Submission to the Tasmanian Legislative Council
Committee Government Administration A
on the provisions of the

Reproductive Health (Access to Terminations) Bill 2013

July 2013

Prepared by:
Ms Tania Penovic, Lecturer in Law at Monash University and Deputy Director, Castan Centre for Human Rights Law.
Dr Ronli Sifris, Lecturer in Law at Monash University and Associate of the Castan Centre for Human Rights Law.

1 Aspects of this submission have been taken from: Ronli Sifris, ‘A Woman’s Right to Choose: Human Rights and Abortion in Australia’ in Paula Gerber and Melissa Castan (eds), Contemporary Human Rights Issues in Australia (Thomson Reuters, 2013) 251-273.
Comments on the Reproductive Health (Access to Terminations) Bill

The Bill removes abortion services from the Criminal Code Act 1924 and places them within the ambit of medical services. We commend the removal of the crime of abortion from the Criminal Code. This approach to reproductive health services advances the rights of women and is consistent with standards of human rights applicable in Tasmania.

Our submission will address a number of provisions of the Bill. We will first consider the removal of the crime of abortion from the Criminal Code in clause 14 of the Bill. We will then provide detailed comments on the Bill, with particular reference to clauses 4 to 9.

Clause 14: Removal of the crime of abortion from the Criminal Code

The Bill removes the crime of abortion from the Criminal Code and introduces a new framework which regulates abortion as a health matter. We commend the removal of the crime of abortion from the Criminal Code for the reasons set out below.

Abortion as a health issue, not a criminal justice issue

The debate around access to abortion remains coloured by intractable and passionately held views. Yet abortions are a fact of human existence. And while for many people the morality of abortion may be shrouded in shades of grey, from a public health perspective the issue is black and white – the accessibility of abortion is a precondition to securing women’s right to health. After all,

[women have always had abortions and will always continue to do so, irrespective of prevailing laws, religious proscriptions, or social norms. Although the ethical debate over abortion will continue, the public-health record is clear and incontrovertible: access to safe, legal abortion on request improves health.]

While the number of unwanted pregnancies can be reduced through education and access to sexual health services, restrictive abortion laws do not erase the universal reality that a large number of women seek to terminate pregnancies every year. Unsafe abortion accounts for 13% of maternal deaths worldwide, with some 47,000 deaths annually. Women living in countries in which abortion is prohibited or available on the most narrow grounds have statistically lower levels of sexual and reproductive health and are in greater danger of complications resulting from unsafe or self-induced abortions. A majority of unsafe abortions are performed in developing countries with restrictive abortion laws and a lack of quality abortion services. The World Health Organisation has observed that unsafe abortion is the cause of serious complications and disability for millions of women each year and a major public health concern which has grown in urgency and significance.

---

Tasmania’s health system may appear far removed from the developing countries in which the majority of unsafe abortions take place. Yet maternal mortality and morbidity resulting from unsafe abortions flows from the ‘universal risk factor’ which is ‘simply the fact of being female’.6 The maintenance of unclear and uncertain criminal provisions (see below) criminalises and stigmatises women and doctors and compromises access to health services. Unsafe abortion is no longer commonplace in Australia. But a study of Australian history a mere 40 years ago reveals a very disturbing picture of systemic failure to deliver fundamental rights to women.7 As long as abortion remains within the ambit of the criminal law, the health and rights of women will remain vulnerable.

It should be noted that the decriminalisation of abortion will not result in an increase in the number of abortions. The passage of the Bill may in fact see a reduction in the abortion rate if combined with advances in public awareness of (and access to) contraceptive methods. The proposed Sexual and Reproductive Health Strategic Framework represents a significant advance in this regard. The World Health Organisation has found that restrictive abortion laws are not associated with lower abortion rates. In contrast with Western Europe where abortion is permitted on broad grounds and the abortion rate is low, Latin American countries tend to have highly restrictive abortion laws and a relatively high number of abortions.8 The liberalisation of abortion law has furthermore been associated with significant advances in health and well-being.9

Reproductive health is fundamental to women’s health and wellbeing. With reference to a study published in The Lancet in January 2012,10 the journal’s editor, Dr Richard Horton made the following observation:

> Abortion is a subject nobody wants to talk about... abortion is ignored, marginalised, stigmatised, and yet it is absolutely central to the health of women worldwide... It’s time for a public health approach that emphasises reducing harm, and that means more liberal abortion laws.11

Access to reproductive health services is fundamental to women’s health and in the 21st century should be regulated as a health matter and not as a matter of criminal law.

**The need for certainty and clarity in the law**

Part 3 of the Bill seeks to amend the current legislative framework. This framework is built upon 19th Century English legislation which was repealed long ago and which pre-dated the guarantees afforded by international human rights law. Despite liberalisation of the Criminal Code Act in 2001, there remains a lack of certainty and clarity with respect to the legality of terminations in Tasmania. This lack of certainty and clarity is extremely problematic for numerous reasons. First, this state of legal ambiguity results in a depiction of the law as an ‘ass’. In Loane Skene’s words, “abortions

---

should not be illegal where they are performed frequently – even for relatively minor reasons – and there are no prosecutions. This makes the law seem foolish and weakens respect for it.”

Indeed, abortion is the only widely practised and publicly funded medical procedure that is also criminalised. Second, if the law is uncertain then people do not know what conduct constitutes a breach of the law. In the abortion context, this applies to both women who are seeking access to abortion services and doctors who perform such services. For example, in a 2005 media release the Australian Medical Association (AMA) stated that:

State and Territory Governments must clarify their laws on abortion in consultation [with] the AMA, the whole medical profession and the public... Doctors need to be working in a safe and clear legal environment. It is not acceptable for doctors and their patients to not know what is required for an abortion to be considered legal.”

Finally, a lack of legal certainty and clarity has the effect of limiting access to services and, in the case of Tasmania, has resulted in women travelling to Victoria in order to access essential health services. Obstacles to accessing abortion services have a disproportionate impact on women who are vulnerable due to socio-economic or other factors. Thus, for example, only women with some financial means are able to travel inter-state to access abortion services.

Even though the Tasmanian Criminal Code provisions have not given rise to prosecutions in recent years, the maintenance of these provisions leaves women and their doctors in a precarious position. The existing potential for prosecution is not fanciful. The 2010 Queensland case of *R v Brennan and Leach* demonstrates this point. This case concerned Tegan Leach and Sergei Brennan, aged 21 and 22 respectively. Upon discovering that Tegan was pregnant they decided to terminate the pregnancy and did so by asking Sergei’s sister in the Ukraine to post them the drugs needed to carry out a medical abortion. Police discovered evidence of these drugs when searching their home for reasons completely unrelated to the abortion. Thus began the process of investigating and prosecuting this young couple. Tegan was charged under section 225 of the Queensland Criminal Code which prohibits a woman from unlawfully attempting to procure her own miscarriage and Sergei was charged under section 226 of the Criminal Code which prohibits a person from unlawfully supplying drugs for the purpose of procuring a miscarriage. In addition to the stigma and humiliation associated with the process of being investigated and prosecuted for a crime, the nature of this particular crime rendered the treatment of Tegan especially degrading. Jo Wainer, who attended much of the trial, made the following observation:

*It felt as though we were watching a village scene from the maybe 17th century, where when people offended against the local culture, they were put in the stocks, and villagers could walk past and throw eggs at them or stones, whatever they wanted really. It was a process of ritual public humiliation. And one of the most difficult things to sit through was watching this video replay of the...*

---

17 See *Criminal Code 1899* (Qld) ss 225 and 226.
police interview with Miss Leach and the police asking her about the date of her last menstrual period, the normal length of her period and how much bleeding did she have; what level of pain did she have, and those are questions which only a doctor in our culture is entitled to ask a woman.¹⁸

Women should not be stigmatised, humiliated and degraded for undertaking what the World Health Organisation has labelled “one of the safest medical procedures.”¹⁹

The above discussion demonstrates why categorising abortion as a crime is problematic, even if it remains widely available. Categorising abortion as a crime contradicts the growing recognition of abortion as a health issue, rather than a criminal justice issue, and contradicts the growing recognition of a woman’s right to choose to terminate a pregnancy as falling within the existing international human rights framework. It also exacerbates the stigma attached to abortion and the women who access abortion services. In addition, the very prospect of investigation and prosecution is humiliating and degrading. Further, categorising abortion as a crime, while carving out a myriad of legal exceptions, leads to a situation of uncertainty and lack of clarity in the law. We commend the drafters of the Bill for including clause 8 which ensures that a woman cannot be found guilty of a crime or offence for participating in a termination on herself. The Queensland case of R v Brennan and Leach²⁰ demonstrated the humiliating and degrading context of an abortion prosecution as well as the absurd consequences of an ambiguous and confusing legal landscape.

Having demonstrated why the status quo is unsatisfactory and why abortion should be removed from the criminal law paradigm, this submission now engages in a more detailed analysis of the Reproductive Health (Access to Terminations) Bill 2013.

Clause 4: Terminations by medical practitioner at not more than 16 weeks

We commend the drafters of the Bill for including a period of gestation during which a pregnant woman may access “abortion on request”. This follows the path of the legal amendments in Victoria, Western Australia and the Australian Capital Territory (ACT) which all allow abortion at the request of the pregnant woman, without a doctor’s specific approval. In Victoria, “abortion on request” is available up to 24 weeks gestation.²¹ In Western Australia, “abortion on request” is available up to 20 weeks gestation.²² In the ACT, there is no gestational limit to a woman’s ability to access abortion services without seeking the approval of a medical practitioner. This is because the ACT, after decriminalising abortion in 2002, included the regulation of abortion in the Health Act 1993 (ACT) and in doing so reframed the lens through which abortion is viewed from a criminal offence to a health issue.²³ Therefore, as with other forms of medical treatment, the specific approval of a medical practitioner is not required for a termination of pregnancy to be performed.

We urge Tasmania to follow the example of the ACT and to remove the gestational limit for “abortion on request”. Removing the gestational limit would enable abortion to be approached in

---

²¹ Abortion Law Reform Act 2008 (Vic) s 4.
²² Health Act 1911 (WA) s 334.
²³ See above discussion regarding the need to approach abortion as a health issue and not a criminal justice issue.
the same way as any other medical procedure – with informed consent rather than period of
gestation being the primary consideration. When the law treats abortion differently to other medical
procedures, it essentially stigmatises abortion by casting such procedures in a deviant light. Brenda
Major and Richard Gramzow researched the effect of the stigmatising aspect of abortion. They
found that women who felt stigmatised by abortion were more likely to feel a need to keep it a
secret from family and friends. Secrecy was related positively to suppressing thoughts of the
abortion, and negatively to disclosing abortion-related emotions to others. Greater thought
suppression was associated with experiencing more intrusive thoughts of the abortion. Both
suppression and intrusive thoughts, in turn, were positively related to increases in psychological
distress over time. In general, it seems that stigmatisation gives rise to increased risk of numerous
health problems, including depression, hypertension, coronary heart disease, and stroke.

Consequently, if it is accepted that the law plays a role in exacerbating or removing social stigma,
then it must be accepted that the creation of a different regulatory regime for abortion as compared
with any other medical procedure exacerbates the stigma attached to abortion. Further, if it is
accepted that individuals who feel stigmatised suffer negative health consequences as a result of
such stigmatisation, then it must be accepted that there is a connection between legal restrictions
on accessing abortion and negative health sequelae.

Therefore, while it is commendable that the drafters of this Bill have included a gestational period
during which a woman may terminate a pregnancy without a doctor’s approval, it is submitted that
by limiting this period to 16 weeks gestation the Bill adopts a different approach to the termination
of pregnancy as compared with the approach which the law adopts with respect to other forms of
medical treatment. In treating abortion differently to other medical procedures, the Bill therefore
perpetuates the existing stigma surrounding abortion. We therefore believe that the Tasmanian
legislature should follow the approach of the ACT and remove any gestational limit for “abortion on
request”. At the very least, we recommend that Tasmania bring its legislation in line with that of
Victoria, the most recent State to reform its abortion laws, which imposes a gestational limit of 24
weeks for “abortion on request”.

Clause 5: Terminations by medical practitioner after 16 weeks

Closely connected to our comments regarding clause 4 of the Bill is clause 5, which imposes a
requirement for the consent of two medical practitioners in respect of terminations to be performed
after 16 weeks gestation.

It is commendable that the Bill enables doctors to take account of “current and future physical,
psychological, economic and social circumstances” when assessing the risk of injury to the woman
posed by continuing with the pregnancy. Nevertheless, it is submitted that the decision to terminate

---

24 Brenda Major and Richard H Gramzow, ‘Abortion as Stigma: Cognitive and Emotional Implications of
Concealment’ (1999) 77(4) Journal of Personality and Social Psychology 735. See also David A Grimes et al,
related to abortion and negative health consequences.
393.
a pregnancy should rest with the woman alone – it should be the woman’s decision and not that of her doctors.

On the surface a “health exception”, such as that contained in clause 5 of the Bill, is a positive development as it provides an avenue for abortion to be legally available. However, from a human rights perspective such a framework removes all rights from the woman and places them with the doctor. Clause 5 therefore creates a situation in which the medical profession is empowered to determine whether an individual woman is able to access abortion services. By adopting such an approach, doctors become the gatekeepers to legal abortion; it is doctors rather than pregnant women who are empowered to determine whether their pregnancy may be terminated. Such an approach entrenches the power imbalance between women and their doctors, removes from women the ability to decide what is in their own best interests, and renders women beholden to the medical profession for allowing them to access abortion services. Thus Sally Sheldon makes the point that, by giving such power to the medical profession, the law constructs ‘women seeking abortion as supplicants, who must go cap in hand to request permission to terminate their pregnancies. Refusals may result in women carrying unwanted pregnancies to term; they will certainly result in later terminations’. An example of this power differential is illustrated by Cath Elliot’s testimony regarding an abortion that she had in 1997 in the United Kingdom:

I went to my GP when I was a couple of weeks pregnant, expecting the process to be straightforward. My doctor kept stalling the process, though. He insisted that I have an NHS pregnancy test, for instance, and, when I went back a few weeks later for the results, he told me bluntly that they hadn’t arrived.

At this point I was in a really emotional state - I had started experiencing morning sickness and I just wanted the whole process to be over.

Eventually, when I visited the GP's surgery again to collect the results, he literally whistled me into his office and announced, “I’m delighted to tell you that you’re pregnant.” It was a really hostile gesture.

Whereas the “health exception” is helpful to women insofar as it provides an avenue for women to access safe abortion services, it does so at the expense of women’s agency and autonomy; it positions women at the mercy of their doctors rather than empowering them to make their own decisions regarding their own bodies. The degradation and humiliation inherent in forcing a woman to request permission from a doctor to terminate a pregnancy is exacerbated in jurisdictions where the authorisation of two medical practitioners is required. Therefore, it is submitted that if the requirement for medical authorisation for abortions after 16 weeks gestation is to be maintained, the authorisation of one medical practitioner should be sufficient. At the very least, the requirement that at least one of the medical practitioners must be a “practitioner who specialises in obstetrics or gynaecology” should be deleted. Such a requirement places unnecessary hurdles in front of women wishing to terminate their pregnancies. Further, this requirement is illogical given that, pursuant to this clause 5 of the Bill, a termination of pregnancy may be authorised on mental health grounds. It is unclear what specific expertise a “practitioner who specialises in obstetrics or gynaecology” has in determining whether the continuation of a pregnancy poses a danger to a woman’s mental health.

In addition, such a requirement may prove particularly challenging for women living in rural areas who may not have easy access to such a specialist.

Clause 6: Conscientious objection and the duty to treat

We commend the inclusion in clause 6 of the Bill of a duty to terminate a pregnancy where necessary to save the life of a pregnant woman. The inclusion of such a clause is consistent with applicable codes of conduct and crucial to ensure that tragedies such as the October 2012 death of Savita Halappanavar in a hospital in Ireland do not occur.29

Clause 7: Obligations on medical practitioners and counsellors

We commend the inclusion in clause 7 of an obligation to refer. Such an approach is in line with the 2008 reforms to Victoria’s legislation.30 The obligation to refer is somewhat contentious as it raises questions regarding the appropriate balance between the doctor’s freedom of religion/conscience and the woman’s right to terminate a pregnancy. In the lead up to the Victorian abortion law reform, the Victorian Law Reform Commission eloquently articulated the dilemma inherent in balancing the rights of such a doctor against the rights of the pregnant patient, stating that “it is important to balance the rights of individuals to operate within their own moral and religious beliefs with the equally important ethical consideration doctors have to act in the best interests of patients.”31

The question of how to resolve a conflict of rights is always difficult. In the context of abortion, a doctor’s right to freedom of conscience and religion must be weighed against a patient’s right to health, privacy, autonomy, equality, and freedom from inhuman or degrading treatment.32 The freedom of thought, conscience and religion is enshrined in article 18 of the International Covenant on Civil and Political Rights (ICCPR). The freedom to manifest one’s religion or beliefs may be subject to such limitations as prescribed by law and are necessary to protect public safety, health and the fundamental rights and freedoms of others. It should not become a means of overriding the rights of women to access health services. Ultimately, the Victorian Law Reform Commission recommended the inclusion of a legislative “requirement that the person inform the patient of his or her conscientious objection and make an effective referral to another provider.”33 Consequently, this requirement was included in the Victorian legislation, ensuring that a doctor’s right to freedom of thought, conscience and religion does not trump a woman’s right to choose to terminate a pregnancy. It is commendable that the drafters of this Bill have seen fit to include a similar requirement in the Tasmanian Bill.

Further, the additional requirement imposing an obligation to refer upon counsellors with a conscientious objection is a positive development. Women in vulnerable situations may be

---

30 Abortion Law Reform Act 2008 (Vic) s 8(1).
32 See below for a discussion of abortion as a human right.
particularly influenced by the views of counsellors who may, even unwittingly, allow their own moral or religious convictions to influence their counselling approach. Therefore, the imposition on counsellors of an obligation to refer is a sensible way of safeguarding a pregnant woman’s decision-making autonomy. Like the access zone introduced by clause 9 and considered below, we believe that clause 6 strikes an appropriate balance between the rights of women and the rights of doctors and counsellors who conscientiously object to terminations. It is to be hoped that other Australian jurisdictions will follow this example.

Clause 9: Access zones

We strongly support the inclusion of access zones in clause 9 of the Bill. This is another initiative which should be adopted in other Australian jurisdictions. Anti-choice protestors utilise a number of mechanisms to try to dissuade women from entering abortion clinics and accessing abortion services. For example, they may block the entrance to a clinic; hold up signs or hand out pamphlets containing disturbing images; yell at or talk to women to try to convince them that they should not terminate their pregnancies. Protestors frequently cause significant distress to women who may already be feeling emotionally vulnerable, having made the often difficult decision to terminate a pregnancy. Protest action exacerbates the stigma attached to the procedure and compromises women’s safety and well-being. Women should be able to access abortion services in a way which respects their dignity and rights and should not have such access impeded by those who disagree with their personal decision.

On occasion, protest action outside Australian abortion clinics has constituted a serious threat to the safety of patients and staff. Such conduct has included death threats directed at staff. In 2001, a security guard was murdered outside a Melbourne abortion clinic as part of a planned massacre which was foiled when the offender was overpowered by staff and clients.34

The right to peaceful protest is a fundamental component of any democracy. This right, however, is not absolute. The freedom of expression as enshrined in article 19 of the ICCPR provides that the right to impart information and ideas may be subject to restrictions which are necessary for the protection of public order, public health and for respect of the rights and reputations of others. As discussed above, the freedom to manifest one’s religion or beliefs (enshrined in article 18 of the Covenant) is also subject to limitations, as prescribed by law, that are necessary to protect public safety, health and the fundamental rights and freedoms of others. Protest action impedes access to reproductive services which are fundamental to securing women’s right to health. Such action also constitutes an interference with patients’ privacy which should be accorded the protection of the law in accordance with article 17 of the ICCPR. On occasions, protest action may constitute inhuman or degrading treatment contrary to article 7 of the ICCPR and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Clause 9 does not breach protesters’ freedom of expression or their freedom to manifest their religious beliefs. It merely qualifies these freedoms in order to protect women’s health and ensure respect for the rights of patients. Those who wish to protest are not barred from expressing their

---

views about abortion. They are subject to a limited geographic restriction with respect to where they can express those views. This restriction is necessary to protect the rights of others. It is not unreasonable to expect that the right to protest be modified so as to ensure that a woman’s right to access abortion services free of intimidation and harassment is concomitantly respected. It is not unreasonable to expect that Tasmanian women should be free to reach their own decisions concerning their own health and seek services accordingly without the interference of strangers. We believe that clause 9 is carefully tailored so as to limit its restriction upon freedom of expression and will represent a significant step in advancing women’s rights.

**Consistency of the Bill with human rights**

The provisions of the Bill are consistent with human rights standards applicable in Tasmania. At the international level, there has been growing recognition that restrictions on access to abortion may violate a number of fundamental rights including the:

- right to life;  
- right to health;  
- right to privacy / autonomy;  
- right to equality / freedom from discrimination;  
- right to be free from torture or cruel, inhuman or degrading treatment or punishment.

---


Removing abortion from the Criminal Code is consistent with the growing recognition within international human rights jurisprudence that the right to terminate a pregnancy is supported by human rights norms. This coincides with a growing recognition that access to safe abortion is a necessary concomitant of securing women’s equality and health.

Australia is a party to the core UN human rights treaties and has participated in international conferences in which the link between access to abortion and restrictive abortion laws has been accepted. Australia’s representatives have recognised at the international level that access to safe, legal abortion is necessary to secure women's health. This recognition should translate to Australian law concerning reproductive health.

The decriminalisation of abortion is consistent with norms of human rights which apply in Tasmania. Tasmanian women should be accorded the protection of these norms.

**Conclusion**

Subject to the concerns expressed with respect to clauses 4 and 5, we strongly support the Bill. The decriminalisation of abortion and regulation of abortion as a medical procedure would ensure that women can exercise reproductive choice free from stigmatisation and with an understanding that they are capable of making their own personal and moral decisions.

We recommend that the Bill be amended to further protect the rights of women. Clauses 4 and 5 should be amended to remove the gestational period in which an abortion may be performed without a doctor’s approval and ensure that the difficult decision as to whether to terminate a pregnancy rests with Tasmanian women. The Castan Centre for Human Rights Law recommends that subject to these amendments, the Bill should be passed.

---


41 See for example the Fourth World Conference on Women held in Beijing in September 1995.