.

**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. This is a serious invasion of privacy and presents a clear danger of further harassment and intimidation of women and workers who are captured in this way. All states and territories that have legislated exclusion zones include an offence under the category of photography but this should be enlarged to that of publication, including publication on social media.

### **Collection of data about terminations of pregnancy**

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

This an extremely important proposal that WEL strongly endorses for Queensland and indeed every other state and territory, through the process of harmonisation of legislation and with the leadership of the Commonwealth.

As is well known South Australia is currently the only jurisdiction that collects such data. Without reliable national statistics it is very difficult to report on trends and plan and tailor services for abortion in the context of reproductive health. WEL recommends that any data collection should be based on geographical boundaries larger than Census Collection Districts, since isolated areas with few residents might enable easy identification of women who have had terminations.