



MONASH University
Castan Centre for Human Rights Law



**Castan Centre for Human Rights Law
Monash University
Melbourne**

Submission to the Queensland Law Reform Commission

Review of termination of pregnancy laws¹

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Prepared by:

Dr Ronli Sifris, Senior Lecturer in Law at Monash University and Deputy Director of the Castan Centre for Human Rights Law.

Dr Tania Penovic, Senior Lecturer in Law at Monash University and Deputy Director of the Castan Centre for Human Rights Law.

¹ Large parts of this submission are drawn from the authors' [Submission](#) to the Tasmanian Legislative Council, Committee Government Administration A, *Reproductive Health (Access to Terminations) Bill 2013*.

The Queensland Law Reform Commission seeks views on the questions below about the proposed new legislation on the termination of pregnancy and related issues:

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?

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

Gestational limits and grounds

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

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?

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

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;

(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?

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

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?

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?

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?

Conscientious objection*

Q-11 Should there be provision for conscientious objection?

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?

(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?

Counselling

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

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?

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

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?

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

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

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?

Collection of data about terminations of pregnancy

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

In this submission, we comment on the following questions:

Who should be permitted to perform or assist in performing terminations

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,

[w]omen 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.²

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.³ 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.⁴ 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.⁵

Queensland’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

² D A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, 1917 (citations omitted).

³ World Health Organization, *Facts on induced abortion worldwide*, January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html

⁴ D A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908.

⁵ WHO, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, Sixth Edition, 2011 at 31.

abortion flows from the 'universal risk factor' which is 'simply the fact of being female.'⁶ The maintenance of unclear and uncertain criminal provisions 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 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. Therefore, **we submit that abortion should be decriminalised and that a woman should not be criminally responsible for the termination of her own pregnancy. Abortion should be treated by law as a health issue and not a criminal justice issue.**

Increase in medical abortion necessitates expansion of acceptable providers¹²

The availability of medical abortion in Australia has a convoluted and controversial history. The drug Mifepristone, also known as the abortion pill RU486, has been available in France since 1988 and has subsequently been registered in around 50 countries. It is also on the World Health Organisation's list of essential medicines.⁷ Nevertheless, its availability in Australia has been slow and incremental.

⁶ R Cook, 'International Protection of Women's Reproductive Rights' (1992) 24 *NYU International Journal of Law and Politics* 545- 727 at 647.

⁷ J Wainer (ed) *Lost: Illegal Abortion Stories* (Melbourne University Press, Melbourne, 2006).

⁸ World Health Organization, *Facts on induced abortion worldwide*, January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html

⁹ World Health Organization, *Facts on induced abortion worldwide*, January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html

¹⁰ G Sedgh et al, 'Induced abortion: incidence and trends worldwide from 1995 to 2008' (2012) 379 *The Lancet* 625.

¹¹ ABC News, A Simmons 'Rise of unsafe abortions 'deeply disturbing'', 19 January 2012 at <http://www.abc.net.au/news/2012-01-19/rise-of-unsafe-abortions-27deeply-disturbing27/3782702>

¹² This section is in part drawn from: R Sifris, 'The Legal and Factual Status of Abortion in Australia' (2013) 38(2) *Alternative Law Journal* 108.

It was not until recently when a company established by Marie Stopes International Australia applied to the Therapeutic Goods Administration (TGA) seeking registration of RU486, and seeking permission to sponsor the drug, that medical abortion became more widely available to Australian women. Finally, in August 2012, the TGA approved the Marie Stopes application and included Mifepristone on the Australian Register of Therapeutic Goods. This decision means that RU486 can be prescribed in Australia by registered medical practitioners in general, as opposed to only those who have been authorised to prescribe the drug through the Authorised Prescriber process. In June 2013, RU486 was included in the Pharmaceutical Benefits Scheme, enhancing its affordability.

The increasing acceptance of medical abortion amongst the medical and general community has meant that a growing number of General Practitioners are willing to prescribe the drugs and assist their patients through the process. This is particularly relevant in certain rural and remote areas of Queensland where there may be no provider of surgical abortion but where a General Practitioner may be willing to provide medical abortion services. Therefore, **we submit that when considering who should be permitted to perform or assist in performing terminations, reference be made to appropriately qualified practitioners with a view that different qualifications will be required for the administration of a medical as against a surgical abortion.**

Gestational limits and grounds

Abortion is available “on request” in a number of Australian jurisdictions: In Victoria up to 24 weeks gestation,¹³ in Western Australia up to 20 weeks gestation,¹⁴ in Tasmania up to 16 weeks gestation¹⁵ and in the Northern Territory up to 14 weeks gestation.¹⁶ Only the ACT imposes no gestational limit on 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.¹⁷ 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 and “abortion on request” is theoretically legally available with no gestational limit.

We urge Queensland to follow the example of the ACT and to refrain from imposing a gestational limit for “abortion on request”. Such an approach would enable abortion to be managed in the same way as any other medical procedure – with informed consent and professional willingness rather than period of gestation being the primary consideration. Period of gestation is in itself a somewhat arbitrary means of regulating access to abortion as ‘measures of gestational age are at best professional estimates, and are routinely off by one or two weeks, especially later in pregnancy.’¹⁸ In addition, many temporal restrictions on access to abortion which are ostensibly

¹³ *Abortion Law Reform Act 2008* (Vic) s 4.

¹⁴ *Health Act 1911* (WA) s 334.

¹⁵ *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4.

¹⁶ *Termination of Pregnancy Law Reform Act 2017* (NT).

¹⁷ See above discussion regarding the need to approach abortion as a health issue and not a criminal justice issue.

¹⁸ J N Erdman, ‘Theorizing Time in Abortion Law and Human Rights’ (2017) 19(1) *Health and Human Rights Journal* 29 at 32.

based on health and safety concerns for the woman are arbitrary and do not withstand an evidence-based approach.¹⁹

Further, when the law treats abortion differently to other medical procedures by imposing gestational limits and grounds, 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.²⁰ In general, it seems that stigmatisation gives rise to increased risk of numerous health problems, including depression, hypertension, coronary heart disease, and stroke.²¹ 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. It should be noted that such stigma and its negative health consequences attaches not only to patients but also to clinicians who participate in pregnancy terminations; thus Joanna Erdman notes that such clinicians may feel ‘professionally marginalized and socially isolated’.²²

We therefore believe that the Queensland legislature should follow the approach of the ACT and remove any gestational limit for “abortion on request”. At the very least, we recommend that Queensland bring its legislation in line with that of Victoria which imposes a gestational limit of 24 weeks for “abortion on request”.²³

Consultation by the medical practitioner

It is submitted that the decision to terminate a pregnancy should rest with the woman alone – it should be the woman’s decision and not that of her doctors. Therefore, a medical practitioner should not 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.

¹⁹ J N Erdman, ‘Theorizing Time in Abortion Law and Human Rights’ (2017) 19(1) *Health and Human Rights Journal* 29 at 34.

²⁰ B Major and R H Gramzow, ‘Abortion as Stigma: Cognitive and Emotional Implications of Concealment’ (1999) 77(4) *Journal of Personality and Social Psychology* 735. See also D A Grimes et al, ‘Unsafe Abortion: The Preventable Pandemic’ (2006) 368 *The Lancet* 1908, 1914 on the link between stigma related to abortion and negative health consequences.

²¹ B Major and L T O’Brien, ‘The Social Psychology of Stigma’ (2005) 56 *Annual Review of Psychology* 393.

²² J N Erdman, ‘Theorizing Time in Abortion Law and Human Rights’ (2017) 19(1) *Health and Human Rights Journal* 29 at 36.

²³ *Abortion Law Reform Act 2008* (Vic) s 4.

Consultation requirements create 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 a 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'.²⁴

Further, a requirement for consultation may exacerbate the challenges already faced by women who live in rural and remote areas. For such women, it may be difficult to find one doctor willing to assist with a termination of pregnancy; finding more than one doctor may prove practically impossible and therefore may pose a significant barrier to access.

Conscientious objection²⁵

In Tasmania, Victoria and the Northern Territory, doctors with a conscientious objection may refuse to participate in an abortion but the law imposes what has become known as an "obligation to refer" to a doctor without such a conscientious objection.²⁶ The one exception to the provisions allowing a doctor with a conscientious objection to refuse to participate in an abortion involves emergency circumstances.²⁷ This specific issue was propelled into the global spotlight in October 2012 when a 31-year-old dentist who was 17 weeks pregnant, sought treatment at a hospital in Ireland. Despite the fact that she was having a miscarriage and the foetus had no chance of survival, the hospital refused to terminate the pregnancy while a foetal heartbeat remained. By the time the abortion was eventually performed, days after she presented to the hospital, she had contracted septicaemia and died as a result.²⁸ This tragedy demonstrates that in the year 2012 it was possible for a woman to walk into a first-world hospital, in Western Europe no less, and be denied a potentially lifesaving abortion. It demonstrates the importance of abortion legislation containing a provision which

²⁴ S Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in J Bridgeman and S Millns (eds), *Law and Body Politics* (Dartmouth Publishing Company Limited, Hants, 1995) 105 at 119.

²⁵ This section is drawn from: R Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900.

²⁶ *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6-7; *Abortion Law Reform Act 2008* (Vic) s 8; *Termination of Pregnancy Law Reform Act 2017* (NT) s 11.

²⁷ See *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6 (where emergency includes threat to life or risk of serious physical injury); *Abortion Law Reform Act 2008* (Vic) s 8 (where emergency refers to threat to life); *Termination of Pregnancy Law Reform Act 2017* (NT) s 10 (where emergency refers to threat to life).

²⁸ D Dalby, 'Hospital Death in Ireland Renews Fight Over Abortion', *The New York Times* (14 November 2012), <http://www.nytimes.com/2012/11/15/world/europe/hospital-death-in-ireland-renews-fight-over-abortion.html>.

requires doctors to perform an abortion in an emergency situation.²⁹ **We submit that conscientious objection should not be permissible in an emergency situation.**

It is clear that many doctors who conscientiously object to abortions possess a sincere, deeply held belief in the immorality of abortion. In Australia, provision for doctors to conscientiously object to participating in an abortion has been relatively uncontroversial. The lion's share of the controversy that has arisen in connection with the issue of conscientious objection has stemmed from laws imposing what has become known as an "obligation to refer". This issue raises the question of how, in a democratic society, a doctor's right to conscientious objection should be balanced against a woman's: right to life; right to health; right to privacy and autonomy; right to equality and freedom from discrimination; and right to be free from torture or cruel, inhuman or degrading treatment or punishment. Here, we focus on a woman's right to health as this right is directly referential to a doctor's ethical obligation to prioritise a patient's health and wellbeing.³⁰

At one end of the spectrum is the view that the right of a patient to receive timely and effective health care should at all times be paramount. Those who support this view argue that the potential negative consequences for women of a doctor's conscientious objection to abortion render it impossible to balance the rights of doctor and patient; they argue that respect for a doctor's conscientious objection invariably results in an infringement of women's rights. This position is to some extent reflected in Sweden, for example, where conscientious objection to abortion is not permitted under law.³¹ Thus pursuant to this approach, the beliefs of individual doctors should never trump the health and wellbeing of people in need of a medical service.³² At the other end of the spectrum is the view that doctors should not only be allowed to refuse to provide abortion services or provide any information about abortion services, they should be allowed (or even required) to actively discourage women from terminating their pregnancies. This position is reflected in the laws of a number of jurisdictions in the United States. A key motivation behind these laws is to dissuade women from accessing abortion services.³³

In addition to the views occupying either end of the spectrum, there are also various positions that fall somewhere on the spectrum. One such position is the position that has been adopted in Tasmania, Victoria and the Northern Territory, that is, a doctor with a conscientious objection to abortion may refuse to participate in the procedure but must direct the patient to a practitioner without such a conscientious objection. While this position appears to go beyond the requirements of the Australian Medical Association's *Code of Ethics*,³⁴ it closely reflects the position adopted in a

²⁹ It should be acknowledged that there is often difficulty in determining with certainty whether in a given situation a woman's life is truly at risk. This means that in practice a doctor who opposes abortion may actually wait until it is too late and then claim that the obligation did not arise because it was not clear that the woman's life was at risk. See C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 14.

³⁰ For an analysis of restrictions on abortion as a violation of the right to health, see R Sifris, 'Restrictive Regulation of Abortion and the Right to Health' (2010) 18(2) *Medical Law Review*, 185.

³¹ See A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 91; A Heino et al, 'Conscientious Objection and Induced Abortion in Europe' (2013) 18 *European Journal of Contraception and Reproductive Health Care* 231.

³² C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 18.

³³ See, for example, Center for Reproductive Rights, *2012: A Look Back* (2013), http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/USLP_endofyear_Report_1.9.12.pdf.

³⁴ The *Code of Ethics*, as revised in 2016, states that: "If you refuse to provide or participate in some form of diagnosis or treatment based on a conscientious objection, inform the patient so that they may seek care

number of other countries³⁵ as well as other ethical codes and guidelines of the medical profession itself. For example, in its *Rights-Based Code of Ethics*, the International Federation of Gynecology and Obstetrics states that a doctor has a right to conscientious objection but that in such circumstances a patient has a right to be referred to a doctor without such a conscientious objection. The Code directs that members should:

[a]ssure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.³⁶

The World Medical Association's *Declaration on Therapeutic Abortion* also affirms the obligation to refer. It states that:

If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw, while ensuring the continuity of medical care by a qualified colleague.³⁷

Similarly, the World Health Organization has stipulated that:

Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health care facility, in accordance with national law.³⁸

Thus it seems that, despite the significant controversy which the obligation to refer has provoked in Australia, it is in fact a position that has been adopted by a number of respected organisations representing the health-care and medical community on a global scale. It seems that there is a widely adopted view within the health-care community that good medical care requires continuity of care. This sentiment is reflected at the local level in the *Code of Ethical Practice* of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which states that:

elsewhere. Do not use your conscientious objection to impede patients' access to medical treatments including in an emergency situation" See:

<https://ama.com.au/system/tdf/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016.pdf?file=1&type=node&id=46014>.

³⁵ See, for example, A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 107.

³⁶ International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003), http://www.who.int/sites/default/files/uploads/wg-publications/wsr/Rights-Based_Code_of_Ethics_October%202003%20-%20Copy%20-%20Copy.pdf.

³⁷ World Medical Association, *Declaration on Therapeutic Abortion, adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970 (amended by the 35th World Medical Assembly, Venice, Italy, October 1983; 57th WMA General Assembly, Pietersburg, South Africa, October 2006)*, <http://www.wma.net/en/30publications/10policies/a1/>.

³⁸ World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed, 2012) at 69.

[d]octors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if ... the therapy required is in conflict with the doctor's personal belief/value system.³⁹

Thus the imposition of an obligation to refer seems like a reasonable way to balance the rights of a doctor against the rights of a patient; it also seems to be an approach which is adopted by a number of key medical organisations both locally and globally. **We submit that Queensland should adopt an obligation to refer provision similar to that which exists in Victoria, Tasmania and the Northern Territory.**

The question nevertheless arises, what should be the approach in areas where the doctor with a conscientious objection is the only doctor within a reasonable geographical proximity of the patient, rendering the obligation to refer of little practical utility should a woman not be in a position to travel. For example, in rural and remote areas of Queensland it is conceivable that the doctor with the conscientious objection may be the only doctor in town (and there may not be a family planning clinic within a reasonable distance) thus giving rise to the possibility that there may in fact be no appropriate point of referral within a reasonable proximity of where a woman lives. We strongly urge the Law Reform Commission to give serious thought to this issue and to the plight of women who may have no point of access to services.

Protection of women and service providers and safe access zones

Legislation providing for safe access zones around clinics which provide abortion services has been introduced in four Australian jurisdictions, namely Tasmania, the Australian Capital Territory, Victoria and the Northern Territory.⁴⁰

The authors of this submission have conducted semi-structured, in depth interviews in both Victoria and Tasmania with people able to comment on the effects of anti-abortion protest and effectiveness of safe access zones. In Victoria, we interviewed the executive officer of a not-for profit organisation concerned with women's health and eleven staff working in medical clinics which provide abortion services. In Tasmania, we conducted seven interviews; interviewees included two obstetricians / gynaecologists and five people working in legal or policy areas of direct relevance to women's reproductive health. We intend to conduct additional interviews in the near future. **The general consensus among our interviewees is that anti-abortion protest is harmful to both patients and staff who work at clinics and that safe access zones go a long way towards helping combat this problem.**

Anti-abortion protesters frequently describe themselves as sidewalk counsellors seeking to render assistance to women.⁴¹ This characterisation differs markedly from what we heard from

³⁹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Code of Ethical Practice* (2006) at 6.

⁴⁰ See *Reproductive Health (Access to Terminations) Act 2013* (Tas), *Health (Patient Privacy) Amendment Act 2015* (ACT), *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic); *Termination of Pregnancy Law Reform Act 2017* (NT) Part 3.

⁴¹ Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017; Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) at 107.

interviewees who spoke of the protesters' unwelcome intrusions into the personal space of patients and staff. Examples of the conduct of anti-abortion protestors provided to us include:

- approaching, following or walking alongside people approaching clinic premises;
- dispensing brochures or plastic foetal dolls;
- displaying posters with distressing words or images, such as photographs of dismembered fetuses;
- castigating patients and staff as murderers;
- chasing, photographing, heckling, threatening and verbally abusing patients and staff;
- preventing patients from exiting their cars or obstructing clinic entrances.

Clinic staff spoke of pervasive concerns about the protesters' unpredictable behaviour. One interviewee perceived 'the physical threat' of harm as 'imminent'⁴² and expressed safety concerns about protesters purporting to be patients, as described here:

My biggest fear was they were going to send up a plant, and the plant would come and see me...and something would happen, or they would expose me, or target where I live, or target the kids. Because they'd done that with other doctors.... What am I going to do if ... I all of a sudden think shit, you're a plant, or you've got an ulterior motive. That was my number one fear. I don't care about being slandered or things like that. It was more a safety threat. Or that they would target my house, or my kids ...will there be any physical harm out of this? Are they going to target my car when I come to work?⁴³

Anti-abortion protests frequently have a negative impact on staff and patients entering and leaving clinics which provide abortion services. Such protests not only invade the privacy of women who are already in a vulnerable situation, they also undermine their health and well-being. For example, anti-abortion protests stigmatise abortion and the women seeking to terminate a pregnancy. In our interview with Susie Allanson, former clinical psychologist at the East Melbourne Fertility Control Clinic, we were told of the importance of a supportive environment for patient well-being and the deleterious impact of an unsupportive or discriminatory environment.⁴⁴ Similar views were expressed by a social worker, who told us that evidence-based research has consistently found that the impact of an abortion should not be traumatic, long lasting and negative but that there are risk factors which contribute to negative consequences and these include stigma, misinformation, shame and guilt, all of which are associated with the protesters' activities.⁴⁵ This risk is particularly high for women with a history of sexual or physical violence or other vulnerabilities.⁴⁶ Protest outside a clinic in Albury, New South Wales, one of the remaining jurisdictions without safe access zones, has reportedly been linked with teenage girls engaging in self-harm and attempted suicide.⁴⁷

⁴² Interview with a nurse practitioner and midwife working in reproductive health, 27 March 2017.

⁴³ Interview with a nurse practitioner and midwife working in reproductive health, 27 March 2017.

⁴⁴ Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017.

⁴⁵ Interview with a social worker, Melbourne, 20 March 2017.

⁴⁶ Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017.

⁴⁷ M Davey, 'Albury's only abortion clinic: protests "push women to point of self-harm"' 9 December 2014 *The Guardian* at <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide>

Our interviews reveal that, generally speaking, the safe access zones are achieving their objectives of protecting the right of patients and staff to privacy, facilitating safe access to health services without fear and reducing misinformation and stigma. This is particularly the case in Victoria where anti-abortion protest has historically been more of an issue than in Tasmania.⁴⁸ All Victorian interviewees took the view that the zones were operating to distance protesters from clinics and prevent them from targeting individuals. Protest action has accordingly been de-individualised; sending ‘a wonderful positive message ... that society won’t condone that sort of behaviour’ targeted at women accessing health services.⁴⁹ **Accordingly, we submit that Queensland should introduce safe access zone legislation which is modelled on the Victorian legislation. We would be happy to provide the Commission with further information about our research findings.**

Collection of data about terminations of pregnancy⁵⁰

In Australia, a lack of health data stymies the making of evidence-based clinical guidelines or health policies regarding elective abortion.⁵¹ There is no systematic collection of health data at a federal level or policy directive regarding abortion, as there is for blood borne diseases or cervical pap screening for example, where national level health directives are implemented at the state level using state level data analysed with a nationwide focus.⁵² Only two jurisdictions, South Australia and Western Australia, collect data on elective abortion systematically, reporting for about 18% of the population.⁵³

Abortion data can be useful as it is an indicator of women’s health at a population level. It informs public health planners about the effectiveness of sexuality education and the accessibility and acceptability of contraception coverage and potentially the fertility outcomes of a population.⁵⁴ This theme recurred during the recent Northern Territory abortion law reform process, where various stakeholders called for public health data in order to understand the magnitude of need, or indeed denounce that there was a need, for better access to health services.⁵⁵ The Northern Territory data was outdated and lacked the nuances sought by stakeholders for decision-making during the

⁴⁸ Interview with a social worker, Melbourne, 20 March 2017.

⁴⁹ Interview with a social worker, Melbourne, 20 March 2017.

⁵⁰ This section is drawn from: R Sifris and S Belton, ‘Australia: Abortion and Human Rights’ (2017) 19(1) *Health and Human Rights Journal* 209 at 215.

⁵¹ C M de Costa et al, ‘Abortion in Australia: still to emerge from the 19th century’ *The Lancet* (2010) 375, no. 9717 804-05.

⁵² A Chan and L C Sage, ‘Estimating Australia’s abortion rates 1985-2003’ (2005) *Medical Journal of Australia* 182(9) 447.

⁵³ M Hutchinson et al, ‘Induced abortions in Western Australia 2010-2012. 4th Report of the Western Australian abortion notification system’ (2013) *Statistical series number 96, edited by Western Australia Department of Health* at 72.

⁵⁴ Government of South Australia, ‘Pregnancy Outcome Statistics’ at <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics/pregnancy+outcome+statistics>.

⁵⁵ Northern Territory Government (2017) ‘Debates 21 March 2017 Termination of Pregnancy Law Reform Serial 15’, at <<https://parliament.nt.gov.au/parliamentary-business/hansard-debates-and-minutes-of-proceedings/draft-daily-hansard,-questions-and-minutes/DEBATES-DAY-4-21-MARCH-2017.pdf>>

legislative reform process.⁵⁶ The reformed law now has a provision which requires that abortions be reported to the chief health officer; this may go some way to the collection of relevant health data and the achievement of the right to the highest standard of health care.

The data and policy vacuum means that conservative forces can incite moral indignation with impunity. Australian experience with neo-conservatives during the 2000s exemplified this; certain politicians publicly suggested that there were too many abortions of convenience with the inevitable tropes against irresponsible and selfish women.⁵⁷ It is difficult to mount a rebuttal when the exact numbers are simply unknown and inferred through complex guessing. The *Sydney Morning Herald* reported, for example:

Deputy Prime Minister John Anderson says he agrees that too many abortions are carried out each year. "Many of us think that they (fetuses) are potential fellow Australians and that some people don't think through carefully enough their responsibilities before they fall pregnant, frankly."⁵⁸

As data is not collected systematically or analysed, a parliamentary research brief in 2005 was unable to enumerate an accurate incidence of elective abortion; it found an imperfect system of information collection and pointed to better ways to obtain information—none of which have been implemented.⁵⁹ **Therefore, we submit that Queensland should introduce mandatory reporting of anonymised data about terminations of pregnancy.**

⁵⁶ X Zhang et al *Trends in the health of mothers and babies, Northern Territory 1986-2005*, (Department of Health and Families, 2010).

⁵⁷ E Millar, "'Too many' anxious white nationalism and the biopolitics of Abortion' (2015) 30(83) *Australian Feminist Studies*, 82.

⁵⁸ Australian Associated Press, 'Church demands abortion enquiry' *The Sydney Morning Herald*, 1 November 2004.

⁵⁹ A Pratt et al, 'How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection' *Research Brief*, (Canberra, Parliament of Australia, 2005).