



## **Review of termination of pregnancy laws**

Report



**Queensland  
Law Reform Commission**

**Review of termination of pregnancy  
laws**

Report

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To: The Honourable Yvette D'Ath MP  
Attorney-General and Minister for Justice  
Leader of the House

In accordance with section 15 of the *Law Reform Commission Act 1968*, the Commission is pleased to present its Report, *Review of termination of pregnancy laws*.

[original signed]

[original signed]

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Chairperson**

**The Honourable Margaret Wilson QC  
Member**

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## Abbreviations and Glossary

<b>AMA</b>	Australian Medical Association
<b>AMA Queensland</b>	Australian Medical Association Queensland
<b>BAQ</b>	Bar Association of Queensland
<b>conscientious objection</b>	A conscientious objection is constituted by a refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner's personal beliefs, values or moral concerns.
<b>the CSCF</b>	The Clinical Services Capability Framework for Public and Licensed Private Health Facilities
<b>the draft Bill</b>	Termination of Pregnancy Bill 2018, contained in Appendix F.
<b>gestation</b>	This refers to the number of weeks progress during the pregnancy and the 'age' of the fetus. It is usually calculated from the first day of the woman's last menstrual period so that the average pregnancy reaches full term at 40 weeks. (In biological terms, it may be counted from the time of fertilisation, to give a full term gestation of 38 weeks, but this time is usually not known with certainty.)
<b>gestational limit</b>	In many jurisdictions, legislation restricts terminations of pregnancy after a certain number of weeks gestation. Gestational limits on the performance of terminations of pregnancy also sometimes operate as a matter of clinical practice.
<b>health practitioner</b>	Person registered under the Health Practitioner Regulation National Law to practise a health profession, other than as a student, including medical practitioners, nurses, midwives and pharmacists.  Also referred to as 'registered health practitioner'.
<b>MBA</b>	Medical Board of Australia
<b>medical practitioner</b>	Person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student. A medical practitioner is a type of 'health practitioner'.
<b>medical termination</b>	The use of pharmaceutical drugs to induce a termination of pregnancy, commonly by the combined use of the drugs mifepristone and misoprostol (which are available together as 'MS-2 Step').
<b>midwife</b>	Person registered under the Health Practitioner Regulation National Law to practise in the midwifery profession, other than as a student. A midwife is a type of 'health practitioner'.
<b>nurse</b>	Person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student. A nurse is a type of 'health practitioner'.

<b>the Parliamentary Committee</b>	<p>Except where otherwise specified, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, which considered the:</p> <ul style="list-style-type: none"> <li>• Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and aspects of the laws governing termination of pregnancy in Queensland (the 'first Bill' and 'Inquiry'); and</li> <li>• Health (Abortion Law Reform) Amendment Bill 2016 (the 'second Bill').</li> </ul>
<b>Parliamentary Committee Report No 24 (2016)</b>	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland</i> (2016)
<b>Parliamentary Committee Report No 33a (2017)</b>	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Health (Abortion Law Reform) Amendment Bill 2016</i> (2017)
<b>pharmacist</b>	Person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession, other than as a student. A pharmacist is a type of 'health practitioner'.
<b>Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014)</b>	Queensland Government, <i>Maternity and Neonatal Clinical Guideline: Perinatal Care at the Threshold of Viability</i> (2014) < <a href="https://www.health.qld.gov.au/qcg/publications#neonatal">https://www.health.qld.gov.au/qcg/publications#neonatal</a> >
<b>Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018)</b>	Queensland Government, <i>Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy</i> (updated 2018) < <a href="https://www.health.qld.gov.au/qcg/publications#maternity">https://www.health.qld.gov.au/qcg/publications#maternity</a> >  Also referred to as 'the clinical guideline'.
<b>QLRC Consultation Paper No 76 (2017)</b>	Queensland Law Reform Commission, Review of termination of pregnancy laws, Consultation Paper, WP No 76 (December 2017)
<b>QLS</b>	Queensland Law Society
<b>RANZCOG</b>	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
<b>safe access zone</b>	A defined area around premises where termination of pregnancy services are provided, in which certain behaviour is prohibited.
<b>surgical termination</b>	Procedure by which the contents of a woman's uterus are surgically removed to terminate a pregnancy, commonly by means of dilation and curettage.

<b>termination of pregnancy (or termination)</b>	Deliberately induced miscarriage (in contrast with a spontaneous miscarriage) by medical or surgical means. Termination is also commonly referred to as 'abortion', including in the context of international human rights.
<b>termination services premises</b>	Premises at which a service of performing terminations on women is provided.
<b>viability</b>	The time at which a fetus, if born prematurely, is said to be capable of existing independently.
<b>VLRC Report (2008)</b>	Victorian Law Reform Commission, <i>Law of Abortion</i> , Report No 15 (2008)
<b>WHO</b>	World Health Organization

\* *Except where otherwise indicated, references to legislation in this Report are references to Queensland legislation.*

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# Executive Summary

## TERMINATION LAWS IN QUEENSLAND

[1] The current law under which terminations are regulated in Queensland — as contained in sections 224, 225 and 226 of the Criminal Code — makes it a crime to ‘unlawfully’ terminate a woman’s pregnancy except in limited circumstances.

[2] The Queensland courts, in interpreting these sections, have adopted a ruling based on decisions in other jurisdictions that a termination by a medical practitioner, with the consent of the woman, is ‘lawful’ if it is necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail, and in the circumstances not out of proportion to the danger to be averted. This has become known as the ‘Menhennitt ruling’.<sup>1</sup>

## TERMS OF REFERENCE

[3] The Commission was asked to conduct a review and investigation into modernising Queensland’s laws relating to the termination of pregnancy.

[4] The Commission’s terms of reference take as their starting point that Queensland should amend its laws to remove terminations that are performed by duly registered medical practitioners (‘medical practitioners’)<sup>2</sup> from sections 224, 225 and 226 of the Criminal Code and to otherwise modernise and clarify the law in relation to terminations.<sup>3</sup> They also require the Commission to make recommendations, and prepare draft legislation based on those recommendations, to achieve those aims.<sup>4</sup>

## CONSULTATION

[5] The Commission consulted widely on this review. It released a detailed consultation paper outlining the relevant legal issues in the review, and seeking submissions on a number of specific questions. The Commission received nearly 1200 submissions.

[6] In accordance with the terms of reference, the Commission also considered the submissions made to the Queensland Parliament’s Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the ‘Parliamentary Committee’) during its consideration of two private members’ Bills, the transcripts of the evidence given to the Parliamentary Committee during its public hearings, and the Parliamentary Committee’s two reports.<sup>5</sup>

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1 See the discussion of the ‘Current law in Queensland’ in Chapter 2.

2 See ‘medical practitioner’ in the Abbreviations and Glossary.

3 See terms of reference, 2 and paras 1, 2 in Appendix A.

4 See terms of reference, 3 in Appendix A.

5 See terms of reference, para D in Appendix A.

## METHODS FOR TERMINATING A PREGNANCY<sup>6</sup>

[7] A termination may be performed as a medical termination or a surgical termination. A ‘medical termination’ refers to the use of pharmaceutical drugs to induce a termination. A ‘surgical termination’ refers to a procedure during which the contents of a woman’s uterus are surgically removed to terminate a pregnancy.

[8] The choice of procedure depends on the gestation of the pregnancy, clinical indications including the risk of complications, the preferences of the woman and other relevant circumstances.

## INCIDENCE OF TERMINATIONS<sup>7</sup>

[9] Between 10 000 and 14 000 terminations are performed in Queensland each year, with most performed in the first trimester of pregnancy. Later terminations are comparatively rare.

## OVERVIEW OF THE TERMINATION OF PREGNANCY BILL 2018

[10] The draft Termination of Pregnancy Bill 2018 (the ‘draft Bill’)<sup>8</sup> implements the Commission’s recommendations. It provides that:

- sections 224 to 226 of the Criminal Code (the current criminal offences relating to termination) are repealed;<sup>9</sup>
- it is an offence for an ‘unqualified person’ to perform, or assist in the performance of, a termination, with a recommended maximum penalty of seven years imprisonment;<sup>10</sup>
- a woman who consents to, assists in, or performs a termination on herself does not commit an offence;<sup>11</sup>
- (as a matter of civil law) a medical practitioner may perform a lawful termination:
  - on request up to the gestational limit of 22 weeks;<sup>12</sup>

<sup>6</sup> See the discussion of ‘Methods for terminating a pregnancy’ in Chapter 2.

<sup>7</sup> See the discussion of the ‘Incidence of terminations’ in Chapter 2.

<sup>8</sup> See Appendix F.

<sup>9</sup> See Rec 1-1 and Termination of Pregnancy Bill 2018 cl 18.

<sup>10</sup> See Recs 3-8 to 3-10 and Termination of Pregnancy Bill 2018 cl 21. For the purposes of the new offence, an ‘unqualified person’ means:

- in relation to performing a termination — a person who is not a medical practitioner; and
- in relation to assisting in the performance of a termination — a person who is not a medical practitioner or a nurse, midwife or authorised pharmacist providing the assistance in the practice of their respective profession.

<sup>11</sup> See Rec 3-7 and Termination of Pregnancy Bill 2018 cl 9.

<sup>12</sup> See Rec 3-1 and Termination of Pregnancy Bill 2018 cl 4.

- after 22 weeks, if the medical practitioner:<sup>13</sup>
  - considers that, in all the circumstances, a termination should be performed having regard to:
    - all relevant medical circumstances;
    - the woman’s current and future physical, psychological and social circumstances; and
    - the professional standards and guidelines applicable to the medical practitioner in the performance of terminations;
  - and has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed;
- after 22 weeks in emergency circumstances;<sup>14</sup>
- a medical practitioner may be assisted in the performance of a termination by certain health practitioners acting in the practice of their health profession;<sup>15</sup>
- a registered health practitioner is required to inform a woman of any conscientious objection<sup>16</sup> to performing or advising about a termination and refer the woman, or transfer her care, to either:<sup>17</sup>
  - another health practitioner who can perform the termination and does not have a conscientious objection; or
  - a health service provider at which the termination can be provided by another health practitioner who does not have a conscientious objection to the termination;
- a failure by a registered health practitioner to comply with the requirements for a lawful termination, or the requirements if a conscientious objection is held, should be subject to the same professional consequences as those that apply in relation to other medical procedures, but no specific penalty should apply;<sup>18</sup>
- a safe access zone of 150 metres (or as varied by the Minister to extend or reduce the zone)<sup>19</sup> is established around premises at which a service of

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<sup>13</sup> See Recs 3-2 to 3-3 and Termination of Pregnancy Bill 2018 cl 5(1), (2).

<sup>14</sup> See Rec 3-4 and Termination of Pregnancy Bill 2018 cl 5(3).

<sup>15</sup> See Rec 3-5 and Termination of Pregnancy Bill 2018 cl 6.

<sup>16</sup> A conscientious objection does not limit any duty of a registered health practitioner to perform or assist in performing a termination in an emergency. See Rec 4-2 and Termination of Pregnancy Bill 2018 cl 7(4).

<sup>17</sup> See Rec 4-1 and Termination of Pregnancy Bill 2018 cl 7(1)–(3).

<sup>18</sup> See Rec 3-6 and 4-3 and Termination of Pregnancy Bill 2018 cl 8.

<sup>19</sup> See Rec 5-3 and Termination of Pregnancy Bill 2018 cl 12.

providing terminations is ordinarily provided ('termination services premises')<sup>20</sup> to protect the safety and well-being, and to respect the privacy and dignity of persons accessing services provided at those premises and employees and other persons who need to access the premises in the course of their duties or responsibilities;<sup>21</sup>

- it is an offence to:
  - engage in 'prohibited conduct' in a 'safe access zone' for termination services premises.<sup>22</sup> ('Prohibited conduct' is defined to mean conduct that relates to terminations, or could reasonably be perceived as relating to terminations, that would be visible or audible to another person in, or entering or leaving, the termination services premises, and that would be reasonably likely to deter a person from entering or leaving, or requesting or undergoing, or performing or assisting in the performance of a termination at the premises);<sup>23</sup> or
  - make, publish or distribute a 'restricted recording' without the other person's consent and without reasonable excuse.<sup>24</sup> (A 'restricted recording' is defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises, and that contains information that identifies, or is likely to lead to the identification of, the person.)<sup>25</sup>
- consequential amendments to the Criminal Code, consistently with the other provisions of the draft Bill, are to be made, by amending:
  - section 282 [Defence of 'Surgical operations and medical treatment'];<sup>26</sup> and
  - section 313 [Offence of 'Killing unborn child'] to provide that a person does not commit an offence against section 313(1) by performing, or assisting in the performance, of a termination under the draft Bill;<sup>27</sup> and
- consequential amendments to other Queensland laws of a minor nature are to be made.<sup>28</sup>

[11] The draft Bill is not intended to affect the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity,

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<sup>20</sup> See Rec 5-2 and Termination of Pregnancy Bill 2018 cl 11.

<sup>21</sup> See Rec 5-1 and Termination of Pregnancy Bill 2018 cl 10.

<sup>22</sup> See Termination of Pregnancy Bill 2018 cl 13(1)–(3).

<sup>23</sup> See Recs 5-4 and 5-6 and Termination of Pregnancy Bill 2018 cl 13(1).

<sup>24</sup> See Recs 5-5 to 5-6 and Termination of Pregnancy Bill 2018 cl 14(2)–(4).

<sup>25</sup> See Termination of Pregnancy Bill 2018 cl 14(1).

<sup>26</sup> See Recs 6-1 to 6-3 and Termination of Pregnancy Bill 2018 cl 19.

<sup>27</sup> See Rec 6-4 and Termination of Pregnancy Bill 2018 cl 20.

<sup>28</sup> See Recs 5-7 and 6-5 to 6-6 and Termination of Pregnancy Bill 2018 cll 22–25.

consent to medical treatment for minors or the regulation of health practitioners, public hospitals and health services and licensed private health facilities.

## KEY PRINCIPLES GUIDING THE COMMISSION'S RECOMMENDATIONS

[12] In developing its recommendations for the draft Bill, the Commission has been guided by a number of key principles, including the following:

- Generally, termination should be treated as a health issue rather than as a criminal matter;
- Women's autonomy and health (including access to safe medical procedures) should be promoted, recognising that:
  - at the earlier stages of pregnancy, a woman's autonomy has greatest weight, and termination is lower risk and safe for the woman;
  - at the later stages of pregnancy, the interests of the fetus have increasing weight, and termination involves higher risk for the woman and creates more complex issues;
- The law should align with international human rights obligations relevant to termination of pregnancy laws, including enabling reasonable and safe access to termination services;
- The law should be consistent with contemporary clinical practice and health regulation; and
- The law should achieve reasonable consistency with other Australian jurisdictions that have modernised their laws relating to termination.<sup>29</sup>

## LAWFUL TERMINATIONS AND GESTATIONAL LIMIT<sup>30</sup>

[13] The Commission considered a range of different approaches and models, and gestational limits and grounds in recommending an appropriate model for lawful terminations.

[14] The Commission settled upon a combined approach of a gestational limit of 22 weeks and a single broad additional ground to be satisfied after that time.

[15] A gestational limit of 22 weeks:

- represents the stage immediately before the 'threshold of viability' under current clinical practice;
- aligns with the Queensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities (the 'CSCF') pursuant to which

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<sup>29</sup> See Appendix E, which provides a brief comparative guide to the provisions the Commission recommends in this Report, reflected in the draft Termination of Pregnancy Bill 2018, and the legislative requirements in other jurisdictions.

<sup>30</sup> See the discussion of 'Gestational limits, grounds and consultation' in Chapter 3.

terminations from 22 weeks gestation are required to be performed at particular hospitals;

- aligns with the local facility level approval process adopted at the Royal Brisbane and Women's Hospital; and
- reflects that terminations after 22 weeks involve greater complexity and higher risk to the woman.

# List of Recommendations

## CHAPTER 1: INTRODUCTION

- 1-1** Sections 224, 225 and 226 of the Criminal Code should be repealed.  
[See *Termination of Pregnancy Bill 2018 cl 18*]
- 1-2** New legislation in the form of the draft Termination of Pregnancy Bill 2018 should be introduced.

## CHAPTER 3: LAWFUL TERMINATIONS

### Lawful terminations

- 3-1** The Termination of Pregnancy Bill should provide that a medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant.<sup>1</sup>  
[See *Termination of Pregnancy Bill 2018 cl 4*]
- 3-2** The Termination of Pregnancy Bill should provide that a medical practitioner may perform a termination on a woman who is more than 22 weeks pregnant if the medical practitioner:
- (a) considers that, in all the circumstances, the termination should be performed; and
  - (b) has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed.
- [See *Termination of Pregnancy Bill 2018 cl 5(1)*]
- 3-3** The Termination of Pregnancy Bill should provide that, in considering whether the termination should, in all the circumstances, be performed, a medical practitioner must have regard to:

<sup>1</sup>

'Medical practitioner' means 'a person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student': *Acts Interpretation Act 1954* (Qld). See also Termination of Pregnancy Bill 2018 sch 1 (definitions of 'termination' and 'woman').

- (a) all relevant medical circumstances;
- (b) the woman's current and future physical, psychological and social circumstances; and
- (c) the professional standards and guidelines that apply to the medical practitioner in the performance of the termination.

[See *Termination of Pregnancy Bill 2018 cl 5(2)*]

- 3-4** The Termination of Pregnancy Bill should provide that a medical practitioner may, in an emergency, perform a termination on a woman who is more than 22 weeks pregnant if the medical practitioner considers it is necessary to perform the termination to save the woman's life or the life of another unborn child.

[See *Termination of Pregnancy Bill 2018 cl 5(3)*]

**Registered health practitioners who may assist**

- 3-5** The Termination of Pregnancy Bill should provide that:

- (a) A medical practitioner may assist another medical practitioner to perform a termination;
- (b) A nurse, midwife or pharmacist may, in the practice of his or her health profession, assist in the performance of a termination by a medical practitioner;<sup>2</sup>
- (c) However, the provisions in paragraphs (a) and (b) do not apply to a termination that the assisting medical practitioner, nurse, midwife or pharmacist knows, or ought reasonably to know, is not being performed under the provisions in Recommendations 3-1 to 3-4 above.
- (d) A reference in Recommendation 3-5(b) above to assisting in the performance of a termination by a medical practitioner includes dispensing, supplying or administering a termination drug on the medical practitioner's instruction.<sup>3</sup>

[See *Termination of Pregnancy Bill 2018 cl 6*]

<sup>2</sup> See also Termination of Pregnancy Bill 2018 sch 1 (definitions of 'midwife', 'nurse', 'pharmacist').

<sup>3</sup> A 'termination drug' means 'a drug of a kind used to cause a termination': Termination of Pregnancy Bill 2018 sch 1 (definition of 'termination drug').

### **Consequences of non-compliance**

- 3-6** The Termination of Pregnancy Bill should provide that, in deciding an issue under an Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner performs a termination, or assists another practitioner to perform a termination, other than as authorised.

[See *Termination of Pregnancy Bill 2018 cl 8(a)–(b)*]

### **Woman does not commit an offence**

- 3-7** The Termination of Pregnancy Bill should provide that, despite any other Act, a woman who consents to, assists in or performs a termination on herself does not commit an offence.

[See *Termination of Pregnancy Bill 2018 cl 9*]

### **Terminations performed by an unqualified person**

- 3-8** The Criminal Code should be amended to provide that:

- (a) an unqualified person who performs a termination commits a crime; and
- (b) an unqualified person who assists in the performance of a termination commits a crime.<sup>4</sup>

[See *Termination of Pregnancy Bill 2018 cl 21(1)–(3)*]

- 3-9** For the purposes of the new offence in Recommendation 3-8 above:

- (a) an 'unqualified person' should be defined to mean:
  - (i) in relation to performing a termination, a person who is not a medical practitioner; or
  - (ii) in relation to assisting in the performance of a termination, a person who is not a medical practitioner or a nurse, midwife or pharmacist providing the assistance in the practice of his or her health profession.

<sup>4</sup> A reference to an unqualified person assisting in the performance of a termination includes:

- supplying, or procuring the supply of, a termination drug for use in a termination; and
- administering a termination drug.

See *Termination of Pregnancy Bill 2018 cl 21* inserting new s 319A(3).

- (b) The definitions of ‘pharmacist’, ‘midwife’, ‘nurse’, ‘termination’, ‘termination drug’, and ‘woman’ should be consistent with the definitions that apply under the provisions for lawful terminations in Recommendations 3-1 to 3-5 above.

[See *Termination of Pregnancy Bill 2018 cl 21(4)*]

- 3-10 The maximum penalty for the provision in Recommendation 3-8 above should be seven years imprisonment.

[See *Termination of Pregnancy Bill 2018 cl 21(1)–(2)*]

#### CHAPTER 4: CONSCIENTIOUS OBJECTION

- 4-1 The Termination of Pregnancy Bill should provide that:

- (a) a registered health practitioner who:
- (i) is asked by a person to:
    - (A) perform a termination on a woman; or
    - (B) assist in the performance of a termination on a woman; or
    - (C) make a decision in accordance with the provision in Recommendation 3-2 above whether a termination should be performed on a woman; or
    - (D) advise the person about the performance of a termination on a woman; and
  - (ii) has a conscientious objection to the performance of the termination;
- (b) is required to:
- (i) disclose their conscientious objection to the person; and
  - (ii) if the request was made by a woman for the practitioner to perform a termination on the woman, or to advise the woman about the performance of a termination on her, refer the woman, or transfer her care, to:

- (A) another registered health practitioner who, in the first practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of the termination; or
- (B) a health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.

[See *Termination of Pregnancy Bill 2018 cl 7(1)–(3)*]

- 4-2 The Termination of Pregnancy Bill should provide that the provision in Recommendation 4-1 above does not limit any duty owed by a registered health practitioner to provide a service in an emergency.

[See *Termination of Pregnancy Bill 2018 cl 7(4)*]

- 4-3 The Termination of Pregnancy Bill should provide that, in deciding an issue under an Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner contravenes the provisions in Recommendations 4-1 or 4-2 above.

[See *Termination of Pregnancy Bill 2018 cl 8(c)*]

## CHAPTER 5: SAFE ACCESS ZONES

- 5-1 The Termination of Pregnancy Bill should include safe access zone provisions and provide that the purpose of these provisions is to protect the safety and well-being, and respect the privacy and dignity of, people accessing the services provided at termination services premises and employees or other persons who need to access those premises in the course of their duties or responsibilities.

[See *Termination of Pregnancy Bill 2018 cl 10*]

**5-2 The Termination of Pregnancy Bill should provide that a place is in the safe access zone for premises at which a service of performing terminations is ordinarily provided ('termination services premises'),<sup>5</sup> if it is in the premises or not more than the prescribed distance from an entrance to the premises.**

*[See Termination of Pregnancy Bill 2018 cl 11, 12(1)]*

**5-3 The Termination of Pregnancy Bill should provide that the prescribed distance is 150 metres, unless otherwise prescribed by the Minister by regulation.<sup>6</sup>**

*[See Termination of Pregnancy Bill 2018 cl 12(2)–(4)]*

**5-4 The Termination of Pregnancy Bill should provide that it is an offence to engage in prohibited conduct in the safe access zone for termination services premises. 'Prohibited conduct' should be defined to mean conduct that: relates to terminations, or could reasonably be perceived as relating to terminations; would be visible or audible to another person in, or entering or leaving, the premises; and would be reasonably likely to deter a person from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, a termination.<sup>7</sup>**

*[See Termination of Pregnancy Bill 2018 cl 13]*

<sup>5</sup> However, 'termination services premises' should not include a pharmacy: see Termination of Pregnancy Bill 2018 cl 11(b). The draft Bill defines 'pharmacy' to mean 'premises in which a pharmacy business within the meaning of the *Pharmacy Business Ownership Act 2001* is carried on': Termination of Pregnancy Bill 2018 sch 1 (definition of 'pharmacy'). 'Pharmacy business' is defined in that Act to mean 'a business providing pharmacy services', but does not include 'a business operated by the State at a public sector hospital' or 'another business at a hospital that provides pharmacy services only to patients at the hospital': *Pharmacy Business Ownership Act 2001* (Qld) sch (definition of 'pharmacy business').

<sup>6</sup> The Minister may recommend to the Governor in Council the making of the regulation only if satisfied that, having regard to the location of the premises, a prescribed distance of 150 metres is insufficient, or greater than is necessary, to achieve the purposes of the safe access zone provisions, in relation to the premises: Termination of Pregnancy Bill 2018 cl 12(4).

<sup>7</sup> A person's conduct may be prohibited conduct whether or not another person sees or hears the conduct or is deterred from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, a termination: Termination of Pregnancy Bill 2018 cl 13(2). However, this offence should not apply to a person employed to provide a service at the termination services premises: Termination of Pregnancy Bill 2018 cl 13(4).

**5-5** The Termination of Pregnancy Bill should provide that it is an offence for a person to make, publish or distribute a restricted recording of another person without the other person's consent and without reasonable excuse. A 'restricted recording' should be defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises, and that contains information that identifies, or is likely to lead to the identification of, the person.

[See *Termination of Pregnancy Bill 2018 cl 14*]

**5-6** The Termination of Pregnancy Bill should prescribe a maximum penalty of 20 penalty units or 1 year's imprisonment for each of the offences in Recommendation 5-4 and 5-5 above.

[See *Termination of Pregnancy Bill 2018 cl 13(3) and 14(2), (3)*]

**5-7** The Termination of Pregnancy Bill should amend section 30 of the *Police Powers and Responsibilities Act 2000*, by including the offences in Recommendation 5-4 and 5-5 above as one of the categories of prescribed circumstances in which a police officer may search a person without a warrant.

[See *Termination of Pregnancy Bill 2018 cl 25*]

## CHAPTER 6: OTHER ISSUES

### Consequential amendments to section 282 of the Criminal Code

**6-1** Section 282(1)(a) of the Criminal Code should be omitted and replaced with a new subsection (1) to provide that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child if performing the surgical operation or providing the medical treatment is reasonable, having regard to all the circumstances of the case.

[See *Termination of Pregnancy Bill 2018 cl 19(1)*]

**6-2** Section 282(1)(b) of the Criminal Code should be omitted and replaced with a new subsection (1A) to provide that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child in an emergency if it is necessary to perform the operation or provide the treatment to save the mother's life or the life of another unborn child.

[See *Termination of Pregnancy Bill 2018 cl 19(1)*]

**6-3** The definitions of 'medical treatment', 'surgical operation' and 'patient' in section 282(4) of the Criminal Code should be omitted and the following new definitions inserted to provide that:

(a) 'medical treatment', for subsection (1), does not include medical treatment carried out by an unqualified person that is intended to adversely affect an unborn child;

(b) 'surgical operation', for subsection (1), does not include a surgical operation performed by an unqualified person that is intended to adversely affect an unborn child; and

(c) 'unqualified person' has the same meaning as in the provision in Recommendation 3-9 above.

[See *Termination of Pregnancy Bill 2018 cl 19(2)–(3)*]

#### **Consequential amendments to section 313 of the Criminal Code**

**6-4** Section 313 of the Criminal Code should be amended to provide that 'a person does not commit an offence against section 313(1) by performing a termination, or assisting in the performance of a termination, under the *Termination of Pregnancy Act 2018*'.

[See *Termination of Pregnancy Bill 2018 cl 20*]

#### **Consequential amendments to other Acts**

**6-5** Section 71(1) of the *Guardianship and Administration Act 2000* should be amended to omit the words 'the termination is necessary to preserve the adult from serious danger to her life or physical or mental health' and to insert the words 'the termination may be performed by a medical practitioner under the *Termination of Pregnancy Act 2018*'.

[See *Termination of Pregnancy Bill 2018 cll 22–23*]

**6-6** Consequential amendments to the provisions of other Queensland laws should be made where necessary and desirable in light of the repeal of sections 224, 225 and 226 of the Criminal Code in Recommendation 1-1 above and the introduction of the new offence in Recommendation 3-8 above.

# Chapter 1

## Introduction

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### BACKGROUND

1.1 In Queensland, the Criminal Code prohibits unlawfully attempting to procure an abortion (a ‘termination’). The relevant offences are found in sections 224, 225 and 226.<sup>1</sup>

1.2 On 10 May 2016, Mr Robert Pyne MP, the then Member for Cairns, introduced a Private Member’s Bill — the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016 (the ‘first Bill’) — into Parliament. The first Bill proposed to remove the crime of abortion from Queensland law by repealing sections 224, 225 and 226 of the Criminal Code.

1.3 The first Bill was referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the ‘Parliamentary Committee’) for detailed consideration.<sup>2</sup> Concurrently, the Parliamentary Committee was also asked to conduct a broader inquiry into options for the reform of Queensland’s laws relating to termination (the ‘Inquiry’).<sup>3</sup> The Parliamentary Committee’s report on the first Bill and Inquiry, which was tabled on 26 August 2016, made one recommendation — that the Bill not be passed.<sup>4</sup>

1.4 On 17 August 2016, Mr Pyne MP introduced a second Private Member’s Bill — the Health (Abortion Law Reform) Amendment Bill 2016 (the ‘second Bill’) —

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<sup>1</sup> Sections 224 to 226 are set out at [2.5] below.

<sup>2</sup> Queensland, *Parliamentary Debates*, Legislative Assembly, 10 May 2016, 1526–8 (R Pyne).

<sup>3</sup> Parliamentary Committee Report No 24 (2016) [1.2].

<sup>4</sup> Parliamentary Committee Report No 24 (2016) Rec 1. The Report and other information relating to the Committee’s consideration of the first Bill and Inquiry (including transcripts of evidence and submissions) are available at <<http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/AbortionLR-WRC-AB2016>>.

into Parliament. The second Bill, which sought to amend the *Health Act 1937* to 'improve clarity for health professionals and patients in the area of medical termination of pregnancy',<sup>5</sup> was referred to the Parliamentary Committee for examination.<sup>6</sup> The Parliamentary Committee's report on the second Bill was tabled on 17 February 2017.<sup>7</sup> The Committee did not reach agreement on whether to recommend that the Bill be passed.

1.5 As part of its consultation process for the first and second Bills and the Inquiry, the Parliamentary Committee held numerous public hearings and received more than 2600 submissions.<sup>8</sup>

1.6 On 28 February 2017, both Bills were withdrawn from Parliament on the motion of Mr Pyne MP.<sup>9</sup> On the same day, the Government announced that it would refer the current laws in relation to termination to the Queensland Law Reform Commission.<sup>10</sup>

## TERMS OF REFERENCE

1.7 On 19 June 2017, the Commission received terms of reference from the then Attorney-General and Minister for Justice and Minister for Training and Skills to conduct a 'review and investigation' into 'modernising Queensland's laws relating to the termination of pregnancy'.<sup>11</sup>

1.8 Specifically, the terms of reference ask the Commission to recommend 'how Queensland should amend its laws relating to the termination of pregnancy to':

<sup>5</sup> Queensland, *Parliamentary Debates*, Legislative Assembly, 17 August 2016, 2892 (R Pyne). The second Bill proposed amendments to the *Health Act 1937* (Qld) in relation to matters such as who may perform a termination, the requirements for terminations after 24 weeks gestation, the circumstances in which a person may refuse to perform a termination, and protections for patients attending facilities at which terminations are performed.

<sup>6</sup> Queensland, *Parliamentary Debates*, Legislative Assembly, 17 August 2016, 2892–3 (R Pyne).

<sup>7</sup> Parliamentary Committee Report No 33a (2107). This report updated Report No 33 to incorporate an erratum tabled by the Committee on 24 February 2017. The Report and other information relating to the Committee's consideration of the second Bill (including transcripts of evidence and submissions) are available at <<http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/18-HealthAbortion>>.

<sup>8</sup> Parliamentary Committee Report No 24 (2016) [1.3]; Parliamentary Committee Report No 33a (2017) [1.2]. In its report on the first Bill and Inquiry, the Committee noted that many submitters 'addressed only whether or not they supported the [Bill], rather than the broader terms of reference': Parliamentary Committee Report No 24 (2016) [1.3.1].

<sup>9</sup> Queensland, *Parliamentary Debates*, Legislative Assembly, 28 February 2017, 282 (R Pyne).

<sup>10</sup> Premier and Minister for the Arts, the Hon Anastacia Palaszczuk MP, Deputy Premier, Minister for Transport and Minister for Infrastructure and Planning, the Hon Jackie Trad MP, and Attorney-General and Minister for Justice and Minister for Training and Skills, the Hon Yvette D'Ath MP, 'Queensland Law Reform Commission to examine termination of pregnancy laws' (Ministerial Media Statement, 28 February 2017) <<http://statements.qld.gov.au/Statement/2017/2/28/queensland-law-reform-commission-to-examine-termination-of-pregnancy-laws>>.

The media statement announced that the Government had been advised that the first and second Bills would be withdrawn, and that the Commission's recommendations would be 'the basis for legislation the Government will introduce to Parliament ... [i]n the next term of Government'.

<sup>11</sup> See terms of reference, 2.

1. Remove terminations of pregnancy that are performed by a duly registered medical practitioner(s) from the Criminal Code sections 224 (Attempts to procure abortion), 225 (The like by women with child), and 226 (Supplying drugs or instruments to procure abortion).
2. Provide clarity in the law in relation to terminations of pregnancy in Queensland.

1.9 The Commission is required to provide its final report, with draft legislation based on its recommendations, by 30 June 2018.

## CONSULTATION PAPER

1.10 In December 2017, the Commission released a Consultation Paper outlining the relevant legal issues in the review, and seeking submissions on a number of specific questions.<sup>12</sup>

1.11 A media statement to publicise the release of the Consultation Paper and call for submissions was issued to the print and electronic media on 21 December 2017.

1.12 An advertisement calling for submissions in response to the Consultation Paper was placed in *The Weekend Australian* and *The Courier Mail* newspapers and in 12 Queensland regional newspapers on Saturday 23 December 2017.<sup>13</sup>

1.13 Notices calling for submissions were also placed on the Commission's website,<sup>14</sup> on the Queensland Government 'qld.gov.au' website and 'Get Involved' website.<sup>15</sup> A notice was also published in the QLS Update (an electronic newsletter of the Queensland Law Society) on 24 January 2018.

1.14 The closing date for submissions was 13 February 2018.

## SUBMISSIONS

1.15 The Commission received and considered nearly 1200 submissions,<sup>16</sup> many of which provided views in response to the specific questions raised by the Commission in its Consultation Paper.

1.16 In accordance with the terms of reference,<sup>17</sup> the Commission has considered the submissions made during the Parliamentary Committee's consideration of the first and second Bills.<sup>18</sup> The Commission has also had regard to

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<sup>12</sup> QLRC Consultation Paper No 76 (2017).

<sup>13</sup> Namely, the Bundaberg News Mail, Cairns Post, Fraser Coast Chronicle, Gladstone Observer, Gold Coast Bulletin, Gympie Times, Queensland Times, Daily Mercury, Rockhampton Bulletin, Sunshine Coast Daily, Toowoomba Chronicle and Townsville Bulletin. The Notice appeared in the Central Queensland News on 12 January 2018 and the North West Star on 13 January 2018.

<sup>14</sup> On 21 December 2017.

<sup>15</sup> On 22 December 2017.

<sup>16</sup> This total includes a single bundle of 278 proforma submissions signed by different respondents.

<sup>17</sup> See terms of reference, para D in Appendix A.

<sup>18</sup> See nn 4, 7 above.

the Parliamentary Committee's two reports and the transcripts of the evidence given to the Parliamentary Committee during its public hearings.

1.17 The submissions raised a large number of issues and reflected a wide range of views. Not all of the matters raised are within the scope of the Commission's terms of reference<sup>19</sup>

1.18 A list of respondents to the Commission's review is set out in Appendix B.

1.19 The Commission would like to thank all those organisations and individuals who participated in the review for their contributions. As well as providing views on the issues raised, a number of consultees provided relevant factual information and data which have greatly assisted the Commission in this review.

## THE DEVELOPMENT OF THE DRAFT BILL

### The terms of reference

1.20 The Commission's terms of reference take as their starting point that Queensland should amend its laws to remove terminations that are performed by duly registered medical practitioners ('medical practitioners')<sup>20</sup> from sections 224, 225 and 226 of the Criminal Code and to otherwise modernise and clarify the law in relation to termination of pregnancy.<sup>21</sup> They also require the Commission to make recommendations, and prepare draft legislation based on those recommendations, to achieve those aims.<sup>22</sup>

1.21 The current law under which terminations are regulated in Queensland — as contained in sections 224, 225 and 226 of the Criminal Code — makes it a crime to 'unlawfully' terminate a woman's pregnancy except in limited circumstances. Women and health practitioners<sup>23</sup> who fail to meet the criteria for a lawful termination face the threat of criminal prosecution and conviction. A lack of certainty under the current provisions as to when a termination is 'lawful' may result in fear and stigma for women,<sup>24</sup> and reluctance by some health practitioners to provide termination services.<sup>25</sup>

1.22 In addition to the uncertainty in the current law, other issues that impact on the accessibility and availability of termination services in Queensland include the location and cost of the services,<sup>26</sup> a health practitioner's conscientious objection to

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<sup>19</sup> For example, some respondents submitted that there should not be any changes made to Queensland's laws relating to terminations.

<sup>20</sup> See 'medical practitioner' in the Abbreviations and Glossary.

<sup>21</sup> See terms of reference, 2 and paras 1, 2.

<sup>22</sup> See terms of reference, 3.

<sup>23</sup> See 'health practitioner' in the Abbreviations and Glossary.

<sup>24</sup> See the discussion of 'Exempting the woman from criminal responsibility' in Chapter 3.

<sup>25</sup> See, eg, [3.84] and [3.130] below.

<sup>26</sup> See the discussion of 'Accessibility and availability' in Chapter 2.

termination<sup>27</sup> and the conduct of persons in or near premises that provide termination services, which may deter women and service providers seeking to access those services or premises.<sup>28</sup>

1.23 Sections 224, 225 and 226 have remained virtually unchanged since their enactment more than 100 years ago.

1.24 Since that time, newer and safer medical procedures for inducing terminations have been developed, including early medical termination. Due to their restrictive nature, sections 224, 225 and 226 do not align with international human rights obligations which recognise and support women's rights to reproductive health, including access to safe and legal termination services.<sup>29</sup> Whilst some members of the community remain opposed to termination, over time there has been a general shift in community attitudes in support of a woman's right to termination.<sup>30</sup>

1.25 Other Australian jurisdictions have reformed their laws to improve access to termination services, including medical termination. In the ACT, the Northern Territory, Tasmania and Victoria, terminations performed by registered medical practitioners are regulated as a form of health care.<sup>31</sup>

1.26 The removal of terminations performed by medical practitioners from sections 224 to 226, as required under the terms of reference, will protect a medical practitioner from the threat of criminal prosecution and conviction. In order to ensure a fair and coherent approach to legislative reform in this area, a woman should also be protected from criminal sanction in respect of the termination of her pregnancy.

1.27 Accordingly, pursuant to the objectives of the terms of reference, sections 224, 225 and 226 should be repealed and replaced by new legislation which modernises and clarifies the law in relation to termination.

### **Principles guiding the development of the draft Bill**

1.28 The development of new legislation relating to terminations involves significantly different legal principles and policy approaches from those that have applied under the current law.

1.29 In developing its recommendations for the draft Bill, the Commission has been guided by a number of key principles, including the following:

- Generally, termination should be treated as a health issue rather than as a criminal matter;
- Women's autonomy and health (including access to safe medical procedures) should be promoted, recognising that:

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<sup>27</sup> See generally Chapter 4.

<sup>28</sup> See generally Chapter 5.

<sup>29</sup> See generally Appendix C.

<sup>30</sup> See the discussion of 'Community attitudes' in Chapter 2.

<sup>31</sup> See the discussion of 'Legislative reforms in other jurisdictions' in Chapter 2.

- at the earlier stages of pregnancy, a woman’s autonomy has greatest weight, and termination is lower risk and safe for the woman;
- at the later stages of pregnancy, the interests of the fetus have increasing weight, and termination involves higher risk for the woman and complex issues;
- The law should align with international human rights obligations relevant to termination of pregnancy laws, including enabling reasonable and safe access to termination services;
- The law should be consistent with contemporary clinical practice and health regulation; and
- The law should achieve reasonable consistency with other Australian jurisdictions that have modernised their laws relating to termination.

### **The draft Bill**

1.30 The draft Termination of Pregnancy Bill 2018 (the ‘draft Bill’), which gives effect to the Commission’s recommendations, is set out in Appendix F.<sup>32</sup>

1.31 To align this area of the law with modern views about women’s health care, the draft Bill distinguishes between lawful conduct (when a termination is performed by a medical practitioner acting in accordance with any requirements for a lawful termination, or the woman) and, under amendments to the Criminal Code, criminal conduct (when a termination is performed by an unqualified person).

1.32 The draft Bill provides certainty and clarity for women, health practitioners and the community about the circumstances in which a termination, including termination at a later gestation, is lawful. It contains additional measures to help improve women’s access to terminations. In this regard, it requires, among other things, a health practitioner who has a conscientious objection to performing or advising about a termination to inform the woman and refer the woman or transfer her care to another health practitioner or health service provider. It also provides for the establishment of safe access zones in which particular conduct, at or near termination services premises, is prohibited.

### **Other laws not affected**

1.33 The draft Bill is not intended to affect the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity, consent to medical treatment for minors or the regulation of health practitioners, public hospitals and health services and licensed private health facilities. If the draft Bill is enacted, those general laws will continue to apply.

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<sup>32</sup>

See also Appendix E, which sets out a brief comparative guide to the provisions the Commission recommends in this Report, reflected in the draft Termination of Pregnancy Bill 2018, and the legislative requirements in other jurisdictions.

## STRUCTURE OF THIS REPORT

1.34 Chapter 2 discusses the current law and clinical framework governing terminations in Queensland, the incidence of terminations, the accessibility and availability of termination services in Queensland and community attitudes towards termination.

1.35 Chapter 3 considers the requirements for when a termination may lawfully be performed by a medical practitioner (including any requirements relating to gestational limits and grounds), the legal position of the pregnant woman and the creation of a new criminal offence in relation to the performance of a termination by an unqualified person.

1.36 Chapter 4 deals with a health practitioner's conscientious objection to termination.

1.37 Chapter 5 deals with safe access zones.

1.38 Chapter 6 recommends consequential amendments to the Criminal Code and other legislation required for the coherent and clear operation of the recommended new legislative provisions. It also deals with counselling and data collection and reporting.

## TERMINOLOGY

1.39 A list of Abbreviations and Glossary of terms commonly used in this Report is set out at the beginning of the Report.

## RECOMMENDATIONS

**1-1 Sections 224, 225 and 226 of the Criminal Code should be repealed.**

*[See Termination of Pregnancy Bill 2018 cl 18]*

**1-2 New legislation in the form of the draft Termination of Pregnancy Bill 2018 should be introduced.**



# Chapter 2

## Termination: An overview

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### CURRENT LAW IN QUEENSLAND

#### Offences under the Criminal Code

2.1 In general terms, the criminal law in Queensland distinguishes between the destruction of a fetus by the procurement of miscarriage (unlawful termination),<sup>1</sup> the unlawful killing of a child that is born alive (unlawful homicide),<sup>2</sup> and the destruction of an unborn child, including a child that is ‘about to be delivered’ (which might be considered neither an unlawful termination nor an unlawful homicide).<sup>3</sup>

2.2 These conceptual differences are reflected in the different offences under the Criminal Code and the penalties attaching to those offences.<sup>4</sup>

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1 Criminal Code (Qld) ss 224, 225, 226.

2 Criminal Code (Qld) ss 292, 294. See also, in general terms, ss 291 (Killing of a human being unlawful), 293 (Definition of *killing*), 300 (Unlawful homicide).

3 Criminal Code (Qld) s 313.

4 Sections 224, 225 and 226 are included in Chapter 22 of the Criminal Code (Offences against morality) and carry penalties of up to 14, seven or three years’ imprisonment, respectively. Cf ss 292, 294 and 313 which are included in Chapter 28 (Homicide—suicide—concealment of birth) and which may attract a penalty of, or up to, life imprisonment.

2.3 The range of offences may also reflect the principle that the fetus should be accorded greater recognition and protection as it advances to birth.

2.4 The relevant offences, along with the defence for surgical procedures and medical treatment, are outlined below.

### **Unlawful termination: sections 224, 225 and 226**

2.5 Sections 224, 225 and 226 of the Criminal Code are the principal offences relating to unlawful termination. They deal with unlawful attempts to procure a miscarriage by or for a woman:<sup>5</sup>

#### **224 Attempts to procure abortion**

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

#### **225 The like by women with child**

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

#### **226 Supplying drugs or instruments to procure abortion**

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

2.6 The Criminal Code does not define 'unlawful' for the purpose of these provisions. However, it contains a defence for surgical operations and medical treatment in section 282.<sup>6</sup> The scope of what is 'unlawful' under sections 224 to 226, and the application of the defence in section 282, have been the subject of judicial interpretation.<sup>7</sup>

<sup>5</sup> These provisions are based on an English statute, *Offences Against the Person Act 1861*, 24 & 25 Vict, c 100, ss 58, 59. They have not been amended since their enactment in Queensland in 1899, except to remove the words 'with hard labour': *Corrective Services (Consequential Amendments) Act 1988* (Qld) s 5, sch 2.

The term 'procure' is not defined in the Criminal Code (Qld). In *R v F; Ex parte Attorney-General* [2004] 1 Qd R 162, [3], [28], [42], the Queensland Court of Appeal observed that 'procure' is a plain English word and not a term of art; its meaning may change depending on the context in which it is used. In that case, Williams JA, at [34], also referred to *Attorney-General's Reference (No 1 of 1975)* [1975] 2 All ER 684, 686 in which Lord Widgery CJ (Bristow and May JJ agreeing) stated that '[t]o procure means to procure by endeavour. You procure a thing by setting out to see that it happens and taking the appropriate steps to produce that happening'. See also *R v Hawke* [2016] QCA 144, [58]. See further *R v Mills* [1963] 1 All ER 202 as to the meaning of the term 'procure', in the context of the phrase 'unlawfully supply or procure', in English legislation equivalent to s 226 of the Criminal Code (Qld).

<sup>6</sup> See [2.22]–[2.33] below.

<sup>7</sup> See [2.38]–[2.42] below.

### **Unlawful killing of a child born alive: sections 292 and 294**

2.7 The common law does not generally regard the killing of a fetus that is still in the womb as murder or manslaughter, because an unborn fetus is not a child or a person capable of being killed. At common law, before there can be an unlawful homicide — the unlawful killing of a person — the victim must be born. This is sometimes referred to as the ‘born alive’ rule,<sup>8</sup> that is:<sup>9</sup>

The definition of homicide requires the victim to be *in rerum natura* or ‘in being’, which means that he must be ‘completely born alive’. (note omitted)

2.8 In Queensland, section 292 of the Criminal Code provides for when a child becomes ‘a person capable of being killed’.<sup>10</sup> It states:<sup>11</sup>

#### **292 When a child becomes a human being**

A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel-string is severed or not.

2.9 Section 294 further provides that, where a child is born alive but dies from acts done or omitted to be done before or during its birth, the child is deemed to have been ‘killed’:<sup>12</sup>

#### **294 Death by acts done at childbirth**

When a child dies in consequence of an act done or omitted to be done by any person before or during its birth, the person who did or omitted to do such act is deemed to have killed the child.

2.10 If section 292 or 294 applies, the killing of the child is unlawful unless it is authorised, justified or excused by law.<sup>13</sup> ‘Killing’ is defined as causing ‘the death of another, directly or indirectly, by any means whatever’.<sup>14</sup> A person who unlawfully

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<sup>8</sup> See generally Westlaw AU, *The Laws of Australia* (at 17 March 2012) ‘Life as a human being begins when a child is “born alive” although the exact time depends on the legal test adopted in each jurisdiction’ [10.1.390]. At common law, see, eg, *R v Iby* (2005) 154 A Crim R 55; *R v Hutty* [1953] VLR 338, 339 (Barry J).

<sup>9</sup> G Williams, *Textbook of Criminal Law* (Stevens & Sons, 1978) ch 11 § 1, 249.

<sup>10</sup> Similar provision is made in the other Code jurisdictions: see Criminal Code (NT) ss 1B, 1C; Criminal Code (Tas) s 153(4); Criminal Code (WA) s 269.

<sup>11</sup> Section 292 has not been amended since its enactment in Queensland in 1899. In *R v Castles* [1969] QWN 36, Lucas J found (at 78) that:

when the section speaks of a child proceeding in a living state from the body of its mother it is referring to the state in which the child proceeds from the body of its mother and that a child who lives, albeit doomed to die, for some period after it has proceeded from the body of its mother, is within the section.

<sup>12</sup> Section 294 has not been amended since its enactment in Queensland in 1899.

<sup>13</sup> Criminal Code (Qld) s 291.

<sup>14</sup> Criminal Code (Qld) s 293.

kills another person 'is guilty of a crime, which is called murder or manslaughter, according to the circumstances of the case'.<sup>15</sup>

### ***Killing unborn child: section 313***

2.11 Section 313 of the Criminal Code creates two offences relating to the killing of an unborn child.

2.12 Section 313(1) deals with acts or omissions when a woman is 'about to be delivered of a child'. It provides:<sup>16</sup>

#### **313 Killing unborn child**

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

2.13 Provisions like section 313(1) were intended to fill the gap between the offences of unlawful termination (which apply to a fetus) and unlawful homicide (which applies to a child born alive).<sup>17</sup> Of the similar provision in England and Wales, it was observed, for example, that:<sup>18</sup>

The crime of abortion is supplemented by the crime of child destruction which was created by the *Infant Life (Preservation) Act, 1929*. The object of this statute was to fill a gap in the legal protection of the child as it was emerging into the world. To kill a child when partially extruded from its mother is not murder; also, it is probably not abortion.

2.14 It has been noted that the meaning of the phrase 'about to be delivered of a child' is uncertain:<sup>19</sup>

Does it mean at or about the time of birth? If so, why is it so limited, or is it a case that a woman is regarded as being about to be delivered of a child at any time while she is pregnant and carrying a live fetus? ... Noting therefore the uncertainties in the proper interpretation of s 290, which may be left for another day, it is sufficient for present purposes to conclude that there is nothing in the

<sup>15</sup> Criminal Code (Qld) s 300. See further ss 302, 303, 305, 310 as to the definition and punishment of murder and manslaughter.

<sup>16</sup> Section 313(1) has not been substantially amended since its enactment in 1899, except to remove the words 'with hard labour' and to change the word 'woman' to 'female': *Corrective Services (Consequential Amendments) Act 1988* (Qld) s 5, sch 2; *Criminal Law Amendment Act 1997* (Qld) s 47(1).

Similar offences, commonly referred to as 'child destruction' offences, apply in other jurisdictions although there is considerable variation in their terms: see *Crimes Act 1900* (ACT) s 42; *Crimes Act 1900* (NSW) s 4(1) (definition of 'grievous bodily harm' para (a)), 33(1)(b); Criminal Code (NT) s 170; *Criminal Law Consolidation Act 1935* (SA) s 82A(7)–(8); *Crimes Act 1958* (Vic) ss 15 (definition of 'serious injury' para (b)), 15A(1); Criminal Code (WA) s 290.

<sup>17</sup> See *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 36–7, 38, 41–2 (McGuire DCJ).

<sup>18</sup> G Williams, 'The Law of Abortion' in *Current Legal Problems* (1952) 130, 146, quoted in *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 36. See also, eg, *R v Woolnough* [1977] 2 NZLR 508, 516 (Richmond P), in the context of the *Crimes Act 1961* (NZ) s 182.

<sup>19</sup> *Martin v The Queen (No 2)* (1996) 86 A Crim Rep 133, 138 (Murray J), in the context of the Criminal Code (WA) s 290 which is in the same terms as the Criminal Code (Qld) s 313(1). See also Report of the Criminal Code Advisory Working Group to the Attorney-General (July 1996) 50.

wording of that section which would necessarily require it to be applied to conduct of the accused person which is closely connected in time with the birth of a dead child.

2.15 The ordinary meaning of the words ‘about to be delivered of a child’ in section 313(1) may suggest that the operation of the section is limited to situations where birth is imminent.<sup>20</sup> On the other hand, it has been suggested that the section may also apply before birth to a ‘viable’ fetus, that is, one that is capable of being born alive.<sup>21</sup>

2.16 The wording of the corresponding provision in England and Wales<sup>22</sup> uses the different phrase ‘a child capable of being born alive’:<sup>23</sup>

The crime [in the *Infant Life (Preservation) Act 1929*] is committed by ‘any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother’. This definition seems to make child destruction overlap abortion, the differences being that abortion covers the whole period of gestation, child destruction only the latter part, when the fetus is viable; while on the other hand, child destruction is possible after birth has started, an event that makes abortion inapplicable.

‘Capable of being born alive’ in the Act clearly means capable of being born alive if delivered at the time when the act was done. The Act provides that evidence that a woman was pregnant for 28 weeks shall be prima facie evidence that she was pregnant of a child capable of being born alive.

2.17 Section 313(2) applies where there is an unlawful assault on a pregnant woman. It provides:

**313 Killing unborn child**

...

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

Maximum penalty—imprisonment for life

<sup>20</sup> See N Cica, ‘Abortion Law in Australia’ (Research Paper No 1 1998-99, Parliamentary Library, Parliament of Australia, 1999) 33; MJ Rankin, ‘The offence of child destruction—Issues for medical abortion’ (2013) 35(1) *Sydney Law Review* 1, 5.

<sup>21</sup> See *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 36–7 (McGuire DCJ). See also *R v Woolnough* [1977] 2 NZLR 508, 516 (Richmond P), in the context of the *Crimes Act 1961* (NZ) s 182 which applies to a person who causes the death ‘of any child that has not become a human being’, unless the death is caused ‘before or during the birth’ of the child by means employed in good faith for the preservation of the mother’s life.

<sup>22</sup> See the *Infant Life (Preservation) Act 1929*, 19 & 20 Geo 5, c 34, s 1. The ‘child destruction’ offence in South Australia uses similar language: *Criminal Law Consolidation Act 1935* (SA) s 82A(7)–(8).

<sup>23</sup> G Williams, ‘The Law of Abortion’ in *Current Legal Problems* (1952) 130, 146, quoted in *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 36.

2.18 Section 313(2) was enacted in 1997,<sup>24</sup> following a review of the Criminal Code.<sup>25</sup> It was introduced in response to *R v Lippiatt*, in which the accused was convicted in relation to having caused the stillbirth of an unborn child by kicking a pregnant woman in the abdomen.<sup>26</sup> Because the child was not born alive, there was no unlawful killing of a person. The accused was instead prosecuted under section 224 of the Criminal Code for the unlawful procurement of a miscarriage, as well as for assault:<sup>27</sup>

The application of Queensland's abortion laws to [the] situation in *R v Lippiatt* seemed to be motivated by the prosecutorial authority's desire to bring the accused to specific and separate legal account for the demise of the victim's child. This could not have been done by prosecuting the accused for murder or manslaughter, because the child in *R v Lippiatt* was born dead. Nor was there any feticide offence in Queensland law under which the accused could have been charged in relation to assaulting and killing the fetus in utero.

2.19 Section 313(2) provides for a separate offence that applies to an 'unlawful' assault that destroys the life of a child before its birth. Arguably, it does not apply to a termination that is otherwise lawful:<sup>28</sup>

The precise scope of the new section 313(2) feticide offence remains unclear. It certainly would apply to the kind of behaviour that occurred in *R v Lippiatt*, which indicates that it is unlikely that future cases involving violent assaults on pregnant women will result in prosecutions under the Queensland provisions that make unlawful abortion a crime. It is less clear, however, whether the new section 313(2) could be applied in the context of medical abortion. Arguably the word 'unlawfully' in section 313(2) would limit its application in that context to those medical abortions that are already prohibited under the Queensland provisions that criminalise unlawful abortion, and thus to abortions that do not satisfy the test in *R v Bayliss and Cullen*. (note omitted)

2.20 The word 'child' is not defined for the purpose of section 313(2), but it has been said that:<sup>29</sup>

<sup>24</sup> See *Criminal Law Amendment Act 1997* (Qld) s 47(2).

<sup>25</sup> See Queensland, *Parliamentary Debates*, Legislative Assembly, 4 December 1996, 4870, 4872 (DE Beanland, Attorney-General and Minister for Justice); and Report of the Criminal Code Advisory Working Group to the Attorney-General (July 1996) 47–53.

The Criminal Code Amendment Bill 1996 (Qld) cl 47 initially gave effect to the recommendations of the Criminal Code Advisory Working Group for the new offence to apply when a person unlawfully assaults a woman who is pregnant with 'a child capable of being born alive' and to include a presumption that the child is capable of being born alive if the woman had been pregnant for 24 weeks or more. However, those aspects of the proposed amendment were removed in Committee during the debates on the Bill: see Queensland, *Parliamentary Debates*, Legislative Assembly, 20 March 1997, 731–4.

<sup>26</sup> *R v Lippiatt* (Unreported, District Court of Queensland, Hoath J, 24 May 1996). The attack involved a karate kick to the woman who was then seven and a half months pregnant. See Cica, above n 20, 26.

<sup>27</sup> Cica, above n 20, 26. See also S Gabriel, 'Child Destruction: A Prosecution Anomaly Under Both the Common Law and the Criminal Codes' (1997) 21 *Criminal Law Journal* 32, 33.

<sup>28</sup> Cica, above n 20, 34–5. See also, eg, Queensland, *Parliamentary Debates*, Legislative Assembly, 20 March 1997, 732 (EA Cunningham): 'It is not abortion because, under these provisions, the woman clearly would not have intended to have her child killed or injured'.

<sup>29</sup> *R v Waigana* (2002) 225 A Crim R 20, [7]–[16] (Henry J). See also Cica, above n 20, 34:

Section 313(2) contains no express qualification or implied qualification as to the age of the unborn child to which it refers. ... In this context the use of the word child to describe the life form with which the mother is pregnant does not suggest the life form must be capable of existence independently of the mother.

2.21 The Commission recommends amendment to section 313.<sup>30</sup>

## Defence for surgical operations and medical treatment: section 282

2.22 Section 282 provides a defence for surgical operations and medical treatment. It provides:<sup>31</sup>

### 282 Surgical operations and medical treatment

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

- (a) a person or an unborn child for the patient's benefit; or
- (b) a person or an unborn child to preserve the mother's life;

if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

(2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.

(3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.

(4) In this section—

**health professional** see the *Hospital and Health Boards Act 2011*, schedule 2.<sup>32</sup>

**medical treatment**, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

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There is no suggestion in this new provision that criminal liability is confined to the later stages of pregnancy. Arguably a 'child' for these purposes includes a fetus at any stage of its gestation, from the very beginning of pregnancy.

<sup>30</sup> See Chapter 6 below.

<sup>31</sup> The words 'preservation' and 'life' in s 282 'do not bear any technical meaning': *R v Ross, McCarthy and McCarthy* [1955] St R Qd 48, 81 (Mansfield SPJ, Mack J agreeing). But, in the context of s 224, see the line of cases discussed at [2.38]–[2.42] below. It has been suggested that the standard of 'reasonable care and skill' is a relative one that depends on the circumstances and status of the person: LexisNexis, *Carter's Criminal Law of Queensland* (at July 2012) '282 Surgical operations and medical treatment' [s 282.20]; RS O'Regan, 'Surgery and Criminal Responsibility under the Queensland Criminal Code' (1990) 14(2) *Criminal Law Journal* 73, 74.

<sup>32</sup> 'Health professional' is defined broadly in the *Hospital and Health Boards Act 2011* (Qld) s 14 sch 2 to mean a person registered under the Health Practitioner Regulation National Law; or a person, other than a person so registered, who provides a health service, including, for example, an audiologist, dietician or social worker.

**patient** means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

**surgical operation**, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child. (note added)

2.23 Before its amendment in 2009,<sup>33</sup> section 282 did not apply to medical treatment but was confined to a surgical operation as follows:<sup>34</sup>

### 282 Surgical operations

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

2.24 The 2009 amendments were intended to update section 282 to 'recognise modern treatments and procedures', such as the administration of a drug. The reasons for the 2009 amendments were set out in the Explanatory Notes to the Bill and included:<sup>35</sup>

Section 282 requires amendment to extend the excuse to encompass the provision of medical treatment. This will ensure that health practitioners treating their patients are provided with appropriate legal protection for the appropriate use of medical and surgical procedures alike.

Concerns have also been raised by medical practitioners in Queensland's public hospitals and the Australian Medical Association (Qld Branch) about the potential liability for criminal prosecution in providing medical terminations.

2.25 The amendment was not otherwise intended to expand the operation of the section:<sup>36</sup>

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

2.26 The words 'to preserve the mother's life' were also expressly retained:<sup>37</sup>

<sup>33</sup> *Criminal Code (Medical Treatment) Amendment Act 2009* (Qld) s 3, commencing 5 September 2009.

<sup>34</sup> *Criminal Code* (Qld) s 282, reprint no 7A at 1 July 2009 to 4 September 2009.

<sup>35</sup> Explanatory Notes, *Criminal Code (Medical Treatment) Amendment Bill 2009* (Qld) 1–2, 3.

<sup>36</sup> Explanatory Notes, *Criminal Code (Medical Treatment) Amendment Bill 2009* (Qld) 2. 'This legislation is not about seeking to alter the current law, which has been clear in Queensland since 1986. It is about making sure that the law is, as far as is possible, certain for both health professionals and the public': Queensland, *Parliamentary Debates*, Legislative Assembly, 1 September 2009, 1981 (CR Dick, Attorney-General and Minister for Industrial Relations).

<sup>37</sup> Explanatory Notes, *Criminal Code (Medical Treatment) Amendment Bill 2009* (Qld) 3–4.

The amendment modernises the excuse to recognise modern treatments and procedures and retains the existing requirement that any procedures undertaken with the intent of adversely affecting an unborn child may only be performed where it is necessary for the preservation of the mother's life. Given this phrase has been the subject of judicial interpretation previously (see *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Repts 8), it [is] proposed that it [be] retained in its current form.

2.27 The definition of 'surgical operation' was added during the Bill's consideration in detail to 'remove any doubt that section 282 does not excuse a person from criminal responsibility for performing a surgical operation upon a mother of an unborn child intending to adversely affect an unborn child unless the operation is to preserve the mother's life'.<sup>38</sup>

2.28 The amendment also included provisions, as a consequence of extending section 282 to medical treatment, to cover the situation where a substance is administered, supplied or procured by another person on the direction or advice of a health professional:<sup>39</sup>

The effect of subsections (2) and (3) is to provide that it is lawful for a person to administer a substance or supply or procure a substance in accordance with the lawful direction or advice of a health professional. This may be relevant to some medical treatments that may involve a health practitioner prescribing medication that in whole or in part is self-administered pursuant to such prescriptions. The subsection also applies where the person acts in the reasonable belief that the advice or direction of the health professional was lawful.

2.29 Where it applies, section 282 operates to excuse criminal responsibility which would be imposed by other provisions of the Criminal Code, including section 313.<sup>40</sup>

2.30 The section is in wide terms.<sup>41</sup> It is not limited to registered medical practitioners, and can apply to others.<sup>42</sup>

2.31 The section requires the surgical operation or medical treatment to be performed with 'reasonable care and skill'.<sup>43</sup>

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<sup>38</sup> See Queensland, *Parliamentary Debates*, Legislative Assembly, 3 September 2009, 2131 (CR Dick, Attorney-General and Minister for Industrial Relations).

<sup>39</sup> Explanatory Notes, Criminal Code (Medical Treatment) Amendment Bill 2009 (Qld) 4; see also 2.

<sup>40</sup> See *R v Patel; ex parte A-G (Qld)* [2011] QCA 81, [35] (McMurdo P, Muir and Fraser JJA). See also *Queensland v Nolan* (2001) 122 A Crim R 517, 519, 522 (Chesterman J); RS O'Regan, 'Surgery and Criminal Responsibility under the Queensland Criminal Code' (1990) 14(2) *Criminal Law Journal* 73, 73–4, 77.

<sup>41</sup> See, eg, *Queensland v Nolan* (2001) 122 A Crim R 517, 522 (Chesterman J). It was held that s 282 was wide enough to encompass the facts of that case, which involved proposed surgery to separate conjoined twins with the purpose of saving the life of one of the twins in circumstances where there was no prospect the other twin would survive the surgery.

<sup>42</sup> See RS O'Regan, 'Surgery and Criminal Responsibility under the Queensland Criminal Code' (1990) 14(2) *Criminal Law Journal* 73, 74 in which it is argued that s 282 might apply to 'a nurse, a dentist, a physiotherapist, an ambulance officer rendering first aid or anyone engaging in the wide range of activity comprehended by the term "surgery"'.<sup>43</sup>

<sup>43</sup> See n 31 above.

2.32 Section 282 is capable of applying 'both where consent is present and where it is absent'.<sup>44</sup> For example, it may be reasonable in some circumstances for emergency medical treatment to be provided without consent.<sup>45</sup>

2.33 Where section 282 is properly raised, the onus is on the prosecution to exclude its operation beyond reasonable doubt.<sup>46</sup>

2.34 The Commission recommends amendments to section 282.<sup>47</sup>

### **Duty of persons doing dangerous acts: section 288**

2.35 Section 288 of the Criminal Code imposes a duty on those who administer 'surgical or medical treatment' to have reasonable skill and use reasonable care to ensure that another person's life is not endangered. It provides:

#### **288 Duty of persons doing dangerous acts**

It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.

2.36 The High Court has held that the words 'surgical treatment' in this section refer to:<sup>48</sup>

all that is involved, from a recommendation that surgery should be performed, to its performance and the post-operative care which is necessary to be given or supervised by the person who conducted the surgery. The duty imposed by s 288 may be breached by a discrete act of gross negligence in carrying out the surgical procedure or if gross negligence attends the making of judgments about a patient's condition and the risks to the patient of the surgical procedure.

2.37 The Commission does not recommend any amendment to section 288.

### **Judicial interpretation: when a termination is 'lawful'**

2.38 In relation to other laws akin to sections 224 and 282 of the Criminal Code, Australian courts have developed a doctrine, based on necessity and proportionality, under which a termination by a medical practitioner, with the consent of the woman, is 'lawful'.

<sup>44</sup> *R v Patel; ex parte A-G (Qld)* [2011] QCA 81, [35] (McMurdo P, Muir and Fraser JJA).

<sup>45</sup> RS O'Regan, 'Surgery and Criminal Responsibility under the Queensland Criminal Code' (1990) 14(2) *Criminal Law Journal* 73, 82. That author argues that consent would be one of the material circumstances relevant to the question whether the surgery or treatment was 'reasonable, having regard to the patient's state at the time and to all the circumstances of the case'. They suggest that, ordinarily, '[i]t would be unreasonable to operate on an adult patient capable of an informed and rational choice without consent', but that it might be different if consent was 'unreasonably refused' in circumstances where the operation or treatment was 'considered reasonably necessary' to save life or prevent serious injury, or where emergency surgery was indicated.

<sup>46</sup> *R v Ross, McCarthy and McCarthy* [1955] St R Qd 48, 80 (Mansfield SPJ, Mack J agreeing).

<sup>47</sup> See Chapter 6 below.

<sup>48</sup> See *Patel v R* (2012) 247 CLR 531, [26] (French CJ, Hayne, Kiefel and Bell JJ).

2.39 In the leading case of *R v Davidson*<sup>49</sup> (known as the 'Menhennitt ruling'), the Supreme Court of Victoria held that, for the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done was:<sup>50</sup>

- necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and
- in the circumstances not out of proportion to the danger to be averted.

2.40 The Menhennitt ruling was followed in New South Wales, in *R v Wald*.<sup>51</sup> In that case, the District Court of New South Wales held that, when assessing the risk to the woman's health, consideration could be given to the woman's 'economic, social or medical' circumstances.<sup>52</sup>

2.41 The Menhennitt ruling was considered in Queensland in *R v Bayliss and Cullen*.<sup>53</sup> In that case, it was held that the same principles applied in Queensland to the operation of section 282 in relation to the statutory offence of unlawful termination of a pregnancy under section 224 of the Criminal Code.<sup>54</sup> However, the Court did not go so far as *R v Wald* to refer to the economic or social circumstances of the woman. The court also emphasised that the doctrine applies 'in exceptional cases' and does not justify 'abortion on demand'.<sup>55</sup>

2.42 *R v Bayliss and Cullen* was followed by the Supreme Court of Queensland in *Veivers v Connolly*.<sup>56</sup> The court found that section 282 allows a termination that is 'necessary to preserve the woman from a serious danger to her mental health which would otherwise be involved should the pregnancy continue'. Further, it held that a 'serious danger' to mental health could include 'a danger which would not fully afflict [the woman] in a practical sense until after the birth'.<sup>57</sup>

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49 [1969] VR 667 (Menhennitt J). That case concerned the application of former s 65 of the *Crimes Act 1958* (Vic) which was in substantially similar terms to the Criminal Code (Qld) s 224.

50 Ibid 672.

51 (1971) 3 DCR NSW 25 (Levine DCJ). The test in *R v Davidson* and *R v Wald* was applied by the New South Wales Court of Appeal in *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

52 *R v Wald* (1971) 3 DCR (NSW) 25, 29.

53 (1986) 9 Qld Lawyer Reps 8, 45 (McGuire DCJ). In that case, the two accused were both doctors charged under s 224 of the Criminal Code (Qld). The accused relied on s 282 as a defence.

54 Ibid.

55 Ibid.

56 [1995] 2 Qd R 326, 329 (de Jersey J).

57 Ibid. This point was approved in *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47, 60 (Kirby ACJ).

## Consent to medical treatment

2.43 At common law, surgical or other medical treatment ordinarily requires the patient's consent.<sup>58</sup> The provision of treatment in the absence of valid consent may give rise to liability in tort or criminal proceedings.

2.44 For an adult's consent to be valid, the adult must be competent to give the consent (that is, have the capacity to understand in broad terms the nature of the procedure to be performed)<sup>59</sup> and the consent must be voluntary<sup>60</sup> and specific to the proposed treatment. A health practitioner must provide a patient with sufficient information to enable the patient to make an 'informed decision' about whether to give consent for the treatment.<sup>61</sup>

2.45 In Queensland, there is a statutory framework for the appointment of a substitute decision-maker for an adult who does not have the capacity to make their own decisions (including giving consent to medical treatment).<sup>62</sup> If a woman does not have the capacity to consent to a termination, the Queensland Civil and Administrative Tribunal may give a valid consent.<sup>63</sup> The Supreme Court of Queensland, exercising its *parens patriae* jurisdiction, may also authorise a termination in such circumstances.<sup>64</sup>

2.46 In some circumstances, a minor can give consent to medical treatment if they have the capacity to do so. Specifically, a child is 'capable of giving informed consent when [the child] "achieves a sufficient understanding and intelligence to

<sup>58</sup> Prior to the performance of a medical procedure, a health practitioner must obtain a patient's consent to undergo the proposed treatment. Generally, consent can be implied, oral or in writing: *Rogers v Whitaker* (1992) 175 CLR 479, 489; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102–103; LexisNexis, *Halsbury's Laws of Australia* (at 10 February 2016) 280 Medicine, 'Consent' [280–3000].

<sup>59</sup> *Chatterton v Gerson* [1981] QB 432, 443; *Rogers v Whitaker* (1992) 175 CLR 479, 489.

<sup>60</sup> *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113–14 (Lord Donaldson MR).

<sup>61</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489; LexisNexis, *Halsbury's Laws of Australia* (at 10 February 2016) 280 Medicine, 'Consent' [280–3000], [208–3005]. This information may include the material risks and possible complications associated with the treatment, the likelihood of a risk or complication eventuating and alternative options for treatment: *Rogers v Whitaker* (1992) 175 CLR 479, 489, 490, citing *F v R* (1983) 33 SASR 189, 192–3.

<sup>62</sup> See generally *Guardianship and Administration Act 2000* (Qld) ch 5; *Powers of Attorney Act 1998* (Qld) ch 3-4. An adult is presumed to have the capacity to consent to their own medical treatment (unless and until that presumption is rebutted): *Guardianship and Administration Act 2000* (Qld) sch 1 pt 1 s 1; *Powers of Attorney Act 1998* (Qld) sch 1 pt 1 s 1. See also the proposed amendments to those Acts by the *Guardianship and Administration and Other Legislation Amendment Bill 2018* (Qld) which was introduced into Parliament on 15 February 2018 but has not yet been debated.

<sup>63</sup> *Guardianship and Administration Act 2000* (Qld) s 68. Termination is defined as 'special health care' under that Act and is not a matter for which a substitute decision-maker for the woman can give consent: s 65, sch 2 pt 2 ss 6, 7(c). The Tribunal may give its consent for a termination for an adult woman 'only if the Tribunal is satisfied the termination is necessary to preserve the adult from serious danger to her life or physical or mental health': s 71. However, a 'termination' does not include 'health care without which an organic malfunction or disease of the adult is likely to cause serious or irreversible damage to the adult's physical health'. A procedure involving the termination of a pregnancy 'may be primarily to treat organic malfunction if the adult is a pregnant woman requiring abdominal surgery for injuries sustained in an accident'. In such a case, it is not necessary to obtain the consent of the Tribunal: s 71, sch 2 pt 2 ss 10, 11.

<sup>64</sup> *Guardianship and Administration Act 2000* (Qld) s 240. The *parens patriae* jurisdiction is based on the need to protect those who lack the capacity to protect themselves: see *Secretary, Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 258–9.

enable [the child] to understand fully what is proposed”<sup>65</sup>. This is also described as having ‘sufficient intelligence and maturity to understand the nature and consequences’ of the proposed medical treatment.<sup>66</sup>

2.47 A child who does not have the capacity to consent to medical treatment cannot give a valid consent.<sup>67</sup> In some circumstances, the parent of a child who does not have the capacity to consent may consent to medical treatment on the child’s behalf. However, consent to some types of medical treatment, including the termination of a child’s pregnancy, is outside the scope of parental decision-making authority. In those circumstances, the Supreme Court, by an order made in its *parens patriae* jurisdiction, may authorise the termination.<sup>68</sup> In making such an order, it must act in the best interests of the pregnant child.<sup>69</sup>

2.48 There is a limited common law exception to the requirement for the patient’s consent that applies to emergency health care. A person will not be criminally or civilly liable for providing medical treatment to another person who is unable to give their consent in an emergency situation, where immediate treatment is reasonable and necessary in order to save a person’s life or to prevent serious injury to a person’s health.<sup>70</sup>

## CURRENT CLINICAL FRAMEWORK

2.49 The provision of lawful termination services in Queensland is governed by a comprehensive legal and regulatory framework, the key features of which are discussed below.

<sup>65</sup> *Marion’s Case* (1992) 175 CLR 218, 237, citing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189. See also LexisNexis, *Halsbury’s Laws of Australia* (at 22 June 2015) 205 Family Law, ‘Medical Treatment of Children’ [205–2130].

<sup>66</sup> Parliamentary Committee Report No 24 (2016) [2.6.1.2], [11.1]; LexisNexis, *Halsbury’s Laws of Australia* (at 22 June 2015) 205 Family Law, ‘Medical Treatment of Children’ [205–2130]. A child who reaches this standard is commonly referred to as ‘Gillick-competent’.

<sup>67</sup> See generally *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; and *Marion’s Case* (1992) 175 CLR 218, 234–8, 249–59.

<sup>68</sup> *State of Queensland v B* [2008] 2 Qd R 562, [17], [23]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [20], [30]–[33].

<sup>69</sup> *Marion’s Case* (1992) 175 CLR 218, 270, 280; *State of Queensland v B* [2008] 2 Qd R 562, [3], [17]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [18]; LexisNexis, *Halsbury’s Laws of Australia* (at 22 June 2015) 205 Family Law, ‘Medical Treatment of Children’ [205–2140]. The Supreme Court’s *parens patriae* jurisdiction does not extend to the unborn child: *K v T* [1983] 1 Qd R 396, 400–401; *State of Queensland v B* [2008] 2 Qd R 562, [4]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [18].

<sup>70</sup> See generally B White, F McDonald and L Willmott, *Health Law in Australia* (Lawbook co, 2nd ed, 2014) [5.120], [5.130]; Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report No 51 (1996) 44 ff, referring to *Marion’s Case* (1992) 175 CLR 218, 310 (McHugh J). See also, eg, *Rogers v Whitaker* (1992) 175 CLR 479, 489.

## Regulation of health practitioners

2.50 Under the Health Practitioner Regulation National Law (Queensland) a person practising in a health profession must be a ‘registered health practitioner’.<sup>71</sup> Relevantly for the provision of termination services, registered health practitioners include medical practitioners, nurses, midwives and pharmacists.<sup>72</sup> There are different types of registration to reflect different levels of training and expertise and to recognise specialists.<sup>73</sup>

2.51 Registered health practitioners must comply with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards), policies and guidelines.<sup>74</sup> Non-compliance may result in a finding that a practitioner’s conduct is in some way unsatisfactory or unprofessional.<sup>75</sup> This finding may result in disciplinary action, for example cautioning or reprimanding a practitioner, or the suspension or cancellation of, or imposition of conditions on, a practitioner’s registration.<sup>76</sup>

<sup>71</sup> Health Practitioner Regulation National Law (Queensland) pt 7. A person must register with the National Board relevant to their profession. For example, medical practitioners must be registered with the Medical Board of Australia (‘MBA’), nurses and midwives with the Nursing and Midwifery Board of Australia, and pharmacists with the Pharmacy Board of Australia: pt 5. The Health Practitioner Regulation National Law (Queensland) applies by virtue of the *Health Practitioner Regulation National Law Act 2009* (Qld) s 4.

<sup>72</sup> Health Practitioner Regulation National Law (Queensland) s 5 (definitions of ‘health practitioner’, ‘health profession’, ‘registered health practitioner’, ‘health service’ and ‘health service provider’), pt 7.

<sup>73</sup> For example, a medical practitioner may be registered as a specialist in obstetrics and gynaecology: Health Practitioner Regulation National Law (Queensland) pt 7 div 2; MBA, *List of specialties, fields of specialty practice and related specialist titles* (1 June 2018); MBA, *Registration Standard: Specialist Registration* (15 February 2018). Specialist registration is available to medical practitioners who have been assessed, by an Australian Medical Council accredited specialist college, as being eligible for fellowship: see MBA, *Specialist Registration* (26 February 2018) <[www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx](http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx)>. RANZCOG trains and accredits medical practitioners in the specialties of obstetrics and gynaecology, and Fellowship of the College (‘FRANZCOG’) is the qualification awarded to a medical practitioner who has completed the FRANZCOG training program to become a specialist obstetrician/gynaecologist: see RANZCOG, *Specialist Training* (2018) <[www.ranzcog.edu.au/Training/Specialist-Training](http://www.ranzcog.edu.au/Training/Specialist-Training)>.

<sup>74</sup> See Health Practitioner Regulation National Law (Queensland) pt 5 div 3, pt 6; and, eg, MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014); Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018); Nursing and Midwifery Board of Australia, *Code of Conduct for Midwives* (March 2018); Pharmacy Board of Australia, *Code of Conduct* (March 2014).

<sup>75</sup> Specifically, it may be decided that the way a registered health practitioner practices the profession, or the practitioner’s professional conduct, is or may be unsatisfactory; or that a practitioner has behaved in a way that constitutes ‘unsatisfactory professional performance’, ‘unprofessional conduct’ or ‘professional misconduct’: Health Practitioner Regulation National Law (Queensland) pt 8, divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107. See also, for the definition of those terms, Health Practitioner Regulation National Law (Queensland) s 5. Registered health practitioners may also be liable for their conduct under other areas of law, for example criminal law or liability for professional negligence.

<sup>76</sup> Health Practitioner Regulation National Law (Queensland) pt 8, divs 10–12; *Health Ombudsman Act 2013* (Qld) s 107. In limited instances, disciplinary action may also include imposition of a fine. See, eg, *Medical Board of Queensland v Freeman* [2010] QCA 93.

2.52 Health practitioners are also required to undergo a process of 'credentialing'<sup>77</sup> and the definition of their scope of clinical practice<sup>78</sup> as part of a wider organisational quality and risk management system.<sup>79</sup>

### Regulation of medications used for terminations

2.53 The *Health (Drugs and Poisons) Regulation 1996* regulates which health practitioners can dispense, prescribe, supply and administer the medications used for terminations.<sup>80</sup> In Queensland, a person must not administer, dispense, issue, obtain, possess, prescribe, sell or destroy a restricted drug, or write a written instruction or give an oral instruction for a restricted drug, unless the person is endorsed to do so under that regulation.<sup>81</sup>

2.54 All prescription medicines must be included on the Australian Register of Therapeutic Goods and are subject to a classification system that controls their supply, among other things.<sup>82</sup>

2.55 Depending on the circumstances, termination services may be provided in public or licensed private health facilities,<sup>83</sup> on an inpatient or an outpatient basis. In

<sup>77</sup> 'Credentialing' means 'the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments': Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 70 (definition of 'credentialing'). See also Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 53 (definition of 'credentialing').

<sup>78</sup> 'Scope of clinical practice' means 'the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation': Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 75 (definition of 'scope of clinical practice'). See also Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 55 (definition of 'scope of clinical practice').

<sup>79</sup> Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 10, Actions 1.23 and 1.24. Queensland Health has also developed a series of documents regarding the credentialing and defining of the scope of clinical practice of health professionals in hospitals and health services: see, eg, Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 58. See also *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1; Chief Health Officer, *Credentials and Clinical Privileges Standard (Version 4)* (1 September 2016) <<https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards>>, in relation to licensed private health facilities.

<sup>80</sup> See [2.74]–[2.75] below in relation to medications commonly used for terminations. See also the discussion of 'the role of registered health practitioners' in Chapter 3 below as to which health practitioners can dispense, prescribe, administer or supply medications used for medical terminations.

<sup>81</sup> *Health (Drugs and Poisons) Regulation 1996* (Qld) s 146. The maximum penalty in each case is 60 penalty units.

<sup>82</sup> See generally Therapeutic Goods Administration, *Medicines and TGA Classifications* <[www.tga.gov.au/medicines-and-tga-classifications](http://www.tga.gov.au/medicines-and-tga-classifications)>; and see *Therapeutic Goods Act 1989* (Cth) s 52D; *Poisons Standard October 2017* (Cth) (The Standard for the Uniform Scheduling of Medicines and Poisons). The *Poisons Standard* is given effect in Queensland by the *Health (Drugs and Poisons) Regulation 1996* (Qld).

<sup>83</sup> As to licensed private health facilities, see generally the *Private Health Facilities Act 1999* (Qld). A 'private health facility' is defined as a private hospital or a day hospital: s 8; see also ss 7, 9–10 as to the meaning of the terms 'health service', 'private hospital' and 'day hospital'.

some instances, termination services may also be provided through a general practitioner or a telehealth service.<sup>84</sup>

## Health facilities and standards of service provision

2.56 Private health facilities are required to be licensed under the *Private Health Facilities Act 1999*.<sup>85</sup> That Act also empowers the Chief Health Officer to make standards ‘for the protection of the health and wellbeing of patients receiving health services at [licensed] private health facilities’.<sup>86</sup> Relevantly, the Speciality Health Services Standard requires that the provision of ‘speciality health services’, which includes termination services, be in accordance with the Clinical Services Capability Framework for Public and Licensed Private Health Facilities (the ‘CSCF’) and the CSCF Companion Manual,<sup>87</sup> and ‘appropriate college / professional body guidelines’.<sup>88</sup>

2.57 The CSCF ‘is applicable to both public [hospitals] and licensed private health facilities’.<sup>89</sup> It sets out ‘the minimum support services, staffing, safety standards and other requirements’ that apply to those facilities in Queensland,<sup>90</sup> including for the delivery of termination services. It categorises clinical services into six service levels, which reflect increasing levels of patient complexity.<sup>91</sup>

84 Access to terminations through a general practitioner or a telehealth service generally relates to a medical termination. As to telehealth services see, for example, the Tabbot Foundation, which is a privately operated service that offers women seeking a termination a telephone consultation with a medical practitioner and (if applicable) a clinical psychologist. Where a termination is approved, the service will provide the medications for a medical termination by mail, and provide support by a registered nurse and an on-call doctor: <<https://www.tabbot.com.au/>>.

85 *Private Health Facilities Act 1999* (Qld) pt 6.

86 *Private Health Facilities Act 1999* (Qld) s 12; *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1.

87 *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1; Chief Health Officer, *Specialty Health Services Standard (Version 5)* (1 September 2016) <<https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards>>. In relation to the CSCF and CSCF Companion Manual, see generally Queensland Health, *Clinical services capability framework* (22 May 2017) <<https://www.health.qld.gov.au/system-governance/licences/private-health/cscf>>. The CSCF Companion Manual is also referred to as the ‘Private Health Facilities’ Companion Document’.

88 Namely, Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018); Queensland Health, Clinical Excellence Division, ‘Guide to Informed Decision-making in Health Care’ (2nd ed, 2017); Australian Day Surgery Nurses Association, ‘Best Practice Guidelines for Ambulatory Surgery and Procedures’ (2013); Australian and New Zealand College of Anaesthetists, ‘Recommendations for the Post-Anaesthesia Recovery Room’ (PS04, 2006); Australian and New Zealand College of Anaesthetists, ‘Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures’ (PS09, 2014); Australian and New Zealand College of Anaesthetists, ‘Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations’ (PS55, 2012); RANZCOG, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016); RANZCOG, ‘Late Termination of Pregnancy’ (C-Gyn 17A, May 2016); and RANZCOG, ‘The use of Mifepristone for Medical Termination of Pregnancy’ (C-Gyn 21, February 2016): Information provided by Queensland Health, 13 December 2017.

89 Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [1], [6.1]. See also [2.56] above.

90 Queensland Health, *Clinical services capability framework* (22 May 2017) <<https://www.health.qld.gov.au/system-governance/licences/private-health/cscf>>. See also Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) 3.

91 Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [7].

2.58 Generally, termination services are ‘to be provided at the lowest service level that can safely facilitate [the] care’.<sup>92</sup> A licensed private health facility that provides termination services must be classified as at least a level three service and satisfy specific requirements relating to the assessment of patients, the provision of care and performance of procedures by appropriate staff, and access to pre-termination and post-termination counselling.<sup>93</sup>

2.59 Since 2014, the CSCF has included a requirement that ‘[w]here termination of a live fetus from 22 weeks gestation or more is clinically indicated, the woman is to be referred to a Level six service with ability to provide this service’.<sup>94</sup> Currently, terminations at 22 weeks gestation or more are permitted to be performed at one major hospital in northern Queensland and three major hospitals in south-east Queensland.<sup>95</sup>

### Queensland Health clinical guideline and other guidance

2.60 Queensland Health has published a clinical guideline for health practitioners about therapeutic termination of pregnancy (the ‘clinical guideline’).<sup>96</sup> Among other things, the clinical guideline sets out requirements, processes and ‘good practice points’ for obtaining consent, undertaking pre-termination assessment, obtaining facility level approval and offering counselling and psychological support. It also deals with considerations relating to the different methods of termination, and recommendations about post-termination care, which may include referrals for counselling and contraceptive advice.<sup>97</sup>

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<sup>92</sup> Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015) 2.

<sup>93</sup> Department of Health, *Clinical services capability framework companion manual: Termination of pregnancy services* (Version 4.3) 3.

<sup>94</sup> Information provided by Queensland Health, 15 December 2017; Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015) 2. The CSCF also states that ‘[c]onsultation with a maternal fetal medicine unit should occur for women where fetal anomaly has been identified’. See also Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6.1].

<sup>95</sup> Information provided by Queensland Health, 15 December 2017.

<sup>96</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018). See also [2.56] above. The term ‘therapeutic termination of pregnancy’, as used in the clinical guideline, ‘refers to the deliberate ending of a pregnancy where necessary to preserve the woman from a serious danger to her life or physical or mental health’ (notes omitted): [1], citing *R v Davidson* [1969] VR 667.

The clinical guideline includes a number of general statements regarding clinical practice and care. Among other things, it states that ‘the guideline is not a substitute for clinical judgment, knowledge and expertise or medical advice’, and ‘variation from the guideline, taking into account individual circumstances, may be appropriate’. The clinical guideline ‘accepts that individual clinicians are responsible for providing care within the context of locally available resources, expertise and scope of practice... [and] meeting all legislative requirements and professional standards’: 2.

<sup>97</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018). In addition, see the Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014) which address perinatal care for births at low gestational ages, referred to in Chapter 3 below and in QLRC Consultation Paper No 76 (2017) [143].

### **Determining gestation**

2.61 The clinical guideline provides that ‘gestational age’ is to be determined as part of the usual pre-termination assessment.<sup>98</sup>

2.62 ‘Gestational age’ (commonly referred to as ‘gestation’ or the duration of the pregnancy) refers to the number of weeks progress during a pregnancy, which is usually measured as the number of weeks since the first day of the woman’s last menstrual period.<sup>99</sup>

2.63 Gestation is estimated by clinical evaluation or ultrasound examination.<sup>100</sup> Clinical evaluation is based on the date, if known, of the first day of the woman’s last menstrual period, the woman’s other relevant medical history, and physical examination.<sup>101</sup> Ultrasound estimation is based on biometric measurements of the fetus, such as the crown-rump length and head circumference.<sup>102</sup>

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98 The pre-termination assessment also includes obtaining a full picture of the circumstances leading to the request for termination, obtaining the woman’s relevant medical history, conducting a physical examination, confirming the diagnosis of pregnancy, considering ectopic pregnancy, undertaking routine antenatal screening, considering other health care such as pap smear and contraception and coordinating relevant referrals: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6]. Gestation may impact on the choice of termination method.

99 See WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) iv; M Porta (ed), *A Dictionary of Epidemiology* (Oxford University Press, 6th ed, 2016); SN MacGregor and RE Sabbagha, *Assessment of Gestational Age by Ultrasound* (2008) Global Library of Women’s Medicine <[http://www.glowm.com/section\\_view/heading/Assessment%20of%20Gestational%20Age%20by%20Ultrasound/item/206](http://www.glowm.com/section_view/heading/Assessment%20of%20Gestational%20Age%20by%20Ultrasound/item/206)>. In biological terms, gestation may be counted from the time of fertilisation, to give a full term gestation of 38 weeks, but this time is usually not known with certainty.

100 See generally Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6]; WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) 31–4; K Butt and K Lim, ‘SCOG Clinical Practice Guidelines: Determination of Gestational Age by Ultrasound’ (2014) 36(2) *Journal of Obstetrics and Gynaecology Canada* 171, 172–3.

101 Physical examination involves bimanual pelvic or abdominal examination: see, eg, WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) 33–4.

102 Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [20.1.1]. See also, eg, Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014) [3].

2.64 Determinations of gestation depend on the individual circumstances, and involve clinical judgment.<sup>103</sup> Ultrasound may be more accurate,<sup>104</sup> and is recommended in particular clinical circumstances.<sup>105</sup>

2.65 In Queensland, the clinical guideline advises medical practitioners to consider using ultrasound to confirm the gestation and to do so in all cases of second trimester termination procedures.<sup>106</sup>

2.66 RANZCOG notes that, whilst it may be necessary to assess gestation more precisely in some circumstances, ultrasound is not considered an essential prerequisite for all terminations.<sup>107</sup> It has also been observed that it may be difficult for women in remote regions to access ultrasound early in pregnancy due to the limited availability of equipment and personnel, and transport costs.<sup>108</sup>

### **Facility level approval**

2.67 The clinical guideline recommends ‘facility level approval’ for terminations. The suggested procedure involves either two medical specialists or, in complex cases, a case review with at least one other relevant health professional.<sup>109</sup>

2.68 The purpose of a facility level approval ‘is to establish and document a considered process for the woman and to provide reassurance and support to the health practitioner’. Each facility should determine its own ‘local approval structure and mechanisms appropriate to its service’.<sup>110</sup>

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<sup>103</sup> For example, the woman’s clinical history may be unreliable due to poor recall of dates, irregular menstrual cycles, bleeding in early pregnancy or the use of oral contraceptives; and the reliability of ultrasound examination may be influenced by the quality of the images, the timing of the ultrasound (with those conducted earlier in pregnancy being most accurate), or the presence of maternal or fetal disease or abnormality: see, eg, Butt and Lim, above n 100, 173–7.

<sup>104</sup> Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [20.1.1]; Butt and Lim, above n 100, 173, 176–7.

<sup>105</sup> The use of ultrasound to assess gestation is recommended where there is a discrepancy between the date of the last menstrual period and physical examination, if the woman has an irregular menstrual cycle, if it is necessary to assess gestation more accurately to offer medical termination, and in all second trimester procedures: see, variously, RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 7; Royal College of Obstetricians and Gynaecologists (UK), ‘The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7’ (2011) 51–2; VJ Davis, ‘SOGC Clinical Practice Guidelines: Induced Abortion Guidelines’ (2006) *Journal of Obstetrics and Gynaecology Canada* 1014, 1016; National Abortion Federation, ‘Clinical Policy Guidelines’ (2018) 25, 32, 37; WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) iv. See also n 121 below as to the use of ‘MS-2 Step’.

<sup>106</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6].

<sup>107</sup> RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 7, citing the Royal College of Obstetricians and Gynaecologists (UK), ‘The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7’ (2011) in which it is observed (at 52) that ‘[t]he insistence of the need for routine pre-abortion ultrasound limits the settings in which abortion can be offered’.

<sup>108</sup> Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [20.2.5].

<sup>109</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2]. See also QLRC Consultation Paper No 76 (2017) [187].

<sup>110</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2]. The guideline suggests that, although it is not a legal requirement, it is ‘strongly recommended’ that a treating obstetrician should observe the local approval process. For terminations of later term pregnancies, usually involving fetal abnormalities, Queensland public hospitals usually refer the request to a hospital committee which may include specialists from multiple disciplines: see QLRC Consultation Paper No 76 (2017) [189]–[191].

### Identifying fetal anomalies

2.69 Nationally, there are also recommendations for tests to be offered to pregnant women, at different stages of pregnancy, for the detection of structural or genetic fetal anomalies.<sup>111</sup> The tests are offered in maternity care to provide the woman with more information.<sup>112</sup>

2.70 Commonly, these include the following:<sup>113</sup>

- ‘Combined’ first trimester screening — uses a combination of ultrasound measurement (recommended at 11 to 13 weeks gestation) and biochemical testing (recommended at 9 to 13 weeks gestation) to identify whether there is a high probability of a chromosomal anomaly.<sup>114</sup>
- Second trimester ‘morphology’ scan — uses diagnostic ultrasound (recommended at 18 to 20 weeks gestation) to assess fetal development and anatomy, and can identify structural anomalies, such as those of the heart, renal tract or neural tube.
- Second trimester diagnostic testing for chromosomal anomalies — offered where a high probability result is obtained from screening; based on chromosomal analysis of cells collected using ‘chorionic villus sampling’ (recommended before 14 weeks gestation) and ‘amniocentesis’ (recommended after 15 weeks gestation).<sup>115</sup>

2.71 Testing is offered on an informed and voluntary basis and, where indicated, should include follow-up with other relevant health practitioners, such as obstetricians, experienced midwives and genetic counsellors.<sup>116</sup>

2.72 It has been observed that access to screening or diagnostic tests may be limited by cost or lack of availability, particularly in regional or remote areas.

<sup>111</sup> See Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [21], [49]–[53]; RANZCOG, ‘Prenatal Screening for Fetal Genetic or Structural Conditions’ (C-Obs 35, March 2016); RANZCOG, ‘Prenatal screening and diagnosis of chromosomal and genetic conditions in the fetus in pregnancy’ (C-Obs 59, March 2015, amended May 2016); RANZCOG, ‘Prenatal assessment of fetal structural conditions’ (C-Obs 60, March 2015, amended May 2016).

<sup>112</sup> RANZCOG, ‘Prenatal Screening for Fetal Genetic or Structural Conditions’ (C-Obs 35, March 2016) [1]. ‘All such testing should be voluntary and only undertaken when the pregnant woman has been informed about the nature of the screening test, the possible results, and the options available to her’: [1].

<sup>113</sup> Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [21], [49]–[53]; RANZCOG, ‘Prenatal Screening for Fetal Genetic or Structural Conditions’ (C-Obs 35, March 2016). Other tests may also be offered.

<sup>114</sup> Chromosomal (or genetic) anomalies include trisomy 21 (a chromosomal anomaly due to an additional chromosome 21, also referred to as Down syndrome); trisomy 18 (a genetic disorder caused by the presence of all or part of an extra 18th chromosome, also referred to as Edwards syndrome or trisomy E); and trisomy 13 (a genetic disorder in which a person has three copies of genetic material from chromosome 13, instead of the usual two copies, also referred to as Patau syndrome or trisomy D): Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [50.1], Glossary.

<sup>115</sup> ‘Chorionic villus sampling’ involves sampling of tissue from a particular part of the placenta; ‘amniocentesis’ involves sampling of fetal skin cells in the amniotic fluid: Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [51].

<sup>116</sup> Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [21.4], [21.5], [50.3], [50.4], [51.3]; RANZCOG, ‘Prenatal Screening for Fetal Genetic or Structural Conditions’ (C-Obs 35, March 2016) [2]–[5].

Additional challenges have also been identified in relation to Aboriginal and Torres Strait Islander women, particularly in remote areas, including late presentation in pregnancy, difficulties in establishing accurate gestation, and travel and other logistical issues.<sup>117</sup>

## Methods for terminating a pregnancy

2.73 A termination may be performed as a medical termination or a surgical termination. The choice of procedure depends on the gestation of the pregnancy, clinical indications including the risk of complications, the preferences of the woman and other relevant circumstances. It may also be influenced by the availability of a procedure in a particular location.<sup>118</sup>

### Medical termination

2.74 A 'medical termination' refers to the use of pharmaceutical drugs to induce a termination.<sup>119</sup> Currently, mifepristone and misoprostol used in combination is the preferred drug regime; however misoprostol alone is also common and, in some circumstances, other drugs may be used.<sup>120</sup>

2.75 In Australia, mifepristone and misoprostol are available together as 'MS-2 Step', which is 'indicated ... for the medical termination of a developing intrauterine pregnancy, up to 63 days [nine weeks] of gestation'.<sup>121</sup> Mifepristone is

117 Australian Government, Department of Health, *Clinical Practice Guidelines: Pregnancy Care* (2018) [21.3.3], [52.1]. It has been found that there is a higher uptake of diagnostic testing for chromosomal anomalies by women in metropolitan areas and in private health care settings: [52.1].

118 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) 3, [6], [6.1].

119 Ibid [7]. See also RANZCOG, 'The use of Mifepristone for Medical Termination of Pregnancy' (C-Gyn 21, February 2016) Rec 1, [2]; M Permezel, S Walker and K Kyprianou, *Beischer & McKay's Obstetrics, Gynaecology and the Newborn* (Elsevier Australia, 4th ed, 2015) 463–4.

120 Ibid; WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 42–6. For example, gemeprost may be used for a termination in the second trimester of pregnancy: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [7].

121 Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Public Summary* (20 October 2016); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product Information* (28 March 2017) 7. It is recommended that the gestation be confirmed by ultrasound (which may also be used to exclude ectopic pregnancy).

MS-2 Step is also included in the Pharmaceutical Benefits Scheme (the 'PBS'). The PBS listing requires treatment 'by a prescriber who is registered with the MS-2 Step Prescribing Program': Australian Government, Department of Health, *The Pharmaceutical Benefits Scheme: Mifepristone & Misoprostol* <<http://www.pbs.gov.au/medicine/item/10211K>>.

MS Health Pty Ltd is the sponsor of the MS-2 Step composite pack: *Therapeutic Goods Act 1989* (Cth) s 3 (definition of 'sponsor'); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Public summary* (20 October 2016); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product information* (28 March 2017).

Mifepristone is separately registered and indicated for use in terminations beyond the first trimester: Australian Register of Therapeutic Goods, ARTG ID 175671, *Mifepristone—Public Summary* (9 June 2015); Australian Register of Therapeutic Goods, ARTG ID 175671, *Mifepristone—Product Information* (28 March 2017) 4–5.

taken first, followed between 24 and 48 hours later by misoprostol. Together, these medications have the effect of causing expulsion of the products of conception.<sup>122</sup>

2.76 In Queensland, the clinical guideline states that the determination of the most appropriate setting for a medical termination depends upon local service capabilities and the woman's circumstances, including her proximity to emergency care. The clinical guideline also states that, generally, a woman may be cared for on an outpatient basis where her pregnancy is less than nine weeks gestation, and she has appropriate support and access to medical care.<sup>123</sup>

2.77 In some circumstances, a pregnancy may be terminated by inducing labour, using medication.<sup>124</sup> This process may involve the administration of mifepristone and misoprostol.<sup>125</sup>

### **Surgical termination**

2.78 A 'surgical termination' refers to a procedure during which the contents of a woman's uterus are surgically removed to terminate a pregnancy.<sup>126</sup>

2.79 Usually, this involves dilation of the woman's cervix. Procedures used to surgically remove the contents of the woman's uterus include vacuum aspiration and curettage.<sup>127</sup>

2.80 In Queensland, the clinical guideline states that surgical curettage is generally suitable for terminations up to 14 weeks gestation. In pregnancies of

<sup>122</sup> Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product Information* (28 March 2017) 3–19; Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Consumer Medicine Information* (28 March 2017) 2; Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) App B; RANZCOG, 'The use of Mifepristone for Medical Termination of Pregnancy' (C-Gyn 21, February 2016) [2], [3.1]; WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 43; Permezel, Walker and Kyprianou, above n 119, 464. It is generally recommended that the misoprostol is taken 24 to 48 hours after the mifepristone for pregnancies less than nine weeks gestation, and 36 to 48 hours after for pregnancies of nine to 12 weeks gestation.

<sup>123</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [7.2]. RANZCOG is also supportive of outpatient care for a pregnancy of less than nine weeks gestation provided there is access to suitable emergency care: RANZCOG, 'The use of Mifepristone for Medical Termination of Pregnancy' (C-Gyn 21, February 2016) Rec 3, [3.3].

Appendix B of the clinical guideline includes some suggested protocols for the use of mifepristone and misoprostol at a gestation of greater than nine weeks and into the second trimester of pregnancy. See also WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 43–5. RANZCOG states that where the gestation exceeds nine weeks, the administration of medication and passing of the products of conception should occur in an appropriate facility: RANZCOG, 'The use of Mifepristone for Medical Termination of Pregnancy' (C-Gyn 21, February 2016) (February 2016) Rec 4, [3.4].

<sup>124</sup> The induction of labour may sometimes be preceded by administration of a chemical to stop the fetus' heart: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6.1]; Permezel, Walker and Kyprianou, above n 119, 82.

Relevant circumstances include, although are not limited to, the gestation of pregnancy being greater than nine weeks and the woman being cared for on an inpatient basis.

<sup>125</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) App B; Permezel, Walker and Kyprianou, above n 119, 82. See generally Parliamentary Committee Report No 24 (2016) [7.2.3].

<sup>126</sup> See generally Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [8]; WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 40–42; Permezel, Walker and Kyprianou, above n 119, 464.

<sup>127</sup> Ibid. Dilation of the woman's cervix may involve the use of mifepristone and misoprostol, misoprostol alone, or other medications: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [8.1].

between 14 and 16 weeks gestation, the clinical guideline recommends that the procedure be performed only by an experienced medical practitioner.<sup>128</sup>

### **Complications of termination**

2.81 Both medical and surgical terminations, when ‘performed by appropriately trained personnel under modern medical conditions’, are safe and effective; side effects commonly include nausea, vomiting, pain and prolonged bleeding, but serious complications are rare.<sup>129</sup>

2.82 Complications may include a failed or incomplete termination, infection, cervical injury, haemorrhage, and uterine perforation or rupture.<sup>130</sup> The risk of such complications decreases with earlier gestations and clinician experience.<sup>131</sup> The risk of maternal death is estimated at less than 1 in 100 000.<sup>132</sup>

2.83 The WHO has also observed that ‘[t]he vast majority of women who have a properly performed induced abortion will not suffer any long-term effects on their general or reproductive health’:<sup>133</sup>

Research shows no association between safely induced first-trimester abortion and adverse outcomes in subsequent pregnancies. Although second-trimester abortions have not been studied as extensively, there is no evidence of an increased risk of adverse outcomes in subsequent pregnancies. Sound epidemiological data show no increased risk of breast cancer for women following spontaneous or induced abortion. Negative psychological sequelae [consequences] occur in a very small number of women and appear to be the continuation of pre-existing conditions, rather than being a result of the experience of induced abortion.

128 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [8].

129 WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) [2.2.6]. See also Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [7.1], [7.3], [7.4], [8.2], App A; RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 2–4, 10, 17–18.

130 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) App A; RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 2–3, 11–12. For example, the risk of cervical injury is estimated as no greater than 1 in 100; the risk of haemorrhage is approximately 1 in 1000 for surgical termination and 1–2 in 1000 for medical termination; and the risk of uterine perforation is approximately 1–4 in 1000 for surgical terminations.

131 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) App A; RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 2–3, 11.

132 Ibid; RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 2, 10–11, 13. See also WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) [2.2.6]. This compares with the estimated rate of maternal death from unsafe terminations of 30 per 100 000 terminations (an ‘unsafe’ termination is one performed by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both): WHO, *Preventing unsafe abortion* (19 February 2018) <<http://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion>>.

133 WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) [2.2.6.8]. Findings are inconsistent, but evidence suggests that termination does not increase the risk of subsequent ectopic pregnancy, placenta praevia or infertility, although there is a possible increased risk of subsequent preterm birth or miscarriage in some cases; there does not appear to be a causal relationship between termination and breast cancer; and lawful and voluntary termination rarely causes negative psychological consequences in healthy women: RANZCOG, ‘Termination of Pregnancy: A resource for health professionals’ (November 2005) 25–7; Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) App A.

2.84 Available studies on long-term consequences vary in their reliability and findings, and patterns may change over time.<sup>134</sup>

## THE INCIDENCE OF TERMINATIONS

### General

2.85 There is no formal national monitoring of the number of terminations in Australia, and the available data for Queensland are incomplete.<sup>135</sup>

2.86 It is estimated that half of all pregnancies in Australia are unplanned, and that half of unplanned pregnancies are terminated. It is also estimated that between one quarter and one third of Australian women will experience a termination.<sup>136</sup>

2.87 Estimated national figures show that the number of terminations in Australia in 2003 was about 84 000, with the highest number among women aged 20 to 24 years, and the lowest among girls aged younger than 15 years.<sup>137</sup>

2.88 Australia's termination rate has been steadily declining. Available estimated national figures show a fall in the termination rate from 21.9 per 1000 woman aged 15 to 44 years in 1995 to 19.7 in 2003.<sup>138</sup>

2.89 Information from the United Nations Department of Economic and Social Affairs indicates that the rate of terminations in Australia has continued to decline from 14.2 per 1000 women aged 15 to 44 years in 2010<sup>139</sup> to 10.6 in 2013.<sup>140</sup>

2.90 An indicative comparison with the rates in other countries is provided below:

<sup>134</sup> See, eg, RANZCOG, 'Termination of Pregnancy: A resource for health professionals' (November 2005) 25. The reliability of studies may be affected, for example, by sample size and selection.

<sup>135</sup> Parliamentary Committee Report No 24 (2016) [7.4.1.1]. South Australia, Western Australia and the Northern Territory are the only Australian jurisdictions in which data collection is required: see the discussion of 'Data collection' in Chapter 6.

<sup>136</sup> Children By Choice, *Australian Abortion Statistics* (19 September 2017) <<https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>>.

<sup>137</sup> See N Grayson, J Hargreaves and EA Sullivan, 'Use of routinely collected national data sets for reporting on induced abortion in Australia' (Perinatal Statistical Series No 17, Australian Institute of Health and Welfare, December 2005) 34.

<sup>138</sup> A Chan and LC Sage, 'Estimating Australia's abortion rates 1985–2003' (2005) 182(9) *Medical Journal of Australia* 447, 449–50. The estimated termination rate for Australia initially increased from 17.9 per 1000 woman aged 15 to 44 years in 1985 up to 21.9 in 1995, before declining to 19.7 in 2003.

Similarly, available data in South Australia show that the rate of terminations per 1000 women aged 15 to 44 years in that jurisdiction increased in the 1970s and 1990s to reach a peak of 17.9 in 1999, but has since declined to 13.8 in 2014: see Pregnancy Outcome (Statistics) Unit, SA Health, *Pregnancy Outcome in South Australia 2014* (2016) 51. The initial increase is attributed 'mainly to the shift from the clandestine sector and to better reporting' of terminations: F Yusuf and S Siedlecky, 'Legal abortion in South Australia: a review of the first 30 years' (2002) 42(1) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 15, 16.

<sup>139</sup> United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (2013) <<https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml>>.

<sup>140</sup> United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* (2014) Annex 4, 46.

	Australia	New Zealand	England Scotland Wales	Ireland	Denmark	Norway	Sweden	Iceland	France	Germany	Canada
2009 / 2010 <sup>141</sup>	14.2	18.2	14.2	4.5	15.2	16.2	20.8	14.5	17.4	6.1	13.7
2011– 13 <sup>142</sup>	10.6	17.3	16.6	n/a	n/a	15.5	20.8	14.5	17.2	7.2	12.1

**Table 1: Termination rates (per thousand), selected countries<sup>143</sup>**

2.91 The scope and availability of official statistics vary between countries, making comparisons difficult. It has been observed, however, that there is a general trend of declining rates of termination among industrialised countries.<sup>144</sup>

2.92 Studies of the worldwide incidence of termination have also found that, 'unrestrictive abortion laws do not predict a high incidence of abortion, and by the same token, highly restrictive abortion laws are not associated with low abortion incidence'.<sup>145</sup> The WHO has highlighted that '[t]he legal status of abortion has no

<sup>141</sup> The rates given are for 2010, with the exception of France and Canada, which are given for 2009. The highest known rate was in the Russian Federation (37.4) and the lowest in Mexico (<0.05): United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (2013) <<https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml>>.

<sup>142</sup> The rates given are for 2012, with the exception of Australia (which are given for 2013); and New Zealand, Sweden, Iceland and France (which are given for 2011). No rate is identified for Ireland or Denmark for a comparative year: United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* (2014) Annex 4.

<sup>143</sup> United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (2013) <<https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml>>; United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* (2014) Annex 4. Rates are per 1000 women aged 15 to 44 years.

<sup>144</sup> See, eg, G Sedgh et al, 'Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends' (2016) 388 *The Lancet* 258 (online). Available data in Canada, for example, show that, whilst there was an initial increase in the rate of terminations following decriminalisation in 1988 (for example, from 11.6 in 1988 to 14.7 in 1991 per 1000 women aged 15 to 44 years), the number of terminations has remained fairly steady and has been decreasing (for example, from 108 844 in 2011 to 100 104 in 2015): see Statistics Canada, *Selected Therapeutic Abortions Statistics, 1970–1991*, Cat No 82-550 (1994) 13; Statistics Canada, *Induced Abortion Statistics 2005*, Cat No 82-223-X (2008) 7, 11; Canadian Institute for Health Information, *Induced Abortions Reported in Canada in 2015* (2017) 5. See also, eg, TC Jatlaoui et al, *Abortion Surveillance—United States, 2014*, Centers for Disease Control and Prevention (24 November 2017) <[https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm?s\\_cid=ss6624a1\\_w](https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm?s_cid=ss6624a1_w)>.

<sup>145</sup> G Sedgh et al, 'Induced abortion: estimated rates and trends worldwide' (2007) 370 *The Lancet* 1338, 1343. See also, G Sedgh et al, 'Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends' (2016) 388 *The Lancet* 258 (online), 6 in which it is reported that:

When countries were grouped according to the grounds under which abortion was legal, we did not find evidence that abortion rates for 2010–14 were associated with the legal status of abortion. The rate was 37 abortion per 1000 women (34–51) where abortion is prohibited altogether or allowed only to save a woman's life, and 34 (29–46) where it is available on request.

Other studies have found that the incidence of termination generally declines as contraceptive use increases: C Marston and J Cleland, 'Relationships between contraception and abortion: a review of the evidence' (2003) 29 *International Family Planning Perspectives* 6, cited in G Sedgh et al, 'Induced abortion: estimated rates and trends worldwide' (2007) 370 *The Lancet* 1338, 1343.

effect on a woman's need for an abortion', but may impact on access to safe termination.<sup>146</sup>

2.93 As noted, few jurisdictions in Australia publish official data, making it difficult to identify any changes in the incidence of terminations following law reform.

2.94 In Western Australia, the introduction of termination legislation in 1998 included a data notification requirement.<sup>147</sup> Published data show that the termination rate declined overall from 19.7 per 1000 women aged 15 to 44 years in 1999 to 16.4 in 2012.<sup>148</sup>

2.95 A recent qualitative study of the impact of the law reform introduced in Victoria in 2008<sup>149</sup> found little perceived change in the provision of termination services, with no increase in access to terminations, including terminations at later gestation.<sup>150</sup>

2.96 It has also been suggested that the provision of terminations has been stable in the Australian Capital Territory following reforms to the law in that jurisdiction in 2002.<sup>151</sup>

146 WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 17. See also United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* (2014) 15, 16.

147 See *Health (Miscellaneous Provisions) Act 1911* (WA) ss 334, 335(5)(d), inserted by the *Acts Amendment (Abortion) Act 1998* (WA); and *Health (Section 355(5)(D) Abortion Notice) Regulations 1998* (WA). See the discussion of 'Data collection' in other jurisdictions in Chapter 6.

148 Department of Health (WA), 'Induced Abortions in Western Australia 2010–2012' (Statistical Series No 96, July 2013) 8. Termination rates for the years prior to 1999 are not available; however, it has been observed that the estimated rates before 1999 were 'comparable' to those immediately after the legislative amendments in 1998. For example, in 1991 the termination rate was estimated as 18.5 per 1000 women aged 15 to 49 or 20.7 per 1000 women aged 15 to 44: Department of Health (WA), 'Induced Abortion in Western Australia 1999–2004' (Report of the WA Abortion Notification System, July 2005) 3.

149 See the *Abortion Law Reform Act 2008* (Vic).

150 LA Keogh et al, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18, 22. The study found that there was, in fact, concern about reduced access to surgical termination and termination after 20 weeks gestation. The study involved a qualitative semi-structured interview with experts from a range of health care settings and geographic locations across Victoria. It did not involve analysis of data: '[d]ue to the lack of routine data collection on abortion provision in Victoria, we are dependent on experts' accounts to describe the impact of law reform': 20–22.

Unofficial statistics compiled from Medicare data suggest that there has been a decline in the number of terminations in Victoria since 2008, continuing an ongoing overall trend of decline since the 1990s: WR Johnston, *Historical abortion statistics, Victoria (Australia)* (3 January 2015) Johnston's Archive <<http://www.johnstonsarchive.net/policy/abortion/australia/ab-aust-vic.html>>. See also, eg, F Hudson, 'Thousands of young women had abortions in Victoria last year', *The Herald Sun* (online), 20 November 2009 which reported on figures provided by the State Government of Victoria showing a decrease in the number of terminations from 2005–06 to 2008–09. As to difficulties relying on Medicare data see n 158 below.

151 See, eg, B Baird, 'Decriminalization and Women's Access to Abortion in Australia' (2017) *Health and Human Rights Journal* (online) <<https://www.hhrjournal.org/2017/06/decriminalization-and-womens-access-to-abortion-in-australia/>>. Unofficial statistics compiled from Medicare data suggest that there has been a small overall decline in the number of terminations in the Australian Capital Territory since 2002, with numbers remaining fairly constant since the 1990s: WR Johnston, *Historical abortion statistics, Australian Capital Territory (Australia)* (3 January 2015) Johnston's Archive <<http://www.johnstonsarchive.net/policy/abortion/australia/ab-aust-act.html>>. As to difficulties relying on Medicare data see n 158 below.

See the *Health Act 1993* (ACT) pt 6; and the *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT).

## Queensland

2.97 It has been estimated that between 10 000 and 14 000 terminations are performed in Queensland each year, with most performed in the first trimester of pregnancy.<sup>152</sup>

2.98 Data from the Queensland Hospital Admitted Patient Data Collection show that a total of 10 421 terminations were performed in Queensland public hospitals and licensed private health facilities in 2016. However, the data do not include terminations performed in an outpatient setting, such as medical terminations carried out by general practitioners in private practice.<sup>153</sup>

2.99 The highest number of terminations in 2016 was among women aged 20 to 29 years (51%) and 30 to 34 years (20%), and the lowest among those aged 40 years or older (6%) and 19 years or younger (9%).<sup>154</sup> Most terminations were performed in the Metro North (35%) and Metro South (29%) regions, followed by the Gold Coast (12.5%) and Sunshine Coast (11%). Comparatively few terminations occurred in remote and regional areas including the South West and North West, and none were performed in the Torres and Cape.<sup>155</sup>

2.100 A small number (11) of terminations performed in the Cairns and Hinterland, Townsville and Gold Coast regions were for women resident in the Torres and Cape; similarly, a small number (36) of terminations in the Townsville and Gold Coast regions were for women resident in the Cairns and Hinterland region.<sup>156</sup>

<sup>152</sup> Parliamentary Committee Report No 24 (2016) [7.4.1.2]; Children By Choice, *Australian Abortion Statistics* (19 September 2017) <<https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>>.

In 2003, an estimated 14 000 Queensland woman underwent a termination: Grayson, Hargreaves and Sullivan, above n 137, 33. It was estimated that 11.5% of those women had the procedure outside their state of residence.

<sup>153</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018. This relates to data for admitted patient episodes, in both public hospitals and licensed private health facilities in Queensland, that are coded at the time of the patient's 'separation' as involving a termination (and is linked with the Queensland Perinatal Data Collection). All public hospitals and licensed private health facilities are required to submit data to the Department of Health about patients 'separated' (meaning discharged, died, transferred or statistically separated) from those hospitals. The data is collated and maintained by the Department of Health as the Queensland Hospital Admitted Patient Data Collection. The data are preliminary and subject to change.

<sup>154</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018:

	≤19	20–24	25–29	30–34	35–39	≥40	Total
2016	971	2658	2693	2067	1396	636	10 421

<sup>155</sup> Information provided by Queensland Health, 20 and 23 February 2018:

	Cairns and Hinterland	Central Qld	Gold Coast	Metro North	Metro South	Sunshine Coast	Townsville	Other regions*	Total
2016	254	388	1305	3623	3066	1172	520	93 total	10 421

\* Darling Downs, Mackay, North West, South West, Torres and Cape, West Moreton and Wide Bay regions.

This is generally consistent with previous years.

<sup>156</sup> Information provided by Queensland Health, 20 February 2018. In 2017, the Cairns and Hinterland Hospital and Health Service referred 66 women for surgical termination to private providers in Queensland or interstate: *ibid.* See also J Walker, 'Regional hospital rejects abortion patients', *The Australian* (Australia), 22 January 2018, 3.

2.101 The total number of terminations identified from the Queensland Hospital Admitted Patient Data Collection has declined overall since 2011:<sup>157</sup>

2011	2012	2013	2014	2015	2016
11 694	11 906	12 020	11 285	10 813	10 421

**Table 2: Total admitted patient episodes for termination services in public hospitals and licensed private health facilities**

2.102 Based on Medicare data, it appears that the number of surgical procedures that include terminations has decreased in Queensland, consistently with the trend in other Australian jurisdictions.<sup>158</sup> On the other hand, it has been suggested that the number of medical terminations has likely increased following the inclusion of the drugs mifepristone and misoprostol on the Australian Register of Therapeutic Goods in 2012.<sup>159</sup>

### **Licensed private health facilities**

2.103 Most termination services in Queensland are provided in the private sector. Of the 10 421 patient admissions for terminations in Queensland in 2016, 9 929 occurred in licensed private health facilities.<sup>160</sup> This excludes public hospital procedures and terminations performed in an outpatient setting, including medical terminations carried out by general practitioners in private practice.

<sup>157</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018. See n 153 above.

<sup>158</sup> For example, the total number of services recorded in Queensland for Medicare items 35639 and 35640 (uterus, curettage of), 35643 (evacuation of the contents of the gravid uterus by curettage or suction curettage) and 16525 (management of second trimester labour) was 17 508 in 2002–03 and 12 552 in 2016–17: see Department of Human Services, *Medicare Item Reports*, Medicare Australia Statistics (24 November 2017) <[http://medicarestatistics.humanservices.gov.au/statistics/mbc\\_item.jsp](http://medicarestatistics.humanservices.gov.au/statistics/mbc_item.jsp)>. (From 1 November 2017, item 16525 will be covered by two items, 16530 and 16531: Australian Government, Department of Health, *Changes to MBS Items for Obstetrics Services* (23 October 2017) <<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>>.) Difficulties have been identified in using Medicare data to estimate the incidence of terminations in Queensland, including that the items are not specific to termination and may cover other procedures: see Grayson, Hargreaves and Sullivan, above n 137, 20–22, 27. See also Parliamentary Committee Report No 24 (2016) [7.5.1].

<sup>159</sup> See Parliamentary Committee Report No 24 (2016) [7.4.1.2]. Mifepristone was made available in Australia in 2006 through the Therapeutic Goods Administration Authorised Prescriber Scheme, and was added to the Australian Register of Therapeutic Goods in 2012: see Department of Health, Therapeutic Goods Administration, *Registration of medicines for the medical termination of early pregnancy* (30 August 2012) <<https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>>.

See further [2.74]–[2.75] above and the discussion of the ‘role of registered health practitioners’ in Chapter 3 below.

<sup>160</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection, for admitted patient episodes in licensed private health facilities between 2011 and 2016. See further n 153 above. See also Parliamentary Committee Report No 24 (2016) [7.4.2] relating to data between 2005 and 2011.

2011	2012	2013	2014	2015	2016
11 410	11 599	11 723	10 967	10 386	9 929

**Table 3: Admitted patient episodes for termination services in licensed private health facilities<sup>161</sup>**

2.104 Most of the 9 929 terminations performed in 2016 in licensed private health facilities were among women aged 20–29 years (52%) and 30–39 years (33%), with the lowest number among those aged 19 years or younger (9.6%) and 40 years or older (6%).<sup>162</sup>

2.105 The majority (89%) of terminations in licensed private health facilities occurred within the metropolitan South-East corner; most occurred in the Metro North and Metro South regions (65%), followed by the Sunshine Coast and Gold Coast (24%).<sup>163</sup>

### Public hospitals

2.106 Queensland public hospitals provide termination services in a limited range of circumstances. Most terminations performed in public hospitals are carried out on the basis of fetal abnormality or maternal illness or complications.<sup>164</sup>

2.107 In 2016, there were 492 terminations performed in public hospitals,<sup>165</sup> a significantly lower number than were performed in licensed private health facilities.

<sup>161</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018.

<sup>162</sup> Ibid. This is generally consistent with previous years.

	≤19	20–24	25–29	30–34	35–39	≥40	Total
2016	952	2569	2580	1930	1303	595	9 929

<sup>163</sup> Information provided by Queensland Health, 23 February 2018:

	Cairns and Hinterland	Central Qld	Gold Coast	Metro North	Metro South	Sunshine Coast	Townsville	Other regions*	Total
2016	211	373	1233	3472	3010	1152	470	8 total	9929

\* Darling Downs, Mackay, North West, South West, Torres and Cape, West Moreton and Wide Bay regions.

This is generally consistent with previous years.

<sup>164</sup> Parliamentary Committee Report No 24 (2016) [7.4.1.3], [7.4.2], [7.5].

<sup>165</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection, for admitted patient episodes in public hospitals between 2011 and 2016. See further n 153 above. See also Evidence to the Parliamentary Committee, 12 July 2016, 10 (Dr J Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health) in relation to 2015 data.

2011	2012	2013	2014	2015	2016
284	307	297	318	427	492

**Table 4: Admitted patient episodes for termination services in public hospitals<sup>166</sup>**

2.108 Most of the 492 terminations performed in 2016 in public hospitals were among women aged 25–34 years (51%), with the lowest number among women aged 19 years or younger (4%).<sup>167</sup>

2.109 The highest number of terminations in public hospitals occurred in the Metro North region (31%), followed by the Gold Coast (15%), Metro South (11.4%) and Townsville (10.2%).<sup>168</sup>

### Later gestation terminations

2.110 Later terminations are comparatively rare.

2.111 Almost all (approximately 99%) of the terminations in public hospitals and licensed private health facilities are performed before 20 weeks gestation. Of the 10 421 patient admissions for terminations in 2016 in Queensland public hospitals and licensed private health facilities, 140 (1.34%) occurred at 20 weeks gestation or more.<sup>169</sup> Of those 140 terminations, 64 occurred at 20–21 weeks gestation and 76 occurred at 22 weeks gestation or more.<sup>170</sup>

<sup>166</sup> Information provided by Queensland Health, 13 December 2017 and 23 February 2018.

<sup>167</sup> Ibid. This is consistent with previous years.

	≤19	20–24	25–29	30–34	35–39	≥40	Total
2016	19	89	113	137	93	41	492

<sup>168</sup> Information provided by Queensland Health, 23 February 2018:

	Cairns and Hinterland	Gold Coast	Metro North	Metro South	Townsville	Other regions*	Total
2016	43	72	151	56	50	120 total	492

\* Central Queensland, Darling Downs, Mackay, North West, South West, Sunshine Coast, Torres and Cape, West Moreton and Wide Bay regions.

The proportion of public hospital terminations across different regions has fluctuated in the previous years. For example, whilst Metro North has consistently accounted for the majority of such terminations (from between 19 and 35% in the years 2011 to 2016), the proportion of terminations at the Gold Coast has, overall, increased (from between 6 and 7% in 2011 to 2013, to between 13 and 14% in 2014 to 2016), and the proportion in the Metro South region has fluctuated (increasing from 7% in 2011 to 17% in 2014, before decreasing to 11% in 2015 to 2016): percentages calculated from data for 2011–2016 provided by Queensland Health, 23 February 2018.

<sup>169</sup> Information provided by Queensland Health, 21 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection: see further n 153 above.

<sup>170</sup> Information provided by Queensland Health, 21 December 2017 and 23 February 2018.

	2011	2012	2013	2014	2015	2016
≤ 19 weeks	11 580	11 786	11 890	11 144	10 681	10 281
≥ 20 weeks	114	120	130	141	132	140
20–21 weeks	68	66	65	70	62	64
≥ 22 weeks	46	54	65	71	70	76
Total	11 694	11 906	12 020	11 285	10 813	10 421

**Table 5: Admitted patient episodes for termination services in public hospitals and licensed private health facilities, by gestation<sup>171</sup>**

2.112 In addition to the Queensland Hospital Admitted Patient Data Collection, the Queensland Perinatal Data Collection provides information about terminations. It records still births of at least 20 weeks gestation or 400 grams in weight and neonatal deaths ('perinatal deaths'). The most recent data show that, in 2016, there were 137 such deaths identified as terminations.<sup>172</sup> The reported number of such terminations has increased, but continues to account for about 1.3% of all terminations performed in Queensland.<sup>173</sup>

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
3	21	66	81	86	91	99	104	115	136	136	137

**Table 6: Perinatal deaths identified as terminations (at least 20 weeks or 400 g)<sup>174</sup>**

<sup>171</sup> Information provided by Queensland Health, 13 and 21 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection: see further n 153 above. Figures for terminations at 20–21 weeks gestation have been calculated from data provided on the number of terminations at ≤ 19 weeks, ≥ 20 weeks and ≥22 weeks gestation (shown above) and those at ≤ 21 weeks gestation:

	2011	2012	2103	2014	2015	2016
≤ 21	11 648	11 852	11 955	11 214	10 743	10 345

<sup>172</sup> The Queensland Perinatal Data Collection is derived from information collected from public hospitals, private hospitals and homebirth practitioners. A 'perinatal death' is a stillbirth (of at least 20 weeks gestation or 400 g birth weight) or a neonatal death (of a live born infant within the first 28 days of life). See Queensland Department of Health, *Perinatal Statistics: Queensland 2016, Preliminary* (January 2018) 9, 12–14, Table 10.13; *Public Health Act 2005* (Qld) ch 6 pt 1. The 2016 figures are preliminary and subject to change.

<sup>173</sup> Based on figures of 10 421 terminations performed in licensed private health facilities and public hospitals in 2016: see table 2 at [2.101] above.

<sup>174</sup> See Parliamentary Committee Report No 24 (2016) [7.5.2]; Table 10.13 in the Queensland Health Perinatal Statistics Annual Reports for 2009–2016 at Queensland Health, *Perinatal reports and information* <<https://www.health.qld.gov.au/hsu/peri>>.

2.113 As explained above, in Queensland, terminations at 22 weeks gestation or more are currently permitted to be performed only at particular hospitals.<sup>175</sup> The majority (approximately 78%) of terminations at 20 weeks or more gestation occur in public hospitals:<sup>176</sup>

	Public	Private	Total
≤ 19 weeks	383	9898	10 281
≥ 20 weeks	109	31	140
20–21 weeks	52	12	64
≥ 22 weeks	57	19	76
<b>Queensland Total</b>	<b>492</b>	<b>9929</b>	<b>10 421</b>

**Table 7: Admitted patient episodes for termination services, by health sector and gestation, 2016<sup>177</sup>**

2.114 Most of the terminations at 20 weeks or more gestation in 2016 were carried out in the Metro North and Metro South regions (61%), followed by the Gold Coast (13%), with small numbers of such terminations in some other larger regional centres, such as Townsville (8.6%) and the Darling Downs (4.3%).<sup>178</sup>

<sup>175</sup> See [2.59] above.

<sup>176</sup> Information provided by Queensland Health, 21 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection: see further n 153 above. See also [2.121]–[2.122] below.

<sup>177</sup> Information provided by Queensland Health, 21 December 2017 and 23 February 2018, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland Perinatal Data Collection: see further n 153 above. This is generally consistent with previous years. Figures for terminations at 20–21 weeks gestation have been calculated from data provided on the number of terminations at ≤ 19 weeks, ≥ 20 weeks and ≥ 22 weeks gestation (shown above) and those at ≤ 21 weeks gestation:

2016	Public	Private	Total
≤ 21	435	9910	10 345

<sup>178</sup> Information provided by Queensland Health, 23 February 2018:

2016	Gold Coast	Metro North	Metro South	Townsville	Daring Downs	Other regions*	Total
(≥ 20 weeks)	18	59	26	12	6	19 total	140

\* Cairns and Hinterland, Central Queensland, Mackay, North West, South West, Sunshine Coast, Torres and Cape, West Moreton and Wide Bay regions.

Between 2011 and 2016, the Metro North region has consistently accounted for the highest number of terminations at 20 weeks or more gestation (and, overall, the highest number of terminations at 22 weeks or more gestation), with the comparative numbers in other regions fluctuating.

## ACCESSIBILITY AND AVAILABILITY

2.115 The accessibility and availability of termination services vary according to where a woman is located, her financial resources and the gestation of her pregnancy.

2.116 One recent study observed that ‘women who are socially, geographically and economically disadvantaged, have limited choice and access to abortion’.<sup>179</sup>

2.117 While there are a number of services providing both surgical and medical terminations in the south-east region of the State, there are fewer options further inland or in north Queensland.<sup>180</sup> Women in rural, regional and remote areas may have to travel long distances to access termination services and face additional financial costs (for example, the cost of travel and accommodation).<sup>181</sup>

### Surgical terminations

2.118 As mentioned above, most terminations in Queensland are performed in licensed private health facilities.<sup>182</sup> This includes private hospitals and private clinics (day hospitals). Terminations may also be performed in public hospitals, depending on their service level capability.<sup>183</sup>

2.119 There are currently nine private clinics that perform surgical terminations. The majority are located in the metropolitan south-east corner (Brisbane, the Gold Coast and Sunshine Coast). There is a clinic in Rockhampton and another in Townsville.<sup>184</sup>

2.120 Children by Choice reported that the cost of a surgical termination up to 11-12 weeks gestation could range from approximately \$350 to \$580 in Brisbane, Gold Coast and Sunshine Coast clinics, and approximately \$715 to \$775 in

179 M Shankar et al, ‘Access, equity and costs of induced abortion services in Australia: a cross-sectional study’ (2017) 41(3) *Australian and New Zealand Journal of Public Health* 309, 313.

180 Information provided by Queensland Health, 20 and 23 February 2018. For example, there are no services providing surgical termination in the Torres and Cape region. Medical terminations are available up to 63 days gestation and Cooktown hospital provides curette if required.

181 See [2.99]–[2.100] and nn 155, 156 above; and see, eg, C Nickson, AMA Smith and JM Shelley, ‘Travel undertaken by women accessing private Victorian pregnancy termination services’ (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329; FM Doran and J Hornibrook, ‘Barriers around access to abortion experienced by women in New South Wales, Australia’ (2016) *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* (online).

182 See [2.103] above.

183 Information provided by Queensland Health, 20 and 23 February 2018. It has been noted that there may sometimes be difficulty obtaining a specialist obstetrician, particularly in rural, regional or remote settings: see J Walker, ‘Regional hospital rejects abortion patients’, *The Australian* (Australia), 22 January 2018, 3, in which it was reported that Cairns Hospital sent 23 women to Sydney for surgical terminations in 2017, ‘after staff doctors refused to perform the procedure’. See also n 156 above.

184 This information has been compiled from Children by Choice, *Queensland abortion providers* (13 June 2018) <<https://www.childrenbychoice.org.au/25-for-women/abortion/23-clinics-qld>>. In its submission to the Parliamentary Committee, Children by Choice stated that this includes all private clinics, but only some general practitioners: Submission 794 to the Parliamentary Committee on the first Bill and Inquiry. These clinics also provide medical terminations, discussed at [2.123] ff below.

Rockhampton and Townsville.<sup>185</sup> The cost for a termination increases after 11–12 weeks gestation of pregnancy. It can be as much as \$650 to \$1410 at 14–15 weeks gestation and \$1500 to \$3065 at 16–19 weeks gestation.<sup>186</sup>

2.121 Most private clinics perform surgical terminations to 14 or 15 weeks gestation. Only a few clinics, all of which are located in the metropolitan South-East corner, offer termination services after this time.<sup>187</sup>

2.122 Private hospitals generally provide surgical terminations to 19 or 21 weeks gestation.<sup>188</sup> As noted above, terminations at 22 or more weeks gestation are currently permitted to be performed only at particular hospitals.<sup>189</sup>

### Medical terminations

2.123 Similarly to surgical terminations, medical terminations are provided by public and private hospitals and private clinics (day hospitals). They can also be provided by general practitioners who are certified prescribers.

2.124 There are a number of clinics offering medical terminations to nine weeks gestation of pregnancy in various locations, including Brisbane, the Gold Coast and Tweed Heads, the Sunshine Coast, Rockhampton, Townsville, Cairns and Cooktown.<sup>190</sup> Some providers also offer telehealth services.<sup>191</sup>

<sup>185</sup> Children by Choice, *How much will an abortion cost?* (14 March 2018) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>. This is the approximate cost for Medicare card holders as it includes the Medicare rebate. The cost is higher for non-Medicare card holders. The cost is higher in Rockhampton and Townsville due to a shortage of locally based, qualified providers, with doctors required to be flown in from Brisbane or interstate: see Parliamentary Committee Report No 24 (2016) [12.3]; Evidence to the Parliamentary Committee, 2 August 2016, 20 (Mr A Apostolellis, Chief Executive Officer, Marie Stopes International Australia).

<sup>186</sup> Children by Choice, *How much will an abortion cost?* (14 March 2018) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>. See also Parliamentary Committee Report 24 (2016) [12.6.4]. The cost may be higher in regional areas: see n 185 above.

<sup>187</sup> Parliamentary Committee Report 24 (2016) [12.6.4]. Women seeking to terminate a pregnancy in a private clinic after this time may travel to Victoria, where clinics are able to provide terminations up to 24 weeks: See, eg, Evidence to the Parliamentary Committee, 2 August 2016, 15 (Mr A Apostolellis, Chief Executive Officer, Marie Stopes International Australia); Nickson, Smith and Shelley, above n 181, 329.

<sup>188</sup> Information provided by Queensland Health, 23 February 2018.

<sup>189</sup> See [2.59] above. See also [2.67]–[2.68] above and QLRC Consultation Paper No 76 (2017) [186]–[190] as to facility level approval processes for later terminations.

<sup>190</sup> See Children by Choice, *Queensland abortion providers* (13 June 2018) <<https://www.childrenbychoice.org.au/25-for-women/abortion/23-clinics-qld>>.

<sup>191</sup> Whilst the medications for termination may be provided by mail following a phone consultation, a woman is still required to have an ultrasound and any other necessary tests (such as a blood test). A woman must be within two hours of a hospital when they take the medication, in case she needs emergency care. See further n 84 above; Marie Stopes Australia, *Medical abortion over the phone (tele-abortion)* <<https://www.mariestopes.org.au/abortion/tele-abortion/>>.

2.125 The cost for medical termination services varies. It is approximately \$400 to \$600 in Brisbane, Gold Coast and Sunshine Coast clinics and approximately \$790 for clinics in Rockhampton and Townsville.<sup>192</sup>

2.126 The medication that is commonly used, MS-2 Step,<sup>193</sup> can be prescribed only by medical practitioners who are registered as certified prescribers with MS Health Pty Ltd (a not-for-profit pharmaceutical company).<sup>194</sup> To become a certified prescriber, a general practitioner must complete an online training module. Obstetricians and gynaecologists may register to become certified prescribers by providing evidence of their specialist qualification.<sup>195</sup>

2.127 A general practitioner who is a certified prescriber must be affiliated with, and have their prescriptions dispensed by, a certified dispenser.<sup>196</sup> A pharmacist must register with MS Health Pty Ltd to become a certified dispenser.<sup>197</sup>

2.128 The cost for a medical termination through a general practitioner is approximately \$350 to \$580, plus the cost of the medication.<sup>198</sup>

2.129 In Queensland, there are currently 212 certified prescribers of MS-2 Step, of whom 118 are general practitioners.<sup>199</sup> There are 647 certified dispensers. In 2016, medication used for medical terminations (such as MS-2 Step and the mifepristone single pack) was dispensed over 3600 times.<sup>200</sup>

<sup>192</sup> This is the initial cost for Medicare card holders. There may be a \$60–\$90 rebate to claim through Medicare depending on the clinic. See Children by Choice, ‘How much will an abortion cost?’ (14 March 2018) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>; Parliamentary Committee Report No 24 (2016) [12.6.4].

<sup>193</sup> See [2.75] above and the discussion of the ‘role of registered health practitioners’ in Chapter 3 below.

<sup>194</sup> MS Health Pty Ltd is the sponsor of the MS-2 Step composite pack: *Therapeutic Goods Act 1989* (Cth) s 3 (definition of ‘sponsor’); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Public summary* (20 October 2016); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product information* (28 March 2017).

MS-2 Step is classified as a ‘restricted drug’: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 5(2), App 9 (definition of ‘restricted drug’); *Poisons Standard June 2018* (Cth) sch 4 entries for ‘mifepristone’ and ‘misoprostol’. See also Queensland Health, *List of Approved Medicines* (1 June 2018), ‘Mifepristone and Misoprostol “MS-2 Step”’; Australian Government, *The Pharmaceutical Benefits Scheme: Mifepristone and Misoprostol* <<http://www.pbs.gov.au/medicine/item/10211K#>>. See n 121 above in relation to the sponsorship of MS-2 Step in Australia by MS Health Pty Ltd.

<sup>195</sup> As they are specialists in this area, obstetricians and gynaecologists are not required to complete the online training, although they may opt to do so: Information provided by Marie Stopes International and MS Health Pty Ltd, 22 November 2017.

<sup>196</sup> Information provided by Marie Stopes, 29 March 2018.

<sup>197</sup> Information provided by Marie Stopes International and MS Health Pty Ltd, 22 November 2017.

<sup>198</sup> Children by Choice, ‘How much will an abortion cost?’ (14 March 2018) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>. Medicare card holders may be eligible for a partial rebate. The cost of medication is between \$12 and \$50, depending on whether the person has a Health Care Card.

<sup>199</sup> In addition, 80 are obstetricians and gynaecologists, four are sexual health physicians and 11 are other specialists: Information provided by Marie Stopes International and MS Health Pty Ltd, 22 November 2017.

<sup>200</sup> *Ibid.* Data is not collected in relation to the number of women who access a medical termination in an outpatient setting. Whilst data on the number of times that certain medications are dispensed gives some indication of the incidence of medical terminations, it does not provide an accurate number (for example, because one pharmacy group in Queensland supplies mifepristone and misoprostol to health professionals in other States): Parliamentary Committee Report No 24 (2016) [7.5.3].

2.130 Whilst the provision of medical termination services by general practitioners has the potential to improve access to terminations, it appears this potential is not yet fully realised for a number of practical reasons.<sup>201</sup>

2.131 A recent study assessing the impact of the 2008 law reform in Victoria concluded that, whilst it had increased clarity and protection for doctors who perform terminations, significant practical barriers remained in relation to the accessibility and availability of termination services.<sup>202</sup> In particular, it noted the lack of a State-wide strategy for equitable service provision and an unsustainable workforce.<sup>203</sup>

2.132 United Nations treaty bodies have recognised that full enjoyment of the right to health, including sexual and reproductive health, requires access to the full range of health services without discrimination, including availability, physical and geographical accessibility, and affordability, particularly for women in rural areas.<sup>204</sup>

## COMMUNITY ATTITUDES

2.133 Several public opinion surveys have been conducted in Australia over the last decade which attempt to gauge community attitudes toward termination, including the Australian Survey of Social Attitudes,<sup>205</sup> the Australian Election Study<sup>206</sup> and various surveys commissioned by particular groups at different times.<sup>207</sup>

201 One study identified a number of practical reasons for the low rate of certification by general practitioners, including inadequate referral pathways in case of complications and lack of support: A Dawson et al, 'Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study' (2017) 14(39) *Reproductive Health* (online).

202 L Keogh et al, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18. See also B Baird, 'Decriminalisation and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197, 198, commenting on the effect of decriminalisation in the Australian Capital Territory, Victoria and Tasmania. Similar concerns have been identified in Canada: see, eg, AM Foster et al, "'If I ever did have a daughter, I wouldn't raise her in New Brunswick': exploring women's experiences obtaining abortion care before and after policy reform' (2017) 95 *Contraception* 477; J Sabourin and M Burnett, 'A Review of Therapeutic Abortions and Related Areas of Concern in Canada' (2012) 34(6) *Journal of Obstetrics and Gynaecology Canada* 532, 539–40 and the sources cited there.

203 Keogh et al, above n 202, 22–3. In 2017, the Victorian Government released a women's sexual and reproductive health strategy. Among other things, the strategy sets out three key actions in the area of reproductive health. They are to: increase women's and primary health professionals' awareness about medical termination; increase women's access to medical termination in primary care; and improve access to surgical termination, especially for women in rural and regional Victoria: State of Victoria, Department of Health and Human Services, *Women's Sexual and Reproductive Health: Key priorities 2017–2020* (March 2017) 12, 15.

204 See the discussion of 'Access to health services, including abortion services' in Appendix C.

205 Australian National University, *The Australian Survey of Social Attitudes* <<http://aussa.anu.edu.au/index.php>>; and Australian Consortium for Social & Political Research Inc, *The Australian Survey of Social Attitudes* <<http://acspr.org.au/aussa>> which is described as the main source of national data for the study of 'social attitudes, beliefs and opinions'.

206 *The Australian Election Study* <<http://australianelectionstudy.org/index.html>> which aims to provide a 'long-term perspective on stability and change in the political attitudes and behaviour of the Australian electorate'.

207 T Gotsis and L Ismay, 'Abortion law: a national perspective' (Briefing Paper No 2/2017, NSW Parliamentary Research Service, Parliament of New South Wales, 2017) [1.2]; VLRC Report (2008) [4.7]–[4.59]; Parliamentary Committee Report No 24 (2016) [8.1].

2.134 Each survey has its own strengths and limitations, which affect its reliability.<sup>208</sup> Taking this into account, the Victorian Law Reform Commission reported in its review of termination laws that the available evidence provides general support for the following conclusions:<sup>209</sup>

- A majority of Australians support a woman's right to choose whether to have an abortion.
- A subset of those supporters regard the right as capable of limitation, with restriction of choice based on factors such as gestational age and women's reasons for seeking the abortion. However, there is insufficient evidence to estimate the size of that subset.
- Several socio-demographic characteristics are associated with positive (and negative) views of abortion. For example, there is less support for abortion among persons with religious beliefs than among persons without religious beliefs; nonetheless, even among persons with religious beliefs, supporters remain in the majority.

2.135 In Queensland, the Parliamentary Committee reported that:<sup>210</sup>

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

2.136 It has been observed that community support for terminations has generally increased over the years.<sup>211</sup> Results from the Australian Election Study in the period from 1979 to 2016 show that the percentage of Australians who believe that terminations should be 'banned' has decreased from 5.3% to 3.6%; the proportion who believe that 'women should be able to obtain an abortion readily when they want one' has increased from 46.2% to 65%; and the percentage who believe that

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<sup>208</sup> VLRC Report (2008) [4.7]–[4.59]; Parliamentary Committee Report No 24 (2016) [8.2]. For example, some surveys may involve only a single question, limiting the interpretation of responses; some may involve multiple or more specific questions, but may have a limited number or sample of respondents; and some may involve leading questions, which could bias the results.

<sup>209</sup> VLRC Report (2008) [4.82], based on conclusions drawn by Professor Studdert, Federation Fellow at the University of Melbourne commissioned by the Victorian Law Reform Commission to analyse the Australian Survey of Social Attitudes, the Australian Election Study and surveys commissioned, respectively, by the Southern Cross Bioethics Institute, the Australian Federation of Right to Life Associations and Marie Stopes International.

<sup>210</sup> Parliamentary Committee Report No 24 (2016) [8.3.1], drawing on the results of an analysis by Professor Matthew Gray and colleagues from the Australian National University commissioned by the Parliamentary Committee to assess the reliability of seven different community attitude surveys, including the Australian Survey of Social Attitudes and the Australian Election Study.

<sup>211</sup> Ibid [8.4]; Gotsis and Ismay, above n 207, 4–5.

'abortion should be allowed only in special circumstances' has decreased from 48.5% to 25.9%.<sup>212</sup>

2.137 Similar trends have been observed for results from that study from Queensland residents:<sup>213</sup>

Between 1996 and 2013, the percentage of Queenslanders believing women should be able to readily obtain an abortion has increased by ten percentage points, from 54.4% to 64%. Similarly, the percentage believing abortion should only be allowed in special circumstances has fallen from 41.9% to 32.5% over the 17-year period. The percentage of Queenslanders who believe abortion should be banned has remained stable between 2.6% (in 2001) and 4.4% (in 2010).

2.138 However, it is also observed that support for a woman's ability to obtain a termination can depend on the circumstances in which termination is sought.<sup>214</sup> For example, responses to the 2009 Australian Survey of Social Attitudes showed that 23% of Australians believe termination is 'always wrong' where it is sought because 'the family has a very low income and cannot afford any more children' (compared to 45% who believe it is not wrong); and 8% believe termination is 'always wrong' where it is sought because 'there is a strong chance of serious defect in the baby' (compared to 67% who believe it is not wrong).<sup>215</sup>

## LEGISLATIVE REFORMS IN OTHER JURISDICTIONS

2.139 Historically, the criminal laws in each of the Australian States and Territories treated unlawful termination as a crime punishable by imprisonment. This reflected the position in England under the *Offences Against the Person Act 1861*.<sup>216</sup>

2.140 Beginning in the 1950s, there has been an overall trend, especially in industrialised countries, toward the liberalisation of such laws and the recognition of termination as a health matter.<sup>217</sup>

212 SM Cameron and I McAllister, 'Trends in Australian Political Opinion: Results from the Australian Election Study 1987–2016' (Australian National University, 2016) 93, App 37 <<http://australianelectionstudy.org/publications.html>>. (From 2010, the survey also provided a response category of 'don't know', accounting for 5.5% of respondents in 2016.) See also Parliamentary Committee Report No 24 (2016) [8.4]. This refers to data from the Australian Election Study, which began in 1987, and the earlier Australian National Political Attitudes Surveys, which were conducted in 1967, 1969 and 1979. As to the latter, see Australian Election Study, *About the Australian National Political Attitudes Surveys (ANPAS)* <<http://australianelectionstudy.org/anpas.html>>.

213 Parliamentary Committee Report No 24 (2016) [8.4], referring to Australian Election Study data.

214 Ibid [8.4.1]; Gotsis and Ismay, above n 207, 4–5.

215 Parliamentary Committee Report No 24 (2016) [8.4.1], App D [6], referring to the Australian Survey of Social Attitudes, 2009.

216 *Offences Against the Person Act 1861*, 24 & 25 Vict, c 100, ss 58, 59.

217 See, eg, L Finer and JB Fine, 'Abortion Law Around the World: Progress and Pushback' (2013) 103(4) *American Journal of Public Health* 585.

2.141 There remain some jurisdictions in which terminations are either prohibited entirely or permitted only to save the woman's life.<sup>218</sup> However, many jurisdictions provide that termination is lawful in a wider range of circumstances.<sup>219</sup> In the least restrictive jurisdictions, terminations are no longer the subject of specific criminal laws and are instead regulated as a health matter.<sup>220</sup>

2.142 In Australia, most jurisdictions have amended their laws to decriminalise terminations in particular circumstances. The least restrictive approach is taken in the Australian Capital Territory, which provides that termination is lawful if carried out by a medical practitioner in an approved medical facility.<sup>221</sup> Victoria has adopted a similar approach, but imposes additional requirements for termination of a pregnancy of more than 24 weeks gestation.<sup>222</sup> Tasmania, the Northern Territory and Western Australia have adopted various combinations of legal grounds, gestational limits and procedural requirements to define the circumstances in which termination performed by a qualified person is lawful.<sup>223</sup>

2.143 In contrast, New South Wales, like Queensland, continues to treat a termination as a criminal offence with limited exceptions.<sup>224</sup>

2.144 Reference to other jurisdictions is made where relevant throughout this report.<sup>225</sup>

218 See, eg, Ireland, where termination is permitted only if there is a risk to the woman's life: *Protection of Life During Pregnancy Act 2013* (Irl) ss 7–9. The Government of Ireland has foreshadowed introducing less restrictive termination laws following a constitutional referendum on 25 May 2018 at which a majority voted to repeal art 40.3(3) of the *Constitution of Ireland* (known as the Eighth Amendment) which protects the right to life of the unborn, with due regard to the equal right to life of the mother: see generally Referendum Ireland, *Referendum on the Thirty-sixth Amendment of the Constitution Bill 2018* <<http://www.referendum.ie/current-referendum/>>; Department of Health (Ireland), *General Scheme of a Bill to Regulate Termination of Pregnancy* (28 March 2018) <<https://health.gov.ie/blog/publications/general-scheme-of-a-bill-to-regulate-termination-of-pregnancy/>>; Referendum Commission (Ireland), *Referendum on the Regulation of Termination of Pregnancy* <<https://refcom2018.refcom.ie/>>. According to some research, as at 2011, 'roughly 39% of the world's population lives in countries with highly restrictive laws governing abortion': Finer and Fine, above n 217, 585.

219 See generally WHO, *Global Abortion Policies Database* (2017) <<http://srhr.org/abortion-policies/>>.

220 See, eg, Canada, where the criminal law was overturned (but where there remain practical barriers to access): see QLRC Consultation Paper No 76 (2017) [127] and n 129.

221 *Health Act 1993* (ACT) pt 6 div 6.1.

222 *Crimes Act 1958* (Vic) s 65 and *Abortion Law Reform Act 2008* (Vic) ss 4–7, introduced following a review by the Victorian Law Reform Commission: see, in particular, proposed 'Model B' in VLRC Report (2008) ch 6.

223 *Criminal Code* (Tas) ss 178D, 178E, *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4-5; *Criminal Code* (NT) s 208A, *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7–10; *Criminal Code* (WA) s 199, *Health (Miscellaneous Provisions) Act 1911* (WA) s 334.

224 *Crimes Act 1900* (NSW) pt 3 div 12. Cf *Criminal Law Consolidation Act 1935* (SA) pt 3 div 17, which retains criminal offences with legislative exceptions where termination is performed on particular grounds and where particular procedural requirements are met.

225 See also QLRC Consultation Paper No 76 (2017) App B which provides a comparative table of other jurisdictions.



# Chapter 3

## Lawful terminations

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### INTRODUCTION

3.1 The terms of reference require that terminations performed by registered medical practitioners ('medical practitioners')<sup>1</sup> be removed from the existing offences in the Criminal Code.<sup>2</sup> They also require the Commission to draft legislation to clarify and modernise the law.<sup>3</sup>

3.2 This chapter considers whether the law should impose any requirements for when a termination may lawfully be performed by a medical practitioner (including gestational limits or grounds), exempt the woman from criminal responsibility and provide for the criminal responsibility of an unqualified person.

### THE ROLE OF REGISTERED HEALTH PRACTITIONERS

#### Background

3.3 As mentioned in Chapter 2, registered health practitioners, including medical practitioners, nurses, midwives and pharmacists, must practise in

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1 See 'medical practitioner' in the Abbreviations and Glossary.

2 See terms of reference, para 1 in Appendix A.

3 See terms of reference, paras 2 and C in Appendix A.

accordance with applicable health legislation, registration standards, and professional codes and guidelines. When providing health care, a registered health practitioner must be suitably qualified and credentialed and be acting within their scope of practice.<sup>4</sup>

3.4 A surgical or medical termination may be performed by a medical practitioner who has the relevant qualifications, experience or skills to do so.<sup>5</sup> Other health practitioners, with the oversight of the medical practitioner, may also assist the practitioner in terminating a pregnancy,<sup>6</sup> for example, by assisting in a surgical termination or administering a drug for an early medical termination.

3.5 A practical consideration in relation to the provision of medical termination is that the drugs generally used to cause a termination, including mifepristone and misoprostol, are regulated at both State and Federal level.

3.6 Both mifepristone and misoprostol are classified as 'restricted drugs' under the *Health (Drugs and Poisons) Regulation 1996*.<sup>7</sup> They may only be prescribed, supplied, administered or dispensed by a person who is authorised under the Regulation to do so.<sup>8</sup> The Regulation relevantly provides that:

- A medical practitioner may prescribe, dispense, administer, supply or obtain a restricted drug.<sup>9</sup> They may also 'give someone who may administer or supply a restricted drug an oral or written instruction to administer or supply the drug'.<sup>10</sup>

<sup>4</sup> See the discussion of the 'Regulation of health practitioners' in Chapter 2. See also 'medical practitioner', 'midwife', 'nurse', 'pharmacist' and 'health practitioner' in the Abbreviations and Glossary.

<sup>5</sup> See generally [2.50] and [2.126] above and [3.8] below.

<sup>6</sup> See generally, *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800, 828–9 (Lord Diplock), 834 (Lord Keith of Kinkel), 838 (Lord Roskill). See also MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) ch 4.

<sup>7</sup> A 'restricted drug' is an 'S4 substance' meaning any poison listed in Schedule 4 of the 'current Poisons Standard': *Health (Drugs and Poisons) Regulation 1996* (Qld) s 5(2), App 9 (definitions of 'restricted drug' and 'S2 to S9'). The *Health (Drugs and Poisons) Regulation 1996* (Qld) is made under the *Health Act 1937* (Qld) s 132. The Poisons Standard is the legal title of the Standard for the Uniform Scheduling of Medicines and Poisons: Poisons Standard (June 2018) sch 4 <<https://www.tga.gov.au/publication/poisons-standard-susmp>>.

<sup>8</sup> *Health (Drugs and Poisons) Regulation 1996* (Qld) s 146. Relevantly, the *Health (Drugs and Poisons) Regulation 1996* (Qld) App 9 includes the following definitions:

**prescribe** means make a written direction (other than a purchase order or written instruction) authorising a dispenser to dispense a stated controlled or restricted drug or a stated poison;

**supply**, for a controlled or restricted drug or a poison, means give, or offer to give, a person 1 or more treatment doses of the drug or poison, to be taken by the person during a certain period;

**administer**, for a controlled or restricted drug or a poison, means—

give a person a single treatment dose of the drug or poison, to be taken by the person immediately; ...

**dispense** means sell on prescription.

<sup>9</sup> To the extent necessary to practise medicine: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 161(1)(c). The doctor must be reasonably satisfied that a person they are treating needs a restricted drug for a therapeutic use as part of the person's medical treatment.

<sup>10</sup> To the extent necessary to practice medicine: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 161(1)(d).

- A registered nurse may administer and, in some cases, supply a restricted drug on the oral or written instructions of a medical practitioner.<sup>11</sup> An enrolled nurse may administer a restricted drug on the oral or written instruction of a medical practitioner, and under the supervision of a medical practitioner, nurse or midwife.<sup>12</sup> In some circumstances, a nurse practitioner, acting within their scope of practice, may prescribe, administer or supply a restricted drug.<sup>13</sup>
- A midwife may administer or supply a restricted drug on the oral or written instruction of a medical practitioner, or under the relevant Drug Therapy Protocol.<sup>14</sup>
- A pharmacist may dispense a restricted drug. In addition, if a pharmacist is practising pharmacy at a public sector hospital, the pharmacist may supply a

<sup>11</sup> To the extent necessary to practise nursing: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 175(1)(b)(i). See *Health (Drugs and Poisons) Regulation 1996* (Qld) s 175(1)(b), (2)(b), (c), (3) which relevantly authorise the administration or supply of a restricted drug, on particular conditions, by a registered nurse, a rural and isolated practice area nurse and a registered nurse practising at a hospital within an isolated practice area.

See also Drug Therapy Protocol—Rural and Isolated Practice Area Endorsed Nurse (December 2016) <[https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0027/443376/dtp-rural-nurse.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0027/443376/dtp-rural-nurse.pdf)> which relevantly provides that an endorsed nurse may administer or supply up to 1000 micrograms of the drug *Misoprostol* and that, if they are of the opinion that the administration or supply would be detrimental to the patient, the nurse must consult a doctor. 'Registered nurse' is defined in App 9 to mean:

a person registered under the Health Practitioner Regulation National Law (Qld) —

(a) to practise in the nursing and midwifery profession, other than as a student; ...

<sup>12</sup> To the extent necessary to practise nursing, except if the enrolled nurse's registration under the Health Practitioner National Law is subject to a condition that they are not qualified to administer restricted drugs: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 162(1)(b), (c), (2). 'Enrolled nurse' is defined in App 9 to mean:

a person registered under the Health Practitioner Regulation National Law—

(a) to practise in the nursing and midwifery profession, other than as a student; and

(b) in the enrolled nurses division of that profession.

<sup>13</sup> To the extent necessary to practise nursing and under the nurse practitioner Drug Therapy Protocol (within their scope of practice): *Health (Drugs and Poisons) Regulation 1996* (Qld) s 175(8)(b)(i); *Drug Therapy Protocol—Nurse Practitioners* (April 2014) <[https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0028/443782/dtp-nurse-practitioner.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0028/443782/dtp-nurse-practitioner.pdf)>. See also s 175(8)(b)(ii)–(iv), which provide that a nurse practitioner may give a nurse, midwife, indigenous health worker, or a rural and isolated practice area endorsed nurse 'an oral or written instruction to administer or supply a restricted drug'. A 'nurse practitioner' is defined in App 9 to mean:

a registered nurse whose registration is endorsed under the Health Practitioner Regulation National Law as being qualified to practice as a nurse practitioner.

Based on their general qualification as a registered nurse, a nurse practitioner may administer a restricted drug on the oral or written instruction of a medical practitioner: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 175(1)(b)(i).

<sup>14</sup> To the extent necessary to practise midwifery: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 167(1)(c),(d). 'Midwife' is defined in App 9 to mean:

a person registered under the Health Practitioner Regulation National Law to practise in the nursing and midwifery profession as a midwife, other than as a student.

See also *Drug Therapy Protocol—Midwives* (No 2) (December 2016) <[https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0027/443097/dtp-midwives.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0027/443097/dtp-midwives.pdf)> which relevantly provides that a midwife may administer or supply up to 1000 micrograms of the drug *Misoprostol* and that, if they are of the opinion that the administration or supply would be detrimental to the patient, the midwife must consult a doctor.

restricted drug on the oral or written instruction of a medical practitioner (but only to an outpatient or a person being discharged from the hospital).<sup>15</sup>

3.7 As mentioned earlier, 'MS-2 Step' (a composite pack containing mifepristone and misoprostol) is widely used for early medical termination.<sup>16</sup> Federally, MS-2 Step is currently subject to approval restrictions imposed by the Therapeutic Goods Administration ('TGA') and prescribing restrictions under the Pharmaceutical Benefits Scheme.<sup>17</sup> (These restrictions are in addition to the general restrictions that apply to mifepristone and misoprostol under the Queensland Regulation).

3.8 As a result of the restrictions at the Federal level, MS-2 Step is currently permitted to be prescribed only by a medical practitioner who is registered as a certified prescriber under the MS-2 Step program. Further, it is permitted to be dispensed only by a pharmacist who is registered as a certified dispenser under the MS-2 Step Program.<sup>18</sup> Nurse practitioners are not currently eligible to become certified to prescribe MS-2 Step.

3.9 The legislation in other Australian jurisdictions, except New South Wales, provides that a termination may be performed by a medical practitioner.<sup>19</sup>

3.10 In the Northern Territory, Tasmania and Victoria, the legislation also recognises other health practitioners who assist in the performance of a termination.<sup>20</sup>

3.11 In the Northern Territory, an ATSI health practitioner, a midwife or a nurse authorised under the *Medicines, Poisons and Therapeutic Goods Act* (NT) may supply or administer a termination drug (or provide assistance in a surgical procedure), and an authorised pharmacist may supply a termination drug to assist in

<sup>15</sup> To the extent necessary to practice pharmacy: *Health (Drugs and Poisons) Regulation 1996* (Qld) s 171(1)(b), (e).

<sup>16</sup> See [2.74]–[2.76] above.

<sup>17</sup> MS Health Pty Ltd, which is the sponsor of MS-2 Step, is a not-for-profit pharmaceutical company registered in Victoria which delivers reproductive health products and medicines, and is a subsidiary of the non-government agency, Marie Stopes International (a registered charity in England and Wales). Under arrangements with the Therapeutic Goods Administration, which regulates the supply of therapeutic goods in Australia, MS Health Pty Ltd is registered on the Australian Register of Therapeutic Goods as the sponsor of the MS-2 Step composite pack (which contains both mifepristone and misoprostol). Consequently, MS Health Pty Ltd is the authorised supplier of MS-2 Step in Australia and is responsible for meeting the regulatory requirements of the therapeutic goods legislation: Marie Stopes Australia, 'About Us' <<https://www.mariestopes.org.au/about-us/>>; MS Health, 'About Us' <<http://www.mshealth.com.au/about-us>>; See further Therapeutic Goods Administration, 'Overview of supplying therapeutic goods in Australia' (12 February 2014) <<http://www.tga.gov.au/overview-supplying-therapeutic-goods-australia>>. See [2.126] above, in relation to the registration requirements for the MS-2 Step program.

<sup>18</sup> See [2.75] and [2.126]–[2.127] above.

<sup>19</sup> *Health Act 1993* (ACT) s 81; *Criminal Code* (NT) s 208A(1)(c), (5)(a); *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 9, 10; *Criminal Law Consolidation Act 1995* (SA) s 82A(1); *Criminal Code* (Tas) s 178D(1)(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; *Crimes Act 1958* (Vic) s 65(1), (3)(a); *Abortion Law Reform Act 2008* (Vic) ss 4–5; *Criminal Code* (WA) s 199(1). The legislation also generally provides that termination is lawful only if performed on certain grounds or in accordance with other requirements.

<sup>20</sup> *Criminal Code Act* (NT) s 208A(1)(c), 5(b)–(e); *Termination of Pregnancy Law Reform Act 2017* (NT) s 8; *Criminal Code Act 1924* (Tas) ss 1 (definition of 'terminate'), 178D(1)(a); *Crimes Act 1958* (Vic) s 65(1), (3)(b); *Abortion Law Reform Act 2008* (Vic) ss 6–7.

the performance of a termination on a woman who is not more than 14 weeks pregnant, if directed to do so by a suitably qualified medical practitioner.<sup>21</sup>

3.12 In Victoria, a registered pharmacist or registered nurse authorised under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) may administer or supply a drug or drugs to cause a termination in a woman who is not more than 24 weeks pregnant.<sup>22</sup>

3.13 In Tasmania, it is a crime for anyone other than a medical practitioner to terminate a pregnancy; however, the offence does not apply to the administration of a drug for the purpose of discontinuing a pregnancy by a nurse or midwife acting under the direction of a medical practitioner, or to the supply or procurement of anything for the purpose of discontinuing a pregnancy.<sup>23</sup>

## Submissions

3.14 In the Consultation Paper, the Commission sought submissions on who should be permitted to lawfully perform, or assist in performing, terminations.<sup>24</sup>

## Overview

3.15 Most respondents who addressed this issue submitted that appropriately qualified and trained medical practitioners and other health practitioners (such as registered nurses, midwives and pharmacists) should be authorised to perform or assist in the performance of a termination.<sup>25</sup>

3.16 It was noted that health practitioners are required to satisfy the legal requirements and professional standards that apply to the practice of their respective professions.<sup>26</sup> It was considered that this health care framework should govern the eligibility of health practitioners to carry out terminations.<sup>27</sup> The Institute for Urban Indigenous Health Ltd submitted that:<sup>28</sup>

21 *Termination of Pregnancy Law Reform Act 2017* (NT) ss 4 (definitions of 'ATSI health practitioner', 'authorised', 'nurse', 'midwife', 'pharmacist'), 8. 'Termination drug' is defined to mean 'a substance or combination of substances, to which the current Poisons Standard applies under the Therapeutic Goods Act 1989 (Cth), used for terminations': s 4. See also Explanatory Statement, *Termination of Pregnancy Law Reform Bill 2017* (NT) 3.

22 *Abortion Law Reform Act 2008* (Vic) ss 3 (definitions of 'registered nurse' and 'registered pharmacist'), 6. At more than 24 weeks, a registered pharmacist or registered nurse may administer or supply a drug or drugs to cause a termination only if they are employed or engaged by a hospital and only at the written direction of a registered medical practitioner: s 7.

23 Criminal Code (Tas) ss 1 (definition of 'terminate'), 178D(1)(a). However, a woman who consents to, assists in or performs a termination on herself is not guilty of a crime or any other offence: Criminal Code (Tas) s 178D(1)(b) and *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 8.

24 See QLRC Consultation Paper No 76 (2017) Q-1.

25 Eg, Submissions 2, 50, 387, 419, 429, 539, 542, 582, 590, 624, 707, 720, 754, 885, 888. In contrast, some respondents considered that the draft legislation should not permit anyone to perform terminations: eg, Submissions 140, 170, 199, 398, 433, 555, 653, 790.

26 Eg, Submissions 429, 436, 547.

27 Eg, Submissions 378, 406, 879.

28 Submission 707.

The level of skill and training should be commensurate with the pregnancy gestation and type of termination being provided .... The provision of later gestation [termination] requires higher levels of skill and training and would usually be provided by a specialist [obstetrician and gynaecologist].

### **Medical practitioners**

3.17 Many respondents — including RANZCOG, AMA Queensland, Marie Stopes Australia and medical practitioners who provide termination of pregnancy services — considered that the draft legislation should provide that medical practitioners with suitable qualifications and training may perform terminations.<sup>29</sup>

3.18 RANZCOG submitted that terminations should be performed only by, or under the direction of, a medical practitioner.<sup>30</sup>

Termination of pregnancy remains a procedure that must be undertaken by a medical practitioner or under the direction of a medical practitioner. Although in most circumstances it is safer for the mother to have a termination than to continue with the pregnancy, the performance of a termination has complexities that mandate a medical background in order to minimise the risk of adverse consequences.

3.19 A specialist obstetrician and gynaecologist similarly considered that a medical practitioner should have ‘oversight, responsibility and involvement’ in the performance of any termination.<sup>31</sup>

3.20 Some respondents observed that surgical and medical terminations require different qualifications, skills and training.<sup>32</sup>

3.21 AMA Queensland submitted that, for a surgical termination, ‘the procedure and the associated anaesthesia should, as with any other medical intervention, be performed by appropriately trained doctors in premises approved by a recognised health standards authority’.<sup>33</sup>

3.22 The Metro North Hospital and Health Service submitted that ‘only qualified and credentialed medical practitioners with health facility approved Scope of Clinical Practice should perform terminations of pregnancy’.<sup>34</sup>

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<sup>29</sup> Eg, Submissions 101, 220, 482, 526, 532, 674, 882, 885.

<sup>30</sup> Submission 482.

<sup>31</sup> Submission 526. This respondent also observed:

The level of involvement is based upon the pregnancy gestation and method of termination chosen, and the level of experience of allied health professionals/nurses under their oversight. Nurses, enrolled nurses, pharmacists, medical students who are under the oversight of a doctor who has directed them to provide care, dispense medications or assist in providing care for women requesting termination of pregnancy should be legally and medicolegally allowed to do so.

<sup>32</sup> Eg, Submissions 526, 674, 707, 882, 885.

<sup>33</sup> Submission 885.

<sup>34</sup> Submission 882. This respondent also noted that health facility credentialing procedures and CSCF levels of the facilities are also relevant considerations.

3.23 Marie Stopes Australia and a specialist obstetrician and gynaecologist with more than 40 years' experience both submitted that surgical terminations should be performed only by medical practitioners who have the requisite qualifications, skills and training to do so.<sup>35</sup> Marie Stopes Australia noted that the authority to prescribe the drugs used for medical terminations is currently limited to general practitioners and specialist obstetricians and gynaecologists who meet the legal certification requirements, and raised the possibility of this prescribing authority being extended to experienced nurse practitioners.<sup>36</sup>

### ***Assistance by other health practitioners***

3.24 Many respondents supported the inclusion of a legislative provision to the effect that medical practitioners and other health practitioners (such as midwives, registered nurses and pharmacists) with appropriate qualifications and training should be permitted to perform, and assist in performing, lawful terminations.<sup>37</sup> A specialist obstetrician and gynaecologist with more than 40 years' experience observed that medical practitioners may be assisted in the performance of a termination by other medical practitioners and health professionals.<sup>38</sup>

3.25 AMA Queensland submitted that, as a matter of clinical practice, other health practitioners, such as nurses, midwives, ATSI health practitioners and pharmacists, may also assist in performing terminations, as long as this occurs under a medical practitioner's direction. This respondent considered that a medical termination should be made available as an alternative to a surgical termination in cases where it is deemed to be the safest and most appropriate option based on an appropriate clinical assessment by a medical practitioner.<sup>39</sup>

3.26 Marie Stopes Australia also submitted that a pharmacist who meets the registration requirements set by MS Health Pty Ltd and the TGA should continue to be able to dispense the drugs used for medical termination.<sup>40</sup>

3.27 The Australian College of Nursing considered that a nurse who assists in the performance of a termination should, at the minimum, be qualified as a registered nurse to 'better ensure the health care team is appropriately resourced with nurses who are responsible and accountable to the Nursing and Midwifery Board of Australia

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35 Submissions 220, 674.

36 Submission 674. Another respondent recommended against limiting the type of health professional who can provide termination care services, noting that '[t]he scope of practice for health professionals, particularly nurse practitioners, changes over time': Submission 378. Another respondent also considered that '[r]estricting the designation to medical professionals only (ie doctors) may constrain access in some locations, and unnecessarily burden an already over-burdened regional health service': Submission 500.

37 Submissions 50, 220, 526, 590, 592, 632, 674, 754.

38 Submission 220. This respondent also observed that medical termination using the drugs mifepristone and misoprostol should be performed 'under the supervision of a medical practitioner, however that practitioner does not need to be physically present when the termination process itself takes place'.

39 Submission 885.

40 Submission 674.

and educationally prepared to provide holistic, person-centred and evidence-based care'.<sup>41</sup>

3.28 The Human Rights Law Centre Ltd submitted that Queensland laws should ensure that a health practitioner who assists with a termination, or who could appropriately be authorised to administer or supply drugs to cause a medical termination, such as a registered nurse, midwife, ATSI health practitioner or pharmacist, is authorised to do so.<sup>42</sup>

### **Accessibility**

3.29 The Metro North Hospital and Health Service and the Institute for Urban Indigenous Health Ltd submitted that the geographical and current service requirements within Queensland mean that there are issues with the accessibility and availability of termination services in rural, regional and remote areas.<sup>43</sup>

3.30 The Institute for Urban Indigenous Health Ltd cautioned against any restrictions that inequitably disadvantage Aboriginal and Torres Strait Islander women, including those that might place practical limitations on the availability and accessibility of termination services.<sup>44</sup>

3.31 Some respondents submitted that the draft legislation should be sufficiently flexible to accommodate future changes in clinical practice that may potentially expand the range of health practitioners who are clinically trained to perform a termination and to help remove practical barriers to access.<sup>45</sup>

### **Conclusion**

#### **Medical practitioners**

3.32 The draft legislation should provide that a medical practitioner may perform a surgical or medical termination on a woman, when acting in accordance with the requirements for performing a termination set out at [3.174]–[3.230] below.

3.33 This is consistent with health regulation and current clinical practice and importantly, provides clarity and certainty for medical practitioners as to their authorisation under the legislation to perform terminations.

3.34 The term 'medical practitioner' is not defined in the draft legislation, as it is separately defined in the *Acts Interpretation Act 1954* to mean 'a person registered under the Health Practitioner Regulation National Law to practise in the medical

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41 Submission 621. See <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx>>.

42 Submissions 882, 888.

43 Submissions 707 and 882.

44 Submission 707.

45 Eg, Submissions 50, 590, 707, 720. However, the Women's Bioethics Alliance cautioned against expanding the categories of practitioner who are permitted to perform terminations to include nurses or midwives: Submission 860. The Australian College of Nursing also explained that it recognises and promotes the requirement for all nurses, at all times, to practice within the legal confines of the jurisdiction in which they work: Submission 621.

profession, other than as a student'.<sup>46</sup> To make it clear that a termination may be a surgical or medical termination, the draft legislation should define a 'termination' to mean 'an intentional termination of a pregnancy in any way, including by administering a drug or using an instrument or other thing'. It should also define a 'woman' to mean 'a female person of any age' so that the legislation applies to both adult women and young women of child-bearing age.<sup>47</sup>

3.35 It is not necessary for the draft legislation to expressly require a medical practitioner to be 'suitably qualified' to perform a termination, as required under the Northern Territory legislation.<sup>48</sup> As explained in Chapter 1, the draft legislation does not affect the operation of other general requirements under health regulation and clinical practice which require medical practitioners to be suitably qualified and credentialed and to act within their scope of practice in relation to any health care (including a surgical or medical termination) which they may provide.<sup>49</sup>

### **Other health practitioners**

3.36 The draft legislation should clarify the role of other health practitioners who may assist a medical practitioner in the performance of a surgical or medical termination.

3.37 A relevant consideration is that the type of assistance that may be provided by an assisting health practitioner (and the extent of their authorisation under the draft legislation) will necessarily depend on the type of termination involved and the practitioner's qualifications and scope of practice.

3.38 The Commission considers that the draft legislation should provide that a medical practitioner may assist another medical practitioner to perform a termination.

3.39 It should also provide that a nurse, midwife or pharmacist may, in the practice of their health profession, assist a medical practitioner to perform a termination. Accordingly, a nurse, midwife or pharmacist is authorised under this provision to assist to the extent that they may do so 'in the practice of their health profession'. For example, a pharmacist may be authorised to assist in the performance of a medical termination by dispensing or, in some circumstances, supplying, a termination drug to a woman (but will not be authorised to assist in a surgical termination as that would fall outside the practice of pharmacy).

3.40 The provision should also specify that 'assisting in the performance of a termination by a medical practitioner' includes dispensing, supplying or administering a termination drug on the medical practitioner's instruction. This will make clear the type of assistance that a nurse, midwife or pharmacist might provide for a medical termination.<sup>50</sup>

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<sup>46</sup> *Acts Interpretation Act 1954* (Qld) sch 1 (definition of 'medical practitioner').

<sup>47</sup> See n 344 below.

<sup>48</sup> See *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definitions of 'credentialed' and 'suitably qualified medical practitioner').

<sup>49</sup> See [1.33] above.

<sup>50</sup> See [3.4]–[3.8] above.

3.41 However, this provision should be expressed not to apply to a termination that an assisting medical practitioner, nurse, midwife or pharmacist knows, or ought reasonably to know, is being performed other than under the draft legislation.<sup>51</sup> In that circumstance, the assisting practitioner would not be authorised to assist in the performance of the termination and may be subject to professional and legal consequences for their actions.<sup>52</sup>

3.42 For the purposes of this provision, the following definitions should apply:<sup>53</sup>

- ‘midwife’ means a person registered under the Health Practitioner Regulation National Law to practise in the midwifery profession as a midwife, other than as a student;
- ‘nurse’ means a person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student, and in the enrolled nurses division or the registered nurses division of that profession;
- ‘pharmacist’ means a person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession, other than as a student; and
- ‘termination drug’ means a drug of a kind used to cause a termination.

## **GESTATIONAL LIMITS, GROUNDS AND CONSULTATION**

### **Different approaches and models**

3.43 The following general approaches to reform, consistent with the terms of reference, can be identified:<sup>54</sup>

- ‘On request’ approach — Termination is treated as a health matter, rather than a criminal matter. There are no legislative gestational limits, grounds or consultation requirements. Under this approach, the lawfulness of termination is determined by the same principles as those that apply to other health matters; if termination is medically indicated and there is valid consent,

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51 See Recs 3-1 to 3-4.

52 See [3.236]–[3.241] below.

53 See n 344 and n 345 below.

54 In addition to the six approaches outlined above, some respondents to the QLRC Consultation Paper No 76 (2017) expressed a preference for no change to the current law, or for the total prohibition of all terminations; neither approach would be consistent with the terms of reference.

termination may be performed.<sup>55</sup> This is the approach taken in the Australian Capital Territory (the ‘ACT model’).<sup>56</sup>

- ‘Combined’ approach with a later gestational limit — Termination is generally treated as a health matter, rather than a criminal matter, but additional requirements are imposed on the performance of later terminations. In Victoria, termination may be lawfully performed up to 24 weeks on request, and after 24 weeks if two medical practitioners concur that it is appropriate in all the circumstances having regard to specified matters (the ‘Victorian model’).<sup>57</sup>
- ‘Combined’ approach with an earlier gestational limit — Termination is treated as a health matter only up to an earlier gestational limit, with additional requirements imposed for all other terminations. In Tasmania, termination may be lawfully performed up to 16 weeks on request, and after 16 weeks if two medical practitioners concur that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated (the ‘Tasmanian model’).<sup>58</sup>
- Other ‘combined’ approaches — Various approaches combining gestational limits with specific grounds and consultation requirements so that termination may be lawfully performed only in specified circumstances. In Western Australia, for example, termination may be performed on limited grounds and,

<sup>55</sup> The extent to which termination of pregnancy is available in practice will depend on various matters related to clinical practice and access: see the discussion of the ‘Current clinical framework’ and ‘Accessibility and availability’ in Chapter 2.

<sup>56</sup> See *Health Act 1993* (ACT) ss 81–82 which provide, in effect, that a medical practitioner may ‘carry out an abortion’ in an approved medical facility. The Act does not otherwise impose any additional requirements that must be satisfied for a termination to be lawful. The former offences in the *Crimes Act 1900* (ACT) relating to procurement of a miscarriage were repealed: *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT), repealing *Crimes Act 1900* (ACT) ss 44–46. A private member’s bill was introduced into the Legislative Assembly on 21 March 2018, but has not yet been debated, which proposes amendments to the *Health Act 1993* (ACT) pt 6 div 6.1 to remove the requirement for a medical termination to be performed at an approved medical facility: Health (Improving Abortion Access Amendment) Bill 2018 (ACT) cl 5.

The position in Canada, where the existing criminal offence of procuring a miscarriage was held invalid by the Supreme Court and no separate federal legislation dealing with the lawfulness of termination has been enacted, is also described as an ‘on request’ approach: see QLRC Consultation Paper No 76 (2017) [127].

<sup>57</sup> See *Abortion Law Reform Act 2008* (Vic) ss 4–7. In considering whether the termination is appropriate in all the circumstances, the medical practitioner must have regard to all relevant medical circumstances and the woman’s current and future physical, psychological and social circumstances: ss 5(2), 7(2). The former offences in the *Crimes Act 1958* (Vic) ss 65, 66 relating to attempts to procure abortion were repealed: *Abortion Law Reform Act 2008* (Vic) s 9.

A 24 week gestational limit also operates in England, Scotland and Wales in respect of the primary ground for termination (risk of injury to the woman’s physical or mental health or that of any of her existing children): see QLRC Consultation Paper No 76 (2017) Appendix B. A private member’s bill was introduced into the House of Lords on 5 July 2017, but has not yet been debated, which proposes to amend the *Abortion Act 1967* (UK) s 1(1)(a) to lower the gestational limit in England and Wales from 24 weeks to 12 weeks: Abortion (Fetus Protection) Bill 2017–19 (UK) cl 1.

<sup>58</sup> See *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4, 5(1). In assessing the risk, the medical practitioners ‘must have regard to the woman’s physical, psychological, economic and social circumstances’: s 5(2). The Criminal Code (Tas) s 178D makes it an offence for a person who is not a medical practitioner or the pregnant woman to perform a termination. The former offences in the Criminal Code (Tas) ss 134, 135 relating to abortion were repealed: *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 14(f).

Earlier gestational limits are also imposed in some overseas jurisdictions including Iceland (16 weeks) and Denmark and Norway (12 weeks): see QLRC Consultation Paper No 76 (2017) Appendix B.

after 20 weeks, only if two medical practitioners from a panel appointed by the Minister concur that the relevant grounds are satisfied.<sup>59</sup>

- ‘Upper limit’ approach — An upper gestational limit is imposed beyond which no termination may be lawfully performed (or may be performed only in exceptional circumstances). This may be combined with specific grounds and consultation requirements for terminations performed before the gestational limit is reached. For example, in the Northern Territory, termination may be lawfully performed only up to 23 weeks and if two medical practitioners concur that it is appropriate in all the circumstances, except in an emergency.<sup>60</sup>
- ‘Grounds only’ approach — No gestational limit is imposed, but specific grounds must be satisfied before any termination may be performed. There may also be a requirement for another medical practitioner to concur that the grounds are satisfied before the termination may be performed. This is the approach in South Australia.<sup>61</sup> It also reflects the current position in Queensland and in New South Wales.<sup>62</sup> Under this approach, termination is generally treated as a criminal matter, with exceptions for lawful terminations.

3.44 These general approaches can be further distinguished by the consequences that apply for non-compliance. In some jurisdictions, termination remains a criminal offence, unless it is performed by a qualified person and in accordance with the legislative grounds for a lawful termination.<sup>63</sup> In contrast, in most of the jurisdictions that have adopted a combined approach, including Victoria and Tasmania, termination is a criminal offence if performed by an unqualified person, but non-compliance with the conditions set out in the termination legislation does not amount to a criminal offence.<sup>64</sup> In those jurisdictions, the termination legislation states in positive terms when a termination may be performed, rather than imposing criminal sanctions for unlawful terminations.

<sup>59</sup> See Criminal Code (WA) s 199(1); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3), (7). Termination after 20 weeks is permitted if the mother or the fetus has a severe medical condition that justifies the procedure.

<sup>60</sup> See *Termination of Pregnancy Law Reform Act 2017* (NT) ss 9, 10.

<sup>61</sup> See *Criminal Law Consolidation Act 1935* (SA) s 82A(1).

<sup>62</sup> See Criminal Code (Qld) ss 224, 225, 226 and 282, discussed in Chapter 2 above; and *Crimes Act 1900* (NSW) ss 82, 83, 84.

<sup>63</sup> See *Criminal Law Consolidation Act 1935* (SA) pt 3 div 17, pursuant to which a person is not guilty of an offence under ss 81 or 82 (of procuring a miscarriage, or supplying or procuring a thing to procure a miscarriage) if it is performed in accordance with the specified conditions in s 82A relating to the persons who may perform a termination and the grounds on which a termination may be performed; and Criminal Code (WA) s 199(1)–(2), pursuant to which it is an offence (punishable by a fine of up to \$50 000) to perform a termination unless it is performed by a medical practitioner and it is justified under the provisions of the *Health (Miscellaneous Provisions) Act 1911* (WA) s 334, which relate to the grounds and conditions on which a termination may be performed.

<sup>64</sup> See Criminal Code (Tas) ss 178D, 178E pursuant to which termination performed by a person who is not a medical practitioner, or without the woman’s consent, is a crime, but non-compliance with the grounds and conditions under the *Reproductive Health (Access to Terminations) Act 2013* (Tas) is not an offence; and *Crimes Act 1958* (Vic) s 65(1) under which termination performed by an unqualified person is an offence, but non-compliance with the grounds and conditions under the *Abortion Law Reform Act 2008* (Vic) is not an offence. See also Criminal Code (NT) s 208A under which termination performed by an unqualified person is an offence, but non-compliance with the grounds and conditions under the *Termination of Pregnancy Law Reform Act 2017* (NT) is not an offence.

3.45 The on request and combined approaches, which generally treat termination as a health matter rather than a criminal matter, are further considered below.

### ***'On request' approach***

3.46 United Nations treaty bodies have urged that laws criminalising termination should be removed and that barriers to access to safe termination should be minimised. Treaty bodies have identified that denying access to termination can constitute discrimination and a violation of women's rights, including the rights to life, health and private and family life.<sup>65</sup> Of the approaches outlined above, the ACT model most closely aligns with the principles of reproductive autonomy and privacy.

3.47 Arguments in favour of an on request approach include that:

- It removes legal barriers to access.
- It accords maximum respect for women's autonomy.
- It allows medical practitioners to focus on their primary role of determining their patients' clinical interests, rather than interpreting and applying additional legal tests.

3.48 Arguments against an on request approach include that:

- There is some community concern that an on request approach does not regulate, and would allow, later terminations up to birth, giving inadequate recognition to the interests of the fetus<sup>66</sup> which are entitled to greater recognition and protection as development towards birth progresses.<sup>67</sup>
- Some concern has also been expressed about laws that allow termination 'on demand' where the reason for termination is considered inadequate (for

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<sup>65</sup> See Appendix C.

<sup>66</sup> See, eg, Parliamentary Committee Report No 24 (2016) [6.5.2.3]; Submissions 541, 551, 597, 623, 680, 1113, 1117 and 1216 to the Parliamentary Committee on the first Bill and Inquiry. See also [3.66]–[3.67] below.

<sup>67</sup> See, eg, *R v Woolnough* [1977] 2 NZLR 508, 516–17 (Richmond P), quoted in *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 39:

it would, I think, be in accordance with the thinking of a great majority of people that the further a pregnancy progresses, the more stringent should be the requirements which will justify its termination.

See also, eg, H Farmer, 'An analysis of New Zealand's abortion law system and a guide to reform' (2013) 1 *Public Interest Law Journal of New Zealand* 147; Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper No 58 (1989) 13; and G Williams, *The Sanctity of Life and the Criminal Law* (1957) 230:

The humane, ethical, and parental feeling of the plain man leads him to wish to extend the protection of the criminal law not only to the newly born child but to the viable child before birth.

See also the discussion of the 'developmental or gradualist view' in Appendix D.

example, termination used as a form of contraception, for convenience or for gender selection).<sup>68</sup>

### **'Combined' approaches**

3.49 Combined approaches seek to balance a range of factors and represent neither total prohibition nor absolute autonomy. Depending on where the gestational limit is drawn, a combined approach may give greater or lesser weight in this balance to the decision-making autonomy of the woman on the one hand, and the interests of the fetus on the other. This may be illustrated by the Tasmanian and Victorian models.

#### ***Tasmanian model***

3.50 The Tasmanian model adopts an earlier gestational limit, giving greater weight to the interests of the fetus by limiting the circumstances in which termination after 16 weeks may be performed. Such an approach might be considered appropriate for a number of reasons:

- It recognises that women's autonomy and choice have greatest weight, as against the interest of the embryo or fetus, at the earliest stages of pregnancy.
- It recognises that termination at an early stage of pregnancy involves lower risk and is safer for the woman.

#### ***Victorian model***

3.51 The Victorian model, in contrast, adopts a later gestational limit. It reflects a 'viability' approach to lawful termination: termination is ordinarily a matter for the woman to decide, but once a pregnancy has reached the stage at which it is generally regarded that an infant would be capable of existing independently if born pre-term, the law imposes additional limits on when a termination can be performed.

3.52 Arguments in favour of such an approach are that:

- It gives greater weight to the autonomy and choice of the woman up to the gestational limit.
- It recognises that the interests of the fetus have increasing weight at the later stages of pregnancy.
- It recognises concerns about later terminations being 'on demand'.<sup>69</sup>
- It recognises that later terminations are higher risk and may involve greater complications.

<sup>68</sup> Eg, Submissions 548, 592, 704, 742, 1066, 1106, 1184, 1190, 1222, 1248 and 1286 to the Parliamentary Committee on the first Bill and Inquiry. See also [3.60] below. With respect to gender selective termination, see, eg, G Gillett and R Wong, 'Think of the children: Sex selection and child welfare' (2015) 22 *Journal of Law and Medicine* 751.

<sup>69</sup> See, eg, [3.48] nn 67, 68 above; QLRC Consultation Paper No 76 (2017) [151] n 204.

3.53 This approach aligns with one of the principles reflected in the criminal law that, at the later stages of pregnancy, the law begins to regard the fetus as a person capable of being killed.<sup>70</sup>

## Submissions

3.54 In the Consultation Paper, the Commission sought submissions on whether any gestational limit should be imposed, whether any specific grounds should be imposed, whether different grounds should apply at different stages of pregnancy, and whether there should be a requirement for a medical practitioner to consult with others or refer to a committee before performing a termination.<sup>71</sup>

3.55 These questions generated mixed responses.

### *Restrictive approaches*

3.56 On the one hand, many individual members of the public, including some current or former health practitioners,<sup>72</sup> preferred a more restrictive approach:

- Some considered there should be a total prohibition on termination at any stage of gestation and for any reason.<sup>73</sup>
- Some considered that termination should be available only on very restrictive grounds, whatever the stage of pregnancy, such as where the woman's life is in danger.<sup>74</sup>
- Some considered there should be no change to the current law.<sup>75</sup>
- Others — including many who were opposed to termination but expressed a view about what the law should provide if termination were to be permitted — considered that there should be an early upper gestational limit, for example, of 12 weeks, beyond which termination should never be permitted or be permitted only in exceptional circumstances.<sup>76</sup>

3.57 Similar views were expressed by a number of organisations and groups, including the Roman Catholic Bishops of Queensland, the Presbyterian Church of

<sup>70</sup> See, eg, Criminal Code (Qld) ss 292 and 313(1), discussed in Chapter 2 above and Chapter 7 below, respectively; and *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 36–9, 41–2 (McGuire DCJ).

<sup>71</sup> See QLRC Consultation Paper No 76 (2017) Q-3 to Q-10.

<sup>72</sup> Eg, Submissions 120, 140, 195, 327.

<sup>73</sup> Eg, Submissions 31, 40, 75, 76, 79, 93, 98, 140, 141, 145, 186, 226, 234, 237, 283, 328, 334, 353, 428, 434, 444, 492, 645, 651, 652, 653.

<sup>74</sup> Eg, Submissions 30, 42, 46, 56, 57, 105, 111, 127, 165, 182, 197, 229, 246, 277, 282, 323, 327, 368, 398, 458, 496, 650, 656, 664, 678, 686.

<sup>75</sup> Eg, Submissions 129, 130, 161, 165, 196, 204, 245, 265, 277, 320, 327, 348, 355, 357, 408, 665. Several other respondents expressed general opposition to the decriminalisation of termination.

<sup>76</sup> Eg, Submissions 1, 36, 43, 55, 62, 64, 69, 84, 87, 112, 115, 120, 122, 128, 129, 155, 159, 169, 189, 193, 228, 231, 238, 252, 271, 272, 284, 285, 323, 326, 335, 367, 375, 394, 404, 427, 432, 441, 477, 666, 680. Most of these respondents suggested a limit of 12 weeks; a few suggested earlier limits of between five and 10 weeks. Some other respondents suggested that the gestational limit should be 'from conception': eg, Submissions 65, 95, 273, 278, 377, 407, 437, 470B.

Queensland, FamilyVoice Australia, Cherish Life Queensland Inc., Priceless House and the World Federation of Doctors who Respect Human Life–Queensland Branch.<sup>77</sup>

3.58 The Presbyterian Church of Queensland submitted, for example, that termination should be available only in the ‘rare circumstance’ where the mother’s life is clearly threatened and the fetus is not yet viable. In its view:<sup>78</sup>

the humanity of the fetus is widely recognised in our community. Indeed, embryologists are clear that fertilization represents the beginning of a human life. What is debated is the degree to which the human fetus deserves protection relative to the needs of the adults who are involved in his/her care.

[A person’s] dignity is not altered by stage of gestational development or demands of care. ... we argue that the fetus, a vulnerable person with no voice, deserves the care and protection of the law equal to any child, regardless of circumstances. The unborn should be given every opportunity to live and be nurtured, regardless of gender, background or disability status.

3.59 Cherish Life Queensland Inc. similarly submitted that:<sup>79</sup>

Cherish Life Queensland has always maintained that all human life, born and unborn, deserves the full protection of the law. This is at least notionally observed by the inclusion of abortion in the Criminal Code. ... to remove abortion from the Criminal Code altogether deprives the unborn child of any legal recognition whatsoever. Abortion is not and never will be just another medical procedure because there is no other medical procedure that has as its immediate and only purpose the killing of another human being.

... we do not believe that it is legitimate for abortion to be performed at any time in pregnancy, and that is because we hold that the first right in order of priority, is the right to life of the unborn human being. ...

any and every abortion results in the loss of an unborn child’s life. Such a grave outcome cannot be justified except in a circumstance where there is a critical urgent risk to the life of the mother. ...

There is not a point along the 38–42 week gestational period that the child growing within the womb is transformed into a human being with the right to life. It is therefore a pointless exercise to try and determine an arbitrary point that separates when it is acceptable to take that unborn child’s life and when it is no longer acceptable.

3.60 Concern was expressed about termination ‘on demand’, especially of later term pregnancies, with some respondents objecting to termination used as a form of contraception, for convenience or for gender selection.<sup>80</sup> The Knights of the Southern Cross (Qld) submitted, for example, that:<sup>81</sup>

<sup>77</sup> Eg, Submissions 105, 170, 433, 448, 491, 495, 587, 589, 601, 679, 819, 836.

<sup>78</sup> Submission 587.

<sup>79</sup> Submission 819.

<sup>80</sup> Eg, Submissions 36, 69, 105, 122, 163, 258, 269, 287, 355, 401, 448, 461, 473, 494, 528, 581, 589, 611, 612, 664, 721, 860, 836, 891.

<sup>81</sup> Submission 555.

we uphold the belief that human life begins from the moment of conception, and we are therefore opposed in principle to [legalising] abortion or termination of life on demand in any form.

3.61 Many respondents considered that, if permitted, termination should be restricted to early term pregnancies. The Lutheran Church of Australia submitted, for example, that:<sup>82</sup>

As a general principle, if abortions are approved, they should occur as early as possible in the pregnancy, preferably within the first trimester.

Terminations should be performed as rarely as possible after the point of viability, at which stage arguments against the child's right to a chance at life are less and less convincing.

3.62 Another respondent similarly suggested that:<sup>83</sup>

abortion should be limited to the earliest stages of pregnancy. A baby who is medically viable outside the womb should never be terminated.

3.63 In particular, many respondents suggested that there should be an upper gestational limit to restrict lawful termination to the first trimester of pregnancy.<sup>84</sup> One respondent commented, for example, that:<sup>85</sup>

I believe that should termination of pregnancy become lawful that there should be an early gestational limit relating to the first trimester of pregnancy. I believe that after the first trimester a human being is formed and is entitled to the right to life. Every assistance including counselling and all the aids of modern medicine available today should be offered to a woman to help her carry to full term.

3.64 Another respondent suggested that:<sup>86</sup>

There should certainly be a gestational limit of the first trimester. Abortion carried out any further into the pregnancy increases the risks to the physical and emotional wellbeing of the mother.

3.65 In this context, it was observed that, in some overseas jurisdictions, there are legislative gestational limits of 12 weeks.<sup>87</sup>

3.66 A number of respondents expressed particular concern about allowing 'late term' termination or termination 'up to birth'.<sup>88</sup> It was submitted, for example, that

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82 Submission 589.

83 Submission 62.

84 Eg, Submissions 43, 64, 69, 84, 87, 115, 120, 122, 129, 155, 159, 169, 189, 193, 231, 252, 271, 272, 284, 285, 323, 326, 335, 375, 427, 432, 441, 477.

85 Submission 375.

86 Submission 120.

87 Eg, Submission 323, referring, for example, to Belgium, France, Denmark, Switzerland and Austria. As to the position in some of those countries, see QLRC Consultation Paper No 76 (2017) Appendix B.

88 Eg, Submissions 34, 39, 66, 78, 83, 84, 85, 86, 92, 95, 96, 97, 100, 102, 107, 120, 129, 138, 151, 152, 219, 230, 269, 274, 288, 333, 354, 355, 364, 401, 408, 427, 440, 448, 462, 464, 483, 665.

'[a]borting babies any day right up to birth would be morally wrong'<sup>89</sup> and 'a grave act of cruelty'.<sup>90</sup> One respondent expressed concern that:<sup>91</sup>

a mother could be having a late term abortion of a fetus of between seven to nine months gestation, and at the same time a woman of the same gestational time could be having a premature baby with doctors and staff doing all in their power to save the baby's life. Why is there a difference in human rights from one baby to another?

3.67 The Roman Catholic Bishops of Queensland considered that termination 'up to birth' is inconsistent with the idea that, as the fetus develops, its interests are entitled to greater protection:<sup>92</sup>

We strongly oppose abortion 'on request until birth.' ... Every day in the womb increases the likelihood of personhood. We maintain this position because, even if one rejects our argument that personhood begins at fertilisation, one cannot reject the fact that an embryo matures over time to become a fetus and then a viable child. Every day longer it spends in the womb, the more probable it is that we are dealing with a human person who is capable of being killed ... [O]ne is required to register a birth and death, and arrange burial or cremation, if the child is born alive at less than 20 weeks, and alive or dead after 20 weeks.<sup>93</sup> This underscores the idea that the longer the gestation, the more likely it is that one is dealing with a person. Efforts to circumvent this by killing the child in the womb, especially after 20 weeks are logically and morally indefensible. (note added)

3.68 Respondents expressed a range of views in support of the restrictive approaches outlined above, including the views that:

- Life begins at conception and the right to life of the unborn should be protected.
- The fetus is able to feel pain and should be protected from harm.
- Termination procedures are 'brutal', particularly in later stages of pregnancy.
- Gestational limits are arbitrary.
- Allowing later terminations and termination up to birth discriminates against the unborn on the basis only of its location (in the womb).
- Termination, especially in later stages of pregnancy, involves risk to the woman's physical and mental health.
- Women should be protected from being coerced or forced into having a termination.

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89 Submission 274.

90 Submission 433.

91 Submission 464.

92 Submission 448.

93 See Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.1] 'Birth registration'; *Births, Deaths and Marriages Registration Act 2003* (Qld) ss 4, 6, 26, 32, sch 2 Dictionary (definitions of 'disposal, of human remains' and 'stillborn child').

- Even if the mother's life is in danger, other measures can be taken to try to save both the mother and child.
- Other options should be considered, such as premature delivery and care of the infant, the provision of support, or adoption.
- Termination on demand will increase the number of terminations.

### ***On request or combined approaches***

3.69 On the other hand, many respondents preferred either an on request approach, like the ACT model,<sup>94</sup> or a combined approach with a later gestational limit, like the Victorian model.<sup>95</sup>

3.70 They included peak health profession bodies, such as RANZCOG, the Royal Australasian College of Physicians, AMA Queensland, the Australian College of Nursing and The Australian Psychological Society Limited.<sup>96</sup>

3.71 RANZCOG considered, for example, that there should be no legislated gestational limit or specified grounds, noting that the 'non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies'. It expressed particular concern that later termination 'must be an option available to women':<sup>97</sup>

Decisions around timing of termination of pregnancy may become more complex in the presence of some specific fetal conditions, multiple pregnancy, late recognition of pregnancy, advancing gestational age and pre-existing maternal disease. The non-availability of late termination of pregnancy may place these women in an untenable position of having to make decisions at times when information is not available or a healthy co-twin is potentially endangered.<sup>98</sup> The College supports a multi-disciplinary approach in assisting women in such circumstances and the availability of late termination of pregnancy for the rare

<sup>94</sup> Eg, Submissions 2, 4, 50, 59, 60, 61, 63, 67, 70, 71, 73, 74, 89, 108, 109, 116, 119, 121, 142, 158, 160, 164, 210, 220, 262, 276, 297, 344, 349, 378, 405, 406, 421, 422, 429, 438, 445, 452, 454, 467, 469, 478, 482, 487, 490, 500, 510, 511, 514, 526, 529, 532, 539, 542, 546, 547, 562, 571, 577, 579, 583, 585, 588, 590, 598, 600, 621, 623, 624, 628, 630, 632, 642, 649, 669, 671, 670, 673, 674, 681, 683, 688, 712, 720, 754, 883, 888.

<sup>95</sup> Eg, Submissions 20, 26, 50, 89, 101, 119, 164, 220, 250, 276, 378, 419, 438, 469, 486, 487, 500, 539, 542, 546, 562, 572, 590, 592, 600, 604, 623, 628, 630, 632, 642, 669, 671, 683, 712, 720, 837, 888. See further [3.81] below.

<sup>96</sup> Eg, Submissions 118, 341, 482, 579, 621, 885.

<sup>97</sup> Submission 482, referring to RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016); RANZCOG, 'Late Termination of Pregnancy' (C-Gyn 17A, May 2016). See also Submission 845 to the Parliamentary Committee on the first Bill and inquiry, in which RANZCOG expressed strong support for the regulation of termination under health laws rather than the Criminal Code.

<sup>98</sup> RANZOG has identified multiple pregnancy involving a severe fetal abnormality to one fetus as one of the 'rare but important circumstances' in which late termination might be necessary:

Where one fetus of a multiple pregnancy has a serious abnormality and the other(s) do not, it is unreasonable to have legislation that compels the mother to make a decision for termination of pregnancy of the seriously abnormal fetus at a time when this procedure carries increased risks to the healthy fetus/es of extreme preterm birth. It is essential to have legislation that enables termination of the abnormal fetus to be deferred until a gestation at which—were preterm birth to ensue—birth of the healthy fetus/es would not result in consequences of extreme prematurity: RANZCOG, 'Late Termination of Pregnancy' (C-Gyn 17A, May 2016) 2.

situations where both managing clinicians and patient believe it to be the most suitable option in the circumstances. (note added)

3.72 The Royal Australasian College of Physicians similarly submitted that:<sup>99</sup>

access to abortion services should not be open only to women whose pregnancy lies within a specified gestational range, as this may discriminate against women who experience medical illnesses that are only manifest in late gestation, who are in the most difficult of clinical circumstances and/or who lack access to maternal healthcare services. In this regard it is worthy of note that the RACP supports the availability of late term abortions when both the clinicians caring for the patient and the patient believe it to be the most appropriate decision—a position that aligns with the RANZCOG *Termination of Pregnancy Statement*.

3.73 The Australian Psychological Society Limited also preferred an approach that ‘recognises women as competent and conscientious decision-makers’ and treats termination like other medical services that are provided in compliance ‘with professional, ethical, legal and best practice Australian standards’.<sup>100</sup>

3.74 Other respondents who supported an approach like the ACT or Victorian models included some medical practitioners and services who provide termination of pregnancy services;<sup>101</sup> health, support and advocacy organisations such as the Women’s Health Services Alliance (Qld), the Public Health Association of Australia and Children by Choice;<sup>102</sup> human rights law and legal advocacy organisations such as the Castan Centre for Human Rights Law, Australian Lawyers for Human Rights, the Human Rights Law Centre Ltd, and the Queensland Council for Civil Liberties;<sup>103</sup> domestic and family violence and sexual assault support services;<sup>104</sup> and some legal practitioners and academics.<sup>105</sup>

3.75 For example, the Public Health Association of Australia submitted that:<sup>106</sup>

abortion is a safe, common medical procedure which should be regulated in the same way as other medical procedures, without additional barriers or conditions. Universal access to safe abortion is an essential element of the provision of high quality reproductive health for women in Australia.

3.76 Similarly, the Castan Centre for Human Rights Law submitted that an on request approach:<sup>107</sup>

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<sup>99</sup> Submission 579, referring to RANZCOG, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016).

<sup>100</sup> Submission 118.

<sup>101</sup> Eg, Submissions 101, 220, 532, 632, 674, 685.

<sup>102</sup> Eg, Submissions 50, 89, 119, 164, 210, 378, 419, 422, 467, 469, 487, 500, 539, 542, 590, 592, 600, 623, 630, 671, 624.

<sup>103</sup> Eg, Submissions 276, 296, 486, 490, 583, 628, 669, 720, 888.

<sup>104</sup> Eg, Submissions 297, 539, 673, 683, 688, 754.

<sup>105</sup> Eg, Submissions 429, 438, 445, 572, 588, 712, 837.

<sup>106</sup> Submission 600.

<sup>107</sup> Submission 276.

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.

3.77 A general practitioner observed that such an approach ‘would not be strictly abortion “on demand”, as the medical practitioner involved would still have to consider the procedure ethically appropriate, with later gestations carrying greater ethical weight’.<sup>108</sup>

3.78 The Human Rights Law Centre Ltd similarly noted that ‘medical practitioners are already subject to high professional standards and guidelines in relation to abortion’, and observed that an on request approach is ‘consistent with human rights and with the position of RANZCOG’.<sup>109</sup>

3.79 Australian Lawyers for Human Rights also submitted that termination should be primarily considered as ‘a health and human rights issue’. In their view:<sup>110</sup>

there should not be a prescribed approach for different gestation periods. Specifying criteria for termination according to different gestation periods is arbitrary, and fails to consider the individual circumstances of each case. It should be a matter for medical practitioners to assess each case according to its circumstances, best practice and clinical guidelines and the circumstances and wishes of the woman involved, in order to support her decision-making.

3.80 The Queensland Law Society similarly considered that these matters ‘should be determined and regulated in accordance with the State’s health care regulatory framework’.<sup>111</sup>

any decision to terminate ought to be made in conjunction with a registered health practitioner, who acts in accordance with good medical practice and in adherence to the relevant health care regulatory framework, and ... the question or appropriateness of the imposition of a gestational limit should be considered in this context.

It would be inappropriate for QLS to suggest the imposition of arbitrary gestational limits which are not grounded in appropriately evidenced health policy and regulation, and which are not informed by the circumstances of the affected woman.

... QLS notes the approaches which have been adopted in the Australian Capital Territory or Victoria, in which the limitations and reasoning applied to a termination of pregnancy are determined in accordance with the State’s health

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108 Submission 110.

109 Submission 888.

110 Submissions 583.

111 Submission 879. The BAQ expressed a similar view, observing that:

Health professionals, being subject to strict education and training requirements mandating a high level of knowledge and skill, are best placed to make any decision concerning the termination of a pregnancy to ensure the health and safety of a woman. There is an existing statutory regime which regulates health professionals whose conduct does not meet these standards, and this would extend to their conduct in termination of pregnancies. Relevantly, the Medical Board of Australia regulates the conduct of health professionals, including issues of professional misconduct (with referral to the Queensland Civil and Administrative Tribunal for a determination where appropriate): Submission 878. (notes omitted)

care regulatory framework, policies and guidelines and which are not otherwise limited by specific grounds such as gestational age or other reasoning ...

3.81 Many respondents preferred an on request approach, but submitted that they would support a combined approach with a later gestational limit, like the Victorian model, mainly for pragmatic reasons in recognition of concerns within the community about later terminations.<sup>112</sup>

3.82 For example, a specialist obstetrician and gynaecologist with more than 40 years' experience submitted that, although legislative safeguards for later terminations may be unnecessary in practice, an approach like the Victorian model would be sensible.<sup>113</sup>

The vast majority of abortions in Australia (around 94%) take place within the first trimester of pregnancy and they are requested for a variety of socio-economic and medical reasons. There is no logical medical or social reason, in 2018, to impose any kind of limitation (eg, 12 or 14 weeks) on these, and this would complicate the situation for women having to make a decision about abortion towards the end of the first trimester, because of the diagnosis of a severe fetal abnormality on antenatal screening tests ... About 5% of abortions in Australia take place between 14 and 20 weeks gestation and are almost always done for medical reasons including severe fetal abnormality that could not be diagnosed earlier in the pregnancy or serious medical conditions in the mother. The remaining one percent (approximately) are also mostly done after 20 weeks for severe fetal abnormality or serious medical conditions in the woman; abortions at greater than 20 weeks in Queensland are almost all done at one of a very small number of hospitals with very dedicated and experienced staff, and involve a number of maternal fetal medicine specialists and other doctors, other health professionals and counsellors as required, taking part in the decision-making with the woman and her partner, and assisting the couple through the process.

Occasionally a lethal condition in the fetus ... will not be diagnosed until after 24 weeks' gestation and doctors need the flexibility to be able to offer termination of the pregnancy at these gestations. However I am aware that not having an upper limit causes concern to some members of the non-medical community who do not appreciate the many safeguards on current and future practice nor the expertise required and provided for these very difficult circumstances. Therefore, since in any post-24 week termination of pregnancy a number of doctors will be involved, following the example of the Victorian legislation which requires two doctors to agree that the termination is medically indicated, seems to me a sensible approach. I would therefore support Queensland adopting this model.

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112 Eg, Submissions 50, 89, 119, 164, 220, 276, 341, 378, 438, 469, 487, 500, 539, 542, 546, 562, 590, 600, 623, 628, 630, 632, 669, 671, 712, 720, 837, 888.

113 Submission 220. See also Submission 116 to the Parliamentary Committee on the first Bill and Inquiry at 4–5 in which Prof de Costa explained that termination of pregnancies after 22 weeks, in situations where the infant has severe and significant abnormalities that have not been diagnosed earlier and cannot survive independently, are 'unusual, uncommon and subject to very significant medical and hospital oversight'.

3.83 The National Alliance of Abortion and Pregnancy Options Counsellors expressed a similar view, observing that:<sup>114</sup>

Unfortunately misinformation regarding actual practice with regard to gestational limits has taken hold within the community, for example, the myth of 'abortion to birth' ... Making reference to gestational limits at law may provide reassurance to the community ...

3.84 Another specialist obstetrician and gynaecologist suggested that a legislative gestational limit for later terminations would provide guidance to medical practitioners:<sup>115</sup>

a lack of legal oversight of gestational limit can make doctors or health care services wary of engaging in late termination of pregnancy in case it may be considered infanticide/homicide. A gestational age limit or recommendation for legal assessment in later pregnancy will provide guidance and support to practitioners who are asked to consider providing late termination of pregnancy.

3.85 A general practitioner observed that:<sup>116</sup>

There will never be a consensus between those who believe the fetus attains full rights at conception and those who believe the woman's autonomy is absolute throughout pregnancy. Viability is often chosen as a point where the fetus' right to consideration outweighs the woman's right to bodily integrity and self-determination.

3.86 Most of the respondents who supported a combined approach like the Victorian model considered that the gestational limit should, like Victoria, be 24 weeks,<sup>117</sup> which is currently cited as the approximate threshold of viability for pre-term birth.<sup>118</sup> Alternatively, a few respondents, including AMA Queensland, suggested a limit of 22 weeks,<sup>119</sup> which would be 'prior to possible survival'.<sup>120</sup>

3.87 A number of respondents expressed concern that legislative restrictions or gestational limits would disproportionately disadvantage vulnerable women seeking termination at later gestations.<sup>121</sup> Children by Choice submitted, for example, that a

<sup>114</sup> Submission 487, citing Evidence to the Parliamentary Committee, 4 August 2016, 6 (Dr C Portmann); and Submission 835 to the Parliamentary Committee on the first Bill and inquiry in which Dr Portmann observed that concerns that the decriminalisation of termination would encourage terminations up to nine months for psychosocial reasons are 'unfounded' given medical practitioners' ethical and regulatory guidelines. See also, eg, Submission 116 to the Parliamentary Committee on the first Bill and inquiry (Prof C de Costa); and Submission 875 to the Parliamentary Committee on the second Bill in which AMA Queensland observed that terminations at greater than 24 weeks gestation are not a frequent occurrence and that this would not be expected to change to a significant degree if termination were decriminalised.

<sup>115</sup> Submission 526.

<sup>116</sup> Submission 110.

<sup>117</sup> Eg, Submissions 20, 26, 50, 89, 101, 119, 164, 250, 276, 378, 419, 438, 454, 469, 486, 487, 500, 539, 542, 546, 562, 572, 590, 592, 600, 604, 623, 628, 630, 632, 669, 671, 683, 712, 720, 837, 888.

<sup>118</sup> See Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014).

<sup>119</sup> Submissions 500, 526, 885.

<sup>120</sup> Submission 526.

<sup>121</sup> Eg, Submissions 50, 89, 119, 164, 438, 454, 469, 562, 590, 592, 630, 670, 681, 683, 707, 712, 720, 883.

gestational limit of less than 24 weeks would ‘impact significantly and unfairly on vulnerable pregnant people and their families’:<sup>122</sup>

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

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

Ultrasound screening for fetal health is routinely recommended around midway through pregnancy, at 18–21 weeks gestation, and many anomalies are not diagnosed until this time. Implicit in this practice is that if those tests return an unexpected or negative diagnosis, women and couples will be supported to make a decision regarding the pregnancy given the knowledge that testing has afforded to them. (notes omitted)

3.88 Other respondents expressed similar concern about the need to ensure that, although less common, later termination is available.<sup>123</sup> Many highlighted the difficult and complex circumstances in which later terminations arise.<sup>124</sup>

3.89 A specialist obstetrician and gynaecologist explained, for example, that:<sup>125</sup>

Late termination of pregnancy for medically indicated situations is usually due to the presence of serious fetal anomalies, usually serious fetal heart or brain issues, or serious maternal medical indications at the perivable gestations where it is thought that survival of the baby is unlikely. ...

... If a woman/family and her doctors are given a very short window of time to make a decision and achieve a termination, there may be emotional and medical pressure to make a decision before complete informed consent and ethical decision-making can be obtained. It may not be possible to receive adequate

<sup>122</sup> Submission 50, citing, eg, Ipas, *Who has second-trimester abortions?* (September 2015) <<http://www.ipas.org/en/Resources/Ipas%20Publications/Who-has-second-trimester-abortions.aspx>>; K Rice, ‘Termination of Pregnancy Post 20 Weeks’ (Background Paper, Women’s Health Victoria, March 2007) <<http://whv.org.au/static/files/assets/9dbc19ef/Abortion-issues-post20.pdf>>; Children by Choice, *Annual Report 2016–17* (2017) 10; South Australia Health, Pregnancy Outcome Unit, *Pregnancy Outcome in South Australia 2015* (2017) 55; and T Todros, E Capuzzo and P Gaglioti, ‘Prenatal diagnosis of congenital anomalies’ (2001) 3(2) *Images in Paediatric Cardiology* 3.

This submission was endorsed and supported by a number of other respondents, including Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, White Ribbon Australia, and a group of academics from Griffith Law School: Submissions 89, 119, 164, 454, 469, 562, 592, 630, 632, 683, 712, 883.

<sup>123</sup> Eg, Submissions 27, 118, 210, 220, 378, 421, 454, 526, 539, 577, 590, 600, 720. See also Submissions 482 and 579 at [3.71]–[3.72] above.

<sup>124</sup> Eg, Submissions 27, 50, 118, 172, 482, 526, 562, 681, 883.

<sup>125</sup> Submission 526. See also Submission 220 at [3.82] above.

counselling from all specialists, obtain all relevant investigations etc if there is a time limitation placed upon options. Fetal development is also a significant issue. Some brain, heart and other issues develop or improve with time. In the absence of allowing this time to pass, some people may make decisions without complete information.

3.90 That respondent further identified that later termination can involve complicated personal and social circumstances, including 'social and geographic isolation, domestic violence, lack of recognition of late gestation, financial issues, [or] mental health issues that are not considered life threatening'.<sup>126</sup>

3.91 The Institute for Urban Indigenous Health Ltd made a similar observation and expressed concern that legislative reform should not inequitably disadvantage Aboriginal and Torres Strait Islander women:<sup>127</sup>

legislative reform must avoid restrictions which inequitably disadvantage Aboriginal and Torres Strait Islander women, such as those which would put practical limitations on the availability and accessibility of termination services.

It is known that women seeking second trimester terminations are more likely to be experiencing disadvantage including poverty, reproductive coercion, domestic violence, geographic or social isolation and fetal abnormalities. Gestational limits discriminate against the most vulnerable of women and women in the most difficult of socio-economic and clinical circumstances. Women with social or geographical disadvantage may not access diagnosis of lethal or serious fetal anomalies until later in their pregnancy.

[The Institute] acknowledges the expertise and experience of obstetricians and gynaecologists and the allied health staff with whom they collaborate in the provision of later gestation termination for patients making difficult, complex, individualised later gestation decisions. We believe the Commission should give due weight to the evidence of the peak bodies, RANZCOG and counselling bodies including Australian Psychological Society, in the consideration of legislation on gestation limits for lawful terminations.

3.92 The Women's Legal Service Queensland observed that, whilst some barriers might be addressed 'by improved access through decriminalisation', other factors such as domestic violence may not:<sup>128</sup>

Between 6 and 22 percent of women seeking an abortion report violence from an intimate partner and concern about violence is a major reason why some women decided to terminate their pregnancy. Women who report violence as a reason for abortion describe not wanting to expose children to violence, and understand

126 Submission 526.

127 Submission 707.

128 Submission 720, citing KS Chibber et al, 'The role of intimate partners in women's reasons for seeking abortion' (2014) 24(1) *Women's Health Issues* 131; M Antonia Biggs, H Gould, DG Foster, 'Understanding why women seek abortions in the US' (2013) 13(1) *BMC Women's Health* 29; LB Finer et al, 'Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives' (2005) 37(3) *Perspectives on Sexual and Reproductive Health* 110.

It has also been observed that pregnancy is a trigger for domestic violence to first occur and can be related to reproductive coercion which can lead to a range of health consequences including higher rates of unintended, unwanted pregnancy and pregnancy complications: Submission 883, citing Australian Bureau of Statistics, *Personal Safety, Australia, 2012* Cat No 4906.0, Table 27; C Garcia-Moreno, A Guedes and W Knerr, 'Understanding and addressing violence against women: Intimate partner violence' (Information Sheet, World Health Organization, 2012) <[http://www.who.int/reproductivehealth/topics/violence/vaw\\_series/en/](http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/)>.

that continuing the pregnancy will tie them to an abusive partner. ... [Women's Legal Service Queensland] has assisted clients who have been unable to access an abortion in the first trimester due to the high levels of control and monitoring from violent partners. For this reason, it is important that women in this vulnerable position are able to access a termination later in their pregnancy, as a means of increasing their safety and wellbeing long-term.

3.93 A range of views was given by respondents in support of an on request approach or a combined approach like the Victorian model, including the views that:

- Termination is and should be treated as a health matter, rather than a criminal matter, for decision by the woman in consultation with her doctor.
- Women's reproductive choice and bodily autonomy should be respected.
- Women should be protected from forced pregnancy.
- These approaches are consistent with Australia's international human rights obligations.
- Legislative restrictions impede access, create barriers and unfair burdens, especially in relation to the most vulnerable or disadvantaged women.
- Gestational limits are arbitrary.
- Most terminations are performed early, but there will always be difficult cases in which termination needs to be available in later gestation (for example, where there is late diagnosis of serious fetal abnormality or domestic or family violence).
- These approaches will not increase the number of later terminations.
- These approaches are consistent with other jurisdictions.

### ***Other combined approaches***

3.94 Some respondents suggested other combined approaches.

3.95 A range of approaches was suggested, some being more restrictive than others. Most involved the combination of an on request gestational limit with specific grounds or conditions, and some involved different grounds at different stages.<sup>129</sup>

3.96 The Uniting Church in Australia, Queensland Synod proposed the following staged approach, with increasingly restrictive grounds at each gestational stage:<sup>130</sup>

<sup>129</sup> Eg, Submissions 27, 49, 172, 517, 526, 690.

<sup>130</sup> Submission 690. This respondent submitted that the following grounds should apply:

8 weeks–23 weeks: Medical risk to the mother's life or her mental or physical health; exceptional social or economic circumstances; pregnancy as a result of rape or incest;

23 weeks onwards: High level risk to mother in continuing pregnancy; very high level of fetal abnormality such that it is incompatible with life; pregnancy as a result of rape or incest.

They also submitted that there should be a requirement for consultation with another medical practitioner in both the second and third gestational stages.

Creating cut-off points poses a difficult question, as there are not any clear indications where those points might be appropriate. We urge consideration of a developmental view—taking account of the increasing motor and sensory abilities of the developing fetus. ...

The stages of gestational limits we would be prepared to accept are:

1. The first stage encompassing embryo and pre-embryo stages—up to eight weeks gestation, with no restrictions ...
2. The second would be from eight to 23 weeks gestation— the fetus stage, up to the generally considered viable age of 23 weeks. During this stage the fetus is growing rapidly and developing his/her ability to move, hear and sense light. He/she looks more and more human-like. The gestational age should be taken into account in decision-making about termination of pregnancy, along with the mother's health and circumstances. ...
3. The third stage would be from 23 weeks gestation onwards, when we believe termination of pregnancy would be appropriate only in extreme circumstances, such as a high level of risk to the mother in continuing the pregnancy. At 23–25 weeks a fetus may be considered viable, and beyond that point considerable effort is made to support that life.

3.97 The Sunnybank Centre for Women expressed support for 'the concept that the interests of the fetus should be recognised and protected with advancing gestation', whilst acknowledging the 'unique, personal, and often tragic circumstances' in which requests for later termination arise. They suggested that there should be broad grounds for termination up to 20 weeks, with more specific grounds applying after 20 weeks.<sup>131</sup> This respondent did not consider that the gestational limit should be based on the 'age of viability', at 24 weeks, given that an infant may be born alive, and have its birth registered, at gestations below that age.<sup>132</sup>

3.98 Some respondents suggested an approach closer to the Victorian model, but with modifications. For example, a medical practitioner submitted that termination should be lawful: on request up to 20 weeks; for 'medical or serious psychological reasons documented by the consulting doctor' and supported by a second health practitioner at 20–24 weeks; and at any time in cases involving fetal abnormality where two medical practitioners concur. In his view, this approach:<sup>133</sup>

balance[s] the rights and choices of a woman along with society's view of the pregnancy timeline, the viability of premature births and also the definite increase in risks, potential side effects and complications with later term abortions.

<sup>131</sup> Submission 27. In particular, they considered that the grounds outlined in QLRC Consultation Paper No 76 (2017) Q-6(a) and Q-6(b) would be suitable, respectively, for terminations before and after 20 weeks, namely:

- Up to 20 weeks: if it is appropriate in all the circumstances, having regard to all relevant medical circumstances, the woman's current and future physical, psychological and social circumstances, and professional standards and guidelines;
- After 22 weeks: if it is necessary to preserve the life or the physical or mental health of the woman; if it is necessary or appropriate having regard to the woman's social or economic circumstances; if the pregnancy is the result of rape or another coerced or unlawful act; or if there is a risk of serious or fatal fetal abnormality.

<sup>132</sup> As to the registration of births and deaths, see n 93 above.

<sup>133</sup> Submission 223.

... No specific grounds should need to be satisfied for an 'on request' termination up to 20 weeks gestation. This is both unfairly intrusive and discriminatory to a woman's choice. It may also act as a barrier to those accessing this choice.

3.99 A specialist obstetrician and gynaecologist, who generally preferred an on request model, suggested an alternative under which termination would be lawful: on request up to 22 weeks, but with 'avenues put in place up to 24 weeks where delay in referral or access to care has occurred'; from 22 weeks, if continuing the pregnancy would be detrimental to the mother's or infant's life, having regard to all medical, social and psychiatric circumstances; and at any time, in cases where a serious fetal abnormality has been identified.<sup>134</sup>

## Grounds

### *A single broad ground*

3.100 Most of those who supported a combined approach like the Victorian model also supported a single broad ground, to apply after the gestational limit.<sup>135</sup> In particular, they expressed support for a ground in the same terms as the Victorian and Northern Territory legislation to the general effect that the medical practitioner must be satisfied that:<sup>136</sup>

termination is appropriate in all the circumstances, having regard to:

- (a) all relevant medical circumstances;
- (b) the woman's current and future physical, psychological and social circumstances; and
- (c) professional standards and guidelines.

3.101 AMA Queensland supported the Victorian approach, observing that this formulation, which requires the medical practitioner to consider 'all the circumstances', is 'very important to avoid one circumstance being considered in isolation of the other[s]'.<sup>137</sup>

3.102 A specialist obstetrician and gynaecologist considered that such an approach would confirm the medical practitioner's existing requirements to 'act professionally and ethically' in regard to all aspects of medical practice.<sup>138</sup> Another

<sup>134</sup> Submission 526. This respondent preferred that there be no legislative gestational limits but acknowledged that such limits might address community concerns and provide guidance to medical practitioners with respect to later term terminations.

<sup>135</sup> Eg, Submissions 50, 89, 119, 164, 220, 378, 419, 429, 438, 454, 469, 487, 532, 539, 542, 546, 571, 590, 592, 604, 623, 629, 630, 632, 671, 683, 707, 712, 885, 888. As noted at [3.81] above, many respondents preferred an 'on request' approach, under which no grounds would need to be satisfied, but would support an approach like the Victorian model, with broad grounds applying for later terminations, to address community concerns.

<sup>136</sup> See QLRC Consultation Paper No 76 (2017) Q-6(a). This draws on the *Abortion Law Reform Act 2008* (Vic) ss 5(2), 7(2) (for lawful terminations performed after 24 weeks); and *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 8(2), 9(b) (for all lawful terminations). The reference to professional standards and guidelines appears only in the Northern Territory provisions.

<sup>137</sup> Submission 885.

<sup>138</sup> Submission 220.

specialist obstetrician and gynaecologist similarly observed that ‘for any medical procedure these grounds should be required to be met’.<sup>139</sup>

3.103 Health Consumers Queensland Ltd. supported this approach, observing that:<sup>140</sup>

Terminations of pregnancy after 24 weeks gestation are sought for complex reasons and already under existing clinical guidelines are seriously considered from all angles by doctors and pregnant women.

3.104 Another respondent, a lawyer, considered that such a ground would provide discretion to consider the individual circumstances:<sup>141</sup>

Any additional requirements for lawful termination of pregnancy after 24 weeks should be sufficiently broad to encompass the range of medical, social and psychological factors that might lead a woman to seek an abortion late in her pregnancy. It would be unwise and overly restrictive to attempt to enumerate all of these reasons specifically. I support a general formulation along the lines of [Q-6(a) in the Consultation Paper] that permits judgment and discretion to be exercised depending on the circumstances of each case.

3.105 An academic from the TC Beirne School of Law, University of Queensland, submitted that:<sup>142</sup>

Terminations should be carried out according to professional standards and guidelines. If terminations can only be carried out by properly trained health professionals it should not be necessary to state this specifically as a ground.

However if a two-tiered approach is deemed appropriate I support the approach taken in Victoria ...

As noted [in the Consultation Paper]:

The World Health Organization has explained that ‘[e]vidence increasingly shows that, where abortion is legal on broad socio-economic grounds and on a woman’s request, and where safe services are accessible, both unsafe abortion and abortion-related mortality [death] and morbidity [injury] are reduced’.

Liberal grounds for abortion would appear to promote the best health outcomes for women.

3.106 A group of academics from the Griffith Law School submitted that ‘[a]ny other grounds may create an undue burden on vulnerable or disadvantaged pregnant persons’. They considered that the broad ground outlined above would be sufficient to ‘cover situations of rape, domestic violence and fetal abnormality’.<sup>143</sup>

3.107 Other respondents similarly submitted that, if a combined approach like the Victorian model were adopted, a broad ground for terminations performed after the

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139 Submission 532.

140 Submission 119.

141 Submission 438, referring to QLRC Consultation Paper No 76 (2017) Q-6(a), as outlined at [3.100] above.

142 Submission 429, referring to WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) 90, quoted in QLRC Consultation Paper No 76 (2017) [109] in Appendix D.

143 Submission 712.

gestational limit would be appropriate, provided it did not 'impose an undue burden on distressed or disadvantaged women' and their doctors.<sup>144</sup>

3.108 Some alternative formulations of the broad ground were also suggested.

3.109 The Queensland Council for Civil Liberties suggested that the ground should additionally refer to the woman's current and future 'economic' circumstances. In their view, the formulation in Victoria would otherwise adequately cover the woman's physical and mental health and situations involving rape or serious or fatal fetal abnormality.<sup>145</sup>

3.110 The Women's Legal Service Queensland suggested the ground should additionally refer to the woman's current and future 'safety needs'. They observed that women who are experiencing 'high levels of control and monitoring from violent partners' may need to access a termination 'as a means of increasing their safety and wellbeing long-term'.<sup>146</sup>

3.111 A group of health law academics suggested a different formulation, namely, that the medical practitioner:<sup>147</sup>

reasonably believes that the abortion is appropriate having regard to all relevant circumstances, taking into account the woman's physical or mental health and/or the serious medical condition of the fetus.

3.112 In their view, a medical practitioner would be 'unlikely' to perform a termination after 24 weeks other than in those circumstances.

3.113 Some respondents expressed concern, however, that a single, broad ground like that in Victoria would be too broad, ambiguous or subjective.<sup>148</sup> For example, one respondent, who opposed termination on request, suggested that:<sup>149</sup>

Criteria such as: 'all relevant medical circumstances' or 'the woman's current and future physical, psychological and social circumstances' are really just another way of applying 'abortion on demand'.

3.114 Another respondent similarly observed that:<sup>150</sup>

Psychological and social reasons are subjective and open to wide interpretation. Having such a clause incorporated into law essentially makes termination of pregnancy lawful for any reason.

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144 Eg, Submission 50, 487, 546, 571, 590, 623.

145 Submission 669. This respondent did not consider it necessary for the ground to include reference to professional standards and guidelines.

146 Submission 720. See further [3.92] above.

147 Submission 572.

148 Eg, Submissions 140, 430, 528, 836.

149 Submission 528.

150 Submission 140.

3.115 In this regard, an academic from the School of Law, University of Notre Dame, observed that '[d]octors have no specialized training to equip them to investigate requests for abortion based on social concerns'.<sup>151</sup>

**List of specific grounds**

3.116 Many respondents, including most of those who supported a combined approach like the Victorian model, opposed the inclusion of a list of specific grounds that would need to be satisfied to perform a lawful termination.<sup>152</sup>

3.117 A number of those respondents expressed agreement with RANZCOG's view 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'.<sup>153</sup>

3.118 RANZCOG affirmed this in its submission, stating that:<sup>154</sup>

The College strongly believes that termination of pregnancy should not be a criminal offence and strongly opposes the introduction of specific legislated grounds to be met for termination of pregnancy to be considered lawful.

3.119 A specialist obstetrician and gynaecologist also objected to a list of specific grounds, stating that:<sup>155</sup>

I do not believe it is possible, nor is it necessary, to define every situation in which termination of pregnancy can be considered lawful. This should be a medical decision made by a woman after discussion with her doctor.

3.120 A number of respondents, including Children by Choice, Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, the Australian Women's Health Network, White Ribbon Australia, and a group of academics from Griffith Law School, considered that a list of specific grounds would remove decision-making autonomy from the woman.<sup>156</sup> They also observed that it would be inconsistent with, and more onerous than, reforms in Victoria, Tasmania and the Northern Territory.<sup>157</sup>

3.121 White Ribbon Australia submitted, for example, that:<sup>158</sup>

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151 Submission 494.

152 Eg, Submissions 50, 89, 119, 164, 419, 429, 438, 454, 469, 478, 482, 487, 532, 542, 546, 562, 571, 590, 592, 600, 623, 629, 630, 632, 649, 683, 688, 707, 712, 720, 754, 810, 883, 888.

153 Eg, Submissions 50, 89, 119, 164, 469, 478, 487, 542, 571, 629, 630, 632, 642, 683, 707, 712, 720, 754, 810, 883, 888, referring to Submission 845 to the Parliamentary Committee on the first Bill and Inquiry, quoted in QLRC Consultation Paper No 76 (2017) [182].

154 Submission 482.

155 Submission 532.

156 Submissions 50, 89, 119, 164, 454, 469, 542, 562, 571, 590, 592, 629, 630, 632, 649, 683, 712, 754, 883.

157 Submissions 50, 89, 119, 164, 454, 469, 562, 571, 590, 592, 630, 632, 683, 712, 754, 883.

158 Submission 883, referring to White Ribbon Australia, 'Women's Reproductive Rights: White Ribbon Australia Position Statement' (Media Release, 23 February 2017) <<https://www.whiteribbon.org.au/2017/02/23/womens-reproductive-rights-white-ribbon-australia-position-statement/>>.

White Ribbon, as an organisation working to prevent violence against women, ... stresses that women should have complete control over their reproductive and sexual health in public life and in their own relationships, including the decision to terminate their own pregnancy. Not doing so risks reinforcing power and control over a woman thereby eroding their ability to control and make decisions about their sexual reproductive health and autonomy.

In addition, White Ribbon's *Women's Reproductive Rights: White Ribbon Australia Position Statement* affirms the need for '[n]ationally consistent access to safe and legal abortion' ... As has been done—with some differences—in other Australian jurisdictions we recognise that it is possible to create a regime that appropriately supports necessary protections for all concerned and removes uncertainty for women and health professionals.

3.122 Similarly, the Public Health Association of Australia commented that '[e]mpowered decision-making should remain with the woman concerned, and should not be subject to the judgment or approval of others'.<sup>159</sup>

3.123 TASC National Limited submitted that a list of specific grounds could be discriminatory and could impede access to safe terminations:<sup>160</sup>

TASC is concerned any legislative provision [imposing specific grounds for lawful termination] could be discriminatory and run contrary to the fundamental principle of equality before the law. Further this provision could breach Australia's obligations under UN Conventions relating to human rights, fair treatment and discrimination. This is because any resultant provision would only apply to 'some' women and have the effect of restricting or criminalising their actions. Additionally TASC believes any grounds could move the decision-making focus from the woman to another party, thereby breaching her right to autonomy of decision-making. Furthermore a restrictive provision may create a barrier to the seeking of health care and lead to unsafe abortions.

3.124 Other respondents, however, preferred that one or more specific grounds should apply.<sup>161</sup> Many of these respondents considered that termination should be permitted, if at all, only in restricted circumstances. For example, one respondent expressed the view that:<sup>162</sup>

Abortion itself is not without medical risk—so any lawful abortion needs to be only on rigorous medical grounds. Socio-economic grounds in this land of Australia are not and should not be valid grounds. Easy options lead not only to abortion being used as a form of birth control but in the process of this promoting a disregard and disrespect for the life of the child in utero. ... In short, abortion is

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159 Submission 600.

160 Submission 629, referring to United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health Around the World* (2014) <<https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>> which states that countries with restrictive termination policies have much higher unsafe termination rates and levels of maternal mortality [death].

161 Eg, Submissions 1, 32, 34, 42, 49, 64, 65, 69, 86, 112, 115, 127, 128, 137, 138, 155, 159, 192, 193, 197, 225, 231, 244, 249, 252, 260, 263, 277, 287, 323, 327, 335, 336, 356, 368, 374, 394, 397, 398, 399, 409, 427, 439, 441, 457, 458, 491, 496, 498, 502, 517, 519, 520, 572, 528, 533, 544, 553, 586, 589, 594, 603, 614, 659, 666, 678, 679, 690.

162 Submission 258.

not simply a woman's right under any circumstances by virtue of the fact that we are considering another human life.

***Risk to the woman's life or health***

3.125 Several respondents expressed support for termination to be lawful if it is necessary to preserve the life or health of the woman, including many of those who otherwise considered that termination should be restricted or prohibited.<sup>163</sup> For example, the Lutheran Church of Australia, explained that:<sup>164</sup>

The Lutheran Church recognises that there are circumstances under which a termination of pregnancy may properly be considered, namely, when competent medical people are of the opinion that the life of the mother can be saved only by terminating the pregnancy. In such a case it's a question, humanly speaking, of choosing between one human life and another.

3.126 A group of health law academics suggested that a criterion based on the woman's physical or mental health:<sup>165</sup>

would promote the woman's health and safety, and would reduce risk and harm, whether physical or [psychological], that may result if the pregnancy were to continue.

3.127 Various formulations were proposed, for example, where there is a significant risk or threat to the woman's health, where the woman is physically or mentally incapable of continuing the pregnancy, or where there is a risk to the woman of severe, permanent physical impairment or death.<sup>166</sup> The Metro North Hospital and Health Service also observed that there may be situations where there is a 'diagnosis of higher order multiple gestations, often as a result of advances in fertility treatments', which may carry a higher risk of harm to the woman and the fetuses.<sup>167</sup>

3.128 In many cases, however, respondents considered that a risk to the woman's mental health should be excluded, with some suggesting that this would be too broad.<sup>168</sup> For example, one respondent submitted that:<sup>169</sup>

I do not agree with killing an unborn child for the sake of the mother's mental health. In our advanced society, there are other options for tending to the mother's mental health while preserving the life of the unborn child.

<sup>163</sup> Eg, Submissions 20, 27, 32, 34, 41, 64, 69, 86, 111, 115, 137, 138, 244, 249, 335, 336, 356, 387, 394, 397, 409, 441, 457, 498, 502, 517, 519, 520, 523, 528, 572, 594, 586, 589, 603, 643, 659, 678, 679, 680, 685, 686, 690, 882.

<sup>164</sup> Submission 589, App, quoting from Lutheran Church of Australia, Doctrinal Statements and Theological Opinions, vol 1, H. Ethical and Social Issues, 'Abortion' (2001)

<sup>165</sup> Submission 572.

<sup>166</sup> Eg, Submissions 37, 69, 397, 409, 457, 589, 690.

<sup>167</sup> Submission 882.

<sup>168</sup> Eg, Submissions 41, 65, 122, 127, 394, 458, 466, 470C, 498, 528, 589, 596, 679. Some respondents also suggested that termination can have an adverse effect on the woman's mental health: eg, Submissions 65, 470C, 836.

<sup>169</sup> Submission 458.

3.129 Several respondents were of the view that a risk to the woman's life<sup>170</sup> or health<sup>171</sup> should be the only circumstance in which termination may lawfully be performed. Some considered that this should apply where the risk is, for example, serious, grave, imminent or high. For example, one respondent considered that:<sup>172</sup>

in order to protect all human life, especially those unborn humans that do not yet have a voice of their own, termination of any pregnancy should only be allowed in extreme circumstances where the life of the respective mother is in significant danger should the pregnancy be continued to full term.

3.130 Other respondents, including many who preferred an on request approach or a combined approach like the Victorian model, expressed concern about the inclusion of a ground based on the risk to the woman's life or health, noting that it may be overly restrictive or uncertain.<sup>173</sup> Children by Choice and others submitted, for example, that a requirement that the termination is 'necessary to preserve the life or the physical or mental health of the woman':<sup>174</sup>

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.

3.131 Other respondents similarly suggested that:<sup>175</sup>

This current requirement is draconian and removes autonomy of decision-making from the woman. Doctors and patients are put into difficult ethical positions to satisfy this requirement.

3.132 Another respondent submitted that this requirement is 'too restrictive, and doesn't factor in the many complex reasons a woman may need to access this treatment at relevant stages of the pregnancy'.<sup>176</sup> The Queensland Medical Students'

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170 Eg, Submissions 30, 37, 41, 46, 56, 57, 65, 84, 105, 122, 127, 162, 181, 182, 192, 229, 263, 264, 277, 282, 285, 287, 323, 325, 327, 333, 368, 377, 397, 398, 407, 427, 432, 437, 458, 466, 496, 507, 544, 548, 549, 553, 587, 679, 680.

171 Eg, Submissions 49, 112, 128, 159, 165, 197, 231, 260, 318, 374, 394, 491, 497, 659, 678, 679.

172 Submission 368.

173 Eg, Submissions 50, 89, 119, 164, 454, 469, 510, 511, 542, 571, 592, 598, 629, 630, 632, 683, 712, 754.

174 Submission 50, 571, 754 [re: Q-6], referring to Submission 794 to the Parliamentary Committee on the first Bill and inquiry in which Children by Choice submitted that:

It would depend on the wording of the bill to pass parliament, but if it included the necessity for an assessment of the risk of serious harm, a legal definition for 'serious harm' would need to be provided, as none currently exists. This is an ongoing cause of confusion for medical practitioners in hospitals based on our clients' experiences of not being provided with terminations because they don't meet a practitioner's own definition of what constitutes 'serious harm', despite there being issues such as rape or incest, repeated suicide attempts, or extreme domestic violence.

Submission 50 was endorsed and supported by a number of other respondents, including Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, White Ribbon Australia, and a group of academics from Griffith Law School: Submissions 89, 119, 164, 454, 469, 592, 630, 632, 683, 712, 883.

175 Submissions 510, 511.

176 Submission 542.

Council suggested that this should be expanded to include ‘consideration of the economic and social circumstances of the woman’.<sup>177</sup>

### ***Serious or fatal fetal abnormality***

3.133 There was some support for termination to be lawful in cases involving fetal abnormality, although this was qualified by some respondents.<sup>178</sup> For example, some respondents considered that this should be limited to conditions that are fatal<sup>179</sup> or involve a major or significant disability or disease.<sup>180</sup> The Metro North Hospital and Health Service suggested, for example, that termination should be permitted on the grounds that ‘there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped or that such was fatal’.<sup>181</sup>

3.134 Some respondents considered that any such ground should be narrowly construed.<sup>182</sup> Others recognised that it involves complex and individual considerations.<sup>183</sup>

3.135 The Queensland Sexual Assault Network and the Women’s Centre each submitted, for example, that:<sup>184</sup>

Considerations around fetal diagnosis are complex and the decision-making [should be] referred back to the pregnant individual with the supports they need to make an informed decision for themselves in the context of their health and own personal circumstances.

3.136 Another respondent similarly submitted that ‘[i]t should be left to the conscience of the parents to make such a decision’.<sup>185</sup>

3.137 A group of health law academics supported the inclusion of a ground referring to ‘the serious medical condition of the fetus’. They observed that:<sup>186</sup>

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177 Submission 662.

178 Eg, Submissions 4, 20, 27, 34, 42, 87, 111, 135, 137, 172, 193, 214, 225, 246, 249, 252, 336, 387, 409, 498, 500, 517, 519, 520, 523, 526, 528, 572, 586, 594, 643, 685, 686, 690, 882.

179 Eg, Submissions 135, 193, 194, 246, 387, 409, 528.

180 Eg, Submissions 42, 87, 135, 214, 586, 594, 643, 686, 882.

181 Submission 882.

182 Eg, Submissions 193, 628.

183 Eg, Submissions 422, 498, 572.

184 Submissions 422, 688. Similar views were expressed in Submissions 673, 713.

185 Submission 498.

186 Submission 572, referring to *Health (Miscellaneous Provisions) Act 1911 (WA) s 334(7)(a)*; *Abortion Act 1967 (UK) s 1(1)(d)*; E Jackson, *Medical Law Texts, Cases and Materials* (2006) 609–13; and I Karpin and K Savell, *Perfecting Pregnancy: Law, Disability and the Future of Reproduction* (Cambridge University Press, 2012) 147, which goes on to state that ‘the meaning of seriousness is not necessarily to be solely determined by the medical condition itself, but that other factors may be important’:

As one member of the WA Parliament said:

termination on the grounds of a child's medical condition is a highly contentious issue. We consider that for an abortion on this ground to be lawful the condition of the fetus must be sufficiently grave. What constitutes a 'serious medical condition' is more appropriately a matter to be determined by Parliament, in consultation with the medical profession. Western Australia is the only Australian jurisdiction which makes a similar provision for abortions post-20 weeks, on the grounds that the 'unborn child has a severe medical condition', yet that terminology is undefined. The United Kingdom also has not defined its analogous provision within the *Abortion Act 1967* (UK). Australian law academics Karpin and Savell note this is because the 'majority (in those Parliaments) understood that contextual matters would be significant in determining the meaning of 'severe medical condition' or 'serious handicap' ...'.

3.138 Many other respondents, including Queensland Advocacy Incorporated and People With Disability Australia, opposed the inclusion of a specific ground based on the risk of a serious or fatal fetal abnormality.<sup>187</sup> Many of these respondents considered that a specific ground would be offensive to people with disability and their families, would be discriminatory or would promote disability-selective termination as the norm, rather than exploring all options.

3.139 Queensland Advocacy Incorporated submitted, for example, that:<sup>188</sup>

extreme care must be taken with drafting, and with the explanations attendant to the introduction of law reform, to ensure that discriminatory stereotypes are not further entrenched. We emphasise the importance of drawing a distinction between a right to terminate based upon a fetal abnormality and a right to terminate based upon the mental health of the woman (which may include a diagnosis of fetal abnormality).

All law and policy reform must be grounded in an explicit acknowledgement of the human rights of all people with disability to equality and non-discrimination.

...

[Queensland Advocacy Incorporated] does not support legislation that makes an exception to legalise termination of pregnancy on the basis of fetal abnormality and potential disability in circumstances where termination of pregnancy is

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'It is not appropriate to define in legislation the abnormalities that we are talking about. This is such a sensitive subject that it should be up to the parents to talk with the expert clinicians who can give them advice in this field and to make this extraordinarily difficult decision': Western Australia, *Parliamentary Debates*, Legislative Assembly, 6 May 1998, 2482 (Ms Warnock).

A private member's bill was introduced into the House of Lords on 11 July 2017, but has not yet been debated. It proposes amendments to the *Abortion Act 1967* (UK) s 1 to introduce a new gestational limit of 24 weeks for termination on the ground of fetal abnormality (for which there is presently no gestational limit) and a new requirement for 'full and accurate' information to be given to the parents about 'all options following a prenatal diagnosis of disability, including the keeping of that child', including information from 'disability family support groups and organisations led and controlled by disabled persons', before a termination may be carried out on the ground of fetal abnormality: *Abortion (Disability Equality) Bill 2017–19* (UK) cl 1.

187 Eg, Submissions 32, 41, 50, 65, 89, 119, 122, 164, 278, 296, 334, 407, 411, 422, 427, 428, 435, 448, 469, 470C, 487, 490, 507, 522, 542, 562, 571, 589, 603, 609, 629, 630, 632, 673, 679, 683, 688, 712, 836, 883.

188 Submission 296, referring to *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, arts 4, 5. This respondent also noted that South Australia and Western Australia are the only Australian jurisdictions to expressly include fetal abnormality as a ground for lawful termination of pregnancy: see *Criminal Law Consolidation Act 1935* (SA) s 82A(a)(a)(ii); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a), discussed at QLRC Consultation Paper No 76 (2017) [175]. They also recognised that 'issues surrounding the human rights of unborn fetuses are not settled', but expressed concern that 'discriminatory stereotypes and myths have historically shaped the decision-making landscape'. In their view, there is a 'need for a change in policy, training and culture in this regard'.

otherwise unlawful. We note that our position in this regard is consistent with the United Nations Committee on the Rights of Persons with Disabilities, which has emphasised the need to ensure that termination of pregnancy laws do not draw distinctions based solely on disability.

3.140 The Roman Catholic Bishops of Queensland expressed similar concerns, submitting that care should be taken to avoid a culture that assumes termination is the only option in such cases:<sup>189</sup>

In the age of prenatal diagnosis, to which the Catholic Church has no moral objection provided it is intended for the purposes of potential treatment, there is an increasing expectation that women will abort fetuses with disabilities. We share the concerns of the United Nations Committee on the Rights of Persons with Disabilities which has stated that ‘termination of pregnancy laws should not involve distinctions based solely on disability.’

Those who discover that they are carrying a child with a risk of or a confirmed disability should receive adequate counselling and support as well as referrals to the numerous organisations advocating for the rights of children and people with disabilities. ... Moreover, care should be taken to actively discourage in society, and especially in health care, a culture that assumes abortion is the only option in such cases. This puts undue pressure on families to terminate pregnancies where there is a risk of disability or a confirmed diagnosis.

### ***Pregnancy resulting from rape, etc***

3.141 The inclusion of rape or another coerced or unlawful act as a specific ground for termination was also a source of contention. Many respondents considered that termination might sometimes be warranted in such cases.<sup>190</sup> Others, however, expressed concern that this should not be singled out as a specific ground for termination, including many who favoured an on request approach or a combined approach like the Victorian model.<sup>191</sup>

3.142 The Centre Against Sexual Violence Inc. submitted that access to lawful termination should not be denied in this context:<sup>192</sup>

In the context of sexual assault, a rape that results in an unplanned pregnancy for a woman takes away a survivor’s right to make decisions about her body. Denying the survivor a right to access a termination of pregnancy by holding her criminally responsible, further prevents the survivor from making decisions about her own body and health. Trauma-informed research demonstrates that empowering survivors to make decisions about their own lives and bodies is key to trauma recovery.

<sup>189</sup> Submission 448, referring to the United Nations Committee on the Rights of Persons with Disabilities’ concluding observations on Spain, Hungary and Austria, discussed at QLRC Consultation Paper No 76 (2017) [84]–[88] in Appendix D. See also the discussion of ‘non-discrimination on the basis of disability’ in Appendix C.

<sup>190</sup> Eg, Submissions 1, 20, 27, 32, 34, 69, 86, 137, 225, 249, 252, 335, 356, 387, 399, 439, 441, 457, 498, 502, 519, 520, 528, 589, 603, 611, 643, 666, 690, 882.

<sup>191</sup> Eg, Submissions 41, 42, 50, 65, 89, 119, 122, 164, 193, 199, 278, 422, 427, 430, 434, 444, 469, 470C, 487, 507, 522, 542, 549, 562, 571, 575, 592, 609, 629, 630, 632, 679, 683, 688, 712, 720, 819, 836, 883.

<sup>192</sup> Submission 312, citing C Kezelman and N Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Adults Surviving Child Abuse, 2012) <[http://www.recoveryonpurpose.com/upload/ASCA\\_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf](http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf)>.

3.143 Similarly, the Gold Coast Centre Against Sexual Violence Inc. commented that ‘where pregnancy occurs as a result of rape the trauma is currently exacerbated with the fear of criminalisation around termination’.<sup>193</sup>

3.144 On the other hand, Cherish Life Queensland Inc. suggested that termination would not address underlying, complex issues in situations of ongoing sexual abuse or incest, and could ‘re-victimise’ the woman, for example, by ‘concealing’ the abuse.<sup>194</sup> Another respondent submitted that:<sup>195</sup>

If the pregnancy is the result of a rape or another coerced or unlawful act, then adding the trauma of an abortion on top of that will not improve the woman’s recovery from the initial trauma. The woman should be given all the support she needs to deliver the baby and supported through her options re adoption etc.

3.145 Many respondents considered that a specific ground would impose a difficult evidentiary burden on women, particularly given low rates of reporting of sexual offences. Children by Choice and others submitted, for example, that:<sup>196</sup>

[Such a ground] 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.

3.146 The Women’s Legal Service Queensland similarly expressed concern that such a ground would require women to ‘meet evidentiary criteria’:<sup>197</sup>

[Women’s Legal Service Queensland] support women who have experienced rape and reproductive coercion within the context of their relationship and have made the decision not to report the crime to police, receive medical treatment or professional support for a variety of valid reasons. [Women’s Legal Service Queensland] acknowledge that for many of the women we support reporting rape and reproductive coercion can lead to further acts of violence by the perpetrator. The choice to report, and thereby create evidence, should have no impact on whether a woman or pregnant person is able to access a termination of pregnancy. [Women’s Legal Service Queensland] also acknowledges that it should not be the rape victim and/or domestic violence victim’s responsibility to

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193 Submission 297.

194 Submission 819.

195 Submission 470C.

196 Submissions 50, 571, 754, referring to Australian Institute of Family Studies, ‘The law and sexual offences against adults in Australia’ (ACSSA Issues No 4, June 2005) <<https://aifs.gov.au/publications/law-and-sexual-offences-against-adults-australia/reporting-and-conviction-rates>>. Submission 50 was endorsed and supported by a number of other respondents, including Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, White Ribbon Australia, and a group of academics from Griffith Law School: Submissions 89, 119, 164, 454, 469, 592, 630, 683, 712, 883.

As to overseas jurisdictions see, eg, United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health Around the World* (2014) <<https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>>; and WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) [4.2.1.3], referred to in the overview table on ‘legal grounds for abortion’ in Appendix C.

197 Submission 720.

prove that rape or reproductive coercion has occurred in order to access any health service.

3.147 Others considered that the unborn child should not suffer because of a wrong done to the woman. One respondent commented, for example, that:<sup>198</sup>

This is a very difficult (if rare) situation. It is completely understandable that a woman, having undergone such a traumatic event, would [not want to] have her life even more significantly impacted by pregnancy, birth and raising a child. However, one horrific act does not justify another. Even if a child is conceived by rape, that does not justify killing that child. The fetal right to life must again be paramount ...

3.148 Another respondent similarly observed that ‘an unlawful act alters only the situation for the mother, not the unborn child’, whose ‘right to life must be paramount’.<sup>199</sup>

### ***Social and economic circumstances***

3.149 Concerns were raised by a number of respondents about the inclusion of a specific ground to the effect that termination is ‘necessary or appropriate having regard to the woman’s social or economic circumstances’.<sup>200</sup>

3.150 Some respondents considered such a ground would be too broad or inappropriate.<sup>201</sup> Priceless House submitted, for example, that:<sup>202</sup>

Economic consideration weighing into a termination decision, in our view is excessive, poorly defined and makes abortion qualification criteria unsafely broad and very arbitrary.

3.151 Another respondent suggested that such a ground would, in effect, allow termination ‘on demand’ without due consideration for the interests of the fetus:<sup>203</sup>

This ground is also far too broad. Having a baby will have significant social and economic impacts and consequently this would in effect allow termination on demand. Any physical, mental, social or economic consequences of pregnancy and birth (if not life-threatening) do not outweigh the right to life for a fetus. As a society we do not condone the taking of life because it will be more convenient for us. If we did, there is no logical reason why such a principle could not apply to terminating newborns or those with severe physical or intellectual disabilities. We need to support those who are tasked with taking care of the dependent and vulnerable rather than callously ‘eliminating the problem’.

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198 Submission 122.

199 Submission 41.

200 Eg, Submissions 32, 41, 42, 49, 50, 65, 89, 119, 122, 164, 192, 193, 258, 427, 430, 454, 466, 469, 470C, 498, 500, 507, 522, 528, 544, 549, 571, 592, 603, 627, 629, 630, 632, 683, 712, 819, 836.

201 Eg, Submissions 32, 122, 140, 427, 430, 470C, 498, 522, 819, 836.

202 Submission 836.

203 Submission 122.

3.152 Others considered that a specific ground would remove decision-making autonomy from the woman and require a value judgment.<sup>204</sup> Children by Choice and others expressed concern, for example, that such a ground ‘relies on someone other than the pregnant person to deem a procedure “necessary or appropriate”’.<sup>205</sup>

3.153 Sustainable Population Australia Inc. (Queensland Branch) considered that these issues may contribute to a woman’s decision-making, but should not be listed as specific grounds for termination:<sup>206</sup>

There should be no specified grounds, at least up to a gestational limit if one applies. Freedom of choice means freedom to choose on what grounds. In particular, social and economic circumstances should never be included in stipulated grounds. No doubt, they will contribute to the decision-making of many women, but it is for her to decide what weight they carry. We consider particularly obnoxious the notion that the State could stipulate which abortion requests are worthy or unworthy.

3.154 Other respondents expressed qualified support for a reference to the woman’s social and economic circumstances, suggesting that such matters should be considered only in ‘exceptional’ or ‘rare’ cases or as part of a single, broad ground referring to the woman’s current and future psychological, physical and social circumstances.<sup>207</sup> One respondent considered that such matters are relevant but should not be considered ‘in isolation’.<sup>208</sup>

### **Requirement to consult or refer to a committee**

3.155 Overall, most respondents considered that there should be a requirement for some form of consultation by the medical practitioner before performing a termination.<sup>209</sup> Many of the individual and organisational respondents who preferred a restrictive approach to termination supported a requirement for consultation with at least one other health practitioner, with many suggesting a combination of different practitioners (including specialists) or referral to a committee or panel.<sup>210</sup> A range of views were given by respondents in support of this approach, including that:

- Termination should include checks and balances.

<sup>204</sup> Eg, Submissions 50, 89, 119, 164, 454, 469, 500, 571, 592, 629, 630, 632, 683, 712, 754.

<sup>205</sup> Submissions 50, 571, 754. Submission 50 was endorsed and supported by a number of other respondents, including Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, White Ribbon Australia, and a group of academics from Griffith Law School: Submissions 89, 119, 164, 454, 469, 592, 630, 632, 683, 712, 883.

<sup>206</sup> Submission 500.

<sup>207</sup> Eg, Submissions 115, 669, 690.

<sup>208</sup> Submission 249. Cf Submission 662 at [3.132] above.

<sup>209</sup> Eg, Submissions 4, 32, 42, 49, 50, 53, 64, 84, 101, 122, 135, 140, 155, 169, 189, 192, 220, 231, 251, 264, 278, 285, 310, 335, 341, 367, 377, 387, 394, 400, 407, 419, 433, 441, 457, 465, 487, 497, 509, 517, 528, 539, 543, 555, 569, 571, 587, 589, 590, 604, 623, 641, 642, 650, 659, 669, 671, 690, 707, 712, 836.

<sup>210</sup> Eg, Submissions 32, 42, 56, 64, 65, 69, 84, 112, 115, 122, 127, 140, 155, 159, 165, 169, 189, 226, 231, 278, 285, 310, 323, 327, 353, 367, 377, 398, 428, 434, 444, 496, 575.

- Termination results in the death of the unborn child and the decision should not be left to one medical practitioner alone.
- Where the woman's life or health is in danger, other practitioners should be involved to identify all medical options.
- Decisions to terminate should be well informed and considered.

3.156 One member of the public submitted, for example, that:<sup>211</sup>

Requiring a medical practitioner to consult with other medical practitioners before performing a termination of pregnancy will make abuse of the system less likely and provide accountability.

3.157 The Catholic Women's League State of Queensland Inc. expressed the view that a requirement to consult with one or more other medical practitioners:<sup>212</sup>

would result in the woman having to take more time to consider whether the abortion is truly wanted and thus decrease the risk of another party attempting to rush the woman through the decision.

3.158 A general practitioner also expressed concern that a consultation requirement is 'necessary to prevent abortion from becoming a commercial commodity'.<sup>213</sup>

3.159 Many of these respondents indicated that consultation with other practitioners should be required for all terminations, except in an emergency.<sup>214</sup> A few suggested that 'emergency' needs clarification or definition.<sup>215</sup> Some respondents considered that an exception should apply in cases of medical emergency, when the woman's 'life is at risk' or is 'in imminent danger'.<sup>216</sup> One respondent gave the example of ectopic pregnancy.<sup>217</sup> Another respondent referred to 'severe trauma caused by an external, usually violent event', submitting that:<sup>218</sup>

Normally persons involved in such situations were not looking at abortion anyway and the emergency department doctors and staff are going to need to make life and death choices on the run. These would be very rare exceptions.

3.160 Others considered that the consultation requirement should always apply, including in emergency situations.<sup>219</sup> A member of the public suggested, for example,

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211 Submission 543.

212 Submission 433.

213 Submission 140.

214 Eg, Submissions 32, 35, 112, 122, 127, 159, 181, 285, 323, 327, 335, 336, 394, 397, 398, 409, 410, 426, 427, 430, 431, 437, 441, 496, 507, 509, 517, 548, 588, 599A, 634.

215 Eg, Submissions 399, 634, 666.

216 Eg, Submissions 122, 327, 409, 437, 517.

217 Submission 548.

218 Submission 599A.

219 Eg, Submissions 263, 407, 434, 444, 528, 575, 678, 679, 819.

that ‘there is no such thing as an emergency abortion’.<sup>220</sup> Cherish Life Queensland Inc. submitted that, if a woman is in an emergency situation, ‘she is in need of more, not less, professional assistance’ and that consultation by the practitioner with others should be mandatory.<sup>221</sup>

3.161 A general practitioner expressed the view that:<sup>222</sup>

approval by a committee should be required in all cases. In an emergency situation, which I would expect to be a rarity, there should be procedures in place so that health professionals can still consult with a representative of the committee.

3.162 Another respondent submitted that the consultation requirement should be modified in some circumstances:<sup>223</sup>

[The requirement should apply] [f]or all abortions—including emergency situations—other than in those relatively rare situations where the requisite second opinion is not available within a time frame that would not put the women’s life at risk (reasonable/objective test). In the latter situation, there should be a requirement that the medical practitioner who performed such an abortion (ie. without a secondary expert opinion), is required to justify his or her decision to perform the abortion without delay to a medical board.

3.163 On the other hand, many of the respondents who preferred the Victorian model expressed support for a simple obligation on the medical practitioner to consult with one other medical practitioner for terminations after the gestational limit.<sup>224</sup> These respondents generally considered that this is consistent with other jurisdictions and recognises that later termination is more complex and attracts greater community concern.

3.164 Other respondents opposed any legislative obligation to consult.<sup>225</sup> Many of those respondents (and many of those who opposed a requirement except after the gestational limit) expressed views that:<sup>226</sup>

- A legislative requirement is unnecessary because of good medical practice and professional guidelines.
- Such a requirement would undermine the woman’s autonomy or privacy.

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220 Submission 263.

221 Submission 819.

222 Submission 140.

223 Submission 528.

224 Eg, Submissions 20, 27, 50, 89, 101, 119, 164, 220, 387, 419, 469, 539, 590, 592, 604, 623, 630, 671, 683, 712, 720.

225 Eg, Submissions 19, 21, 45, 59, 67, 73, 105, 109, 118, 160, 210, 276, 344, 378, 421, 422, 454, 467, 500, 510, 511, 542, 562, 572, 583, 598, 600, 624, 637, 673, 674, 687, 688, 754.

226 Eg, Submissions 18, 105, 109, 210, 276, 378, 387, 406, 422, 467, 490, 510, 542, 673, 674.

- Such a requirement would add delay and cost, and would create a barrier to access for women in rural, regional and remote areas where there are workforce limitations.

3.165 A specialist obstetrician and gynaecologist observed, for example, that:<sup>227</sup>

for all medical and surgical abortions after the first trimester a number of doctors are almost always involved in both the decision making and the procedure. Doctors can be relied upon to seek second opinions and help from colleagues when needed, this is part of normal 21st century medical practice. There is no need for further regulation.

3.166 The Public Health Association of Australia expressed the view that a 'medically unnecessary requirement for secondary approval could negatively affect the quality and timeliness of a termination procedure'.<sup>228</sup> Marie Stopes Australia expressed a similar view, observing that the choice of termination method can be 'time-sensitive' and that the risks associated with termination procedures increase with advancing gestation.<sup>229</sup>

3.167 Australian Lawyers for Human Rights submitted that termination should be regulated in the 'same way as any other medical procedure, leaving consultation and referral in appropriate cases to clinical practice'. In their view:<sup>230</sup>

this would accord greater respect for the autonomy, dignity and privacy of the woman, and avoids the perceived need and difficulty for the woman to 'persuade' others of her need for termination ...

Moreover, there is a serious question of equity for women across Queensland. An 'on request' approach avoids the delay, uncertainty and associated burden on the woman that might be involved in consulting with a second practitioner or referring to a committee in every case. As Professor Heather Douglas notes:

The requirements for panels and specialists to be involved is expensive, may cause delays and would risk developing a two tiered system where wealthier women in the more populated parts of Queensland have much greater access to abortion services than their poorer sisters in the rural and remote parts of the state where access to numbers of doctors and specialists is more difficult.

[Australian Lawyers for Human Rights] specifically considers any requirement for the approval of up to two medical practitioners, including a specialist, to be excessive. Medical practitioners have a duty of care to their patients and are bound by professional medical obligations. Medical practitioners must refer to specialists in certain circumstances, for example for reasons such as level of expertise and complexity of a case. (notes omitted)

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227 Submission 220.

228 Submission 600.

229 Submission 674.

230 Submission 583, citing C Zampas and JM Gher, 'Abortion as a Human Right—International and Regional Standards' (2008) 8 *Human Rights Law Review* 249; and quoting from Submission 879 (Prof H Douglas) to the Parliamentary Committee on the first Bill and inquiry.

3.168 Many respondents, including RANZCOG, also specifically opposed a requirement for requests for termination to be referred to a multi-disciplinary committee or panel for similar reasons.<sup>231</sup>

3.169 RANZCOG expressed the view that such a committee or panel may ‘restrict the rights of women in two respects’:<sup>232</sup>

- Firstly, a panel is a gross infringement of privacy in this the most sensitive of all health matters. It is the view of the College that a minimum number of individuals should be involved in accessing the information and making decisions for a woman in this most private and personal of matters.
- Secondly, experience elsewhere has shown that panels are frequently dysfunctional in that as the numbers of clinicians empowered to make these decisions expand, there is an increasing likelihood that individuals with varying degrees of prejudice against termination of pregnancy come to influence the decision making around the needs of individual women.

3.170 The Australian Association of Social Workers (Qld) expressed similar concern. They considered that, ‘in complex cases, there would need to be appropriate consultation’ with other health practitioners, but expressed the view that:<sup>233</sup>

The imposition of panels or committees ... would create further barriers to a woman’s agency; position the health practitioners in the position of power over a woman’s body and decision making; and create even further barriers for women who live in rural, regional or remote locations, women who have experienced sexual assault or domestic and family violence, Aboriginal and/or Torres Strait Islander women and women from [culturally and linguistically diverse] backgrounds.

3.171 Another respondent, a lawyer, considered that an approach like that in Victoria would be preferable if any consultation requirement were to be imposed:<sup>234</sup>

If it is determined that some additional oversight is appropriate for lawful termination of pregnancy after 24 weeks, it is critical to ensure that the procedure to be followed is not unduly onerous and can be conducted in a timely way that is respectful of the rights and needs of the woman concerned. Requiring a doctor to certify that the abortion is appropriate in all the circumstances ... would not be unreasonable, possibly in consultation with a second medical practitioner. I am strongly opposed to referring the decision to a committee since this is likely to be unwieldy, time-consuming and highly stressful for the woman concerned, without obviously improving the quality of the decision made.

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231 Eg, Submissions 20, 26, 27, 50, 89, 105, 119, 122, 135, 164, 220, 419, 422, 429, 438, 454, 469, 482, 487, 490, 500, 539, 542, 562, 572, 577, 592, 623, 629, 630, 632, 669, 681, 683, 707, 712, 754, 885, 888.

232 Submission 482. This position was supported by the Sunnybank Centre for Women: Submission 27.

233 Submission 26.

234 Submission 438.

## Conclusion

3.172 The Commission recommends that the draft legislation adopt a combined approach similar to the Victorian model, but with some modifications, namely:

- An on request gestational limit of 22 weeks;
- A single broad ground, applying after 22 weeks;
- A requirement for the medical practitioner to consult with another medical practitioner, after 22 weeks; and
- An exception to the requirements, after 22 weeks, for emergencies.

3.173 The Commission's view is informed by a number of matters.

## Consent

3.174 As explained in Chapter 2, a medical practitioner is under a common law obligation to obtain the patient's consent to surgical or medical treatment. The law imposes requirements about the validity of an adult's consent, consent given by or for a minor, and limited exceptions to the requirement for consent.<sup>235</sup> Statutory provisions of general application also apply in relation to adults with impaired capacity.<sup>236</sup>

3.175 As explained in Chapter 1, the draft legislation is not intended to affect the laws that regulate health practitioners or that govern consent to medical treatment, including consent to medical treatment for minors and substitute decision-making for adults with impaired capacity. If the draft legislation is enacted, those general laws will continue to apply.

3.176 Accordingly, the Commission does not recommend that the draft legislation include any express requirements about obtaining consent; however, the usual requirements under the general law about consent for surgical or medical treatment will continue to operate and will apply to terminations performed under the draft legislation.

3.177 The requirement to obtain consent is reflected in the CSCF Companion Manual, which applies to all public hospitals and licensed private health facilities.<sup>237</sup>

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<sup>235</sup> See the discussion of 'Consent to medical treatment' in Chapter 2.

<sup>236</sup> See generally, the *Guardianship and Administration Act 2000* (Qld).

<sup>237</sup> See Department of Health, Clinical services capability framework: Fundamentals of the framework (Version 3.2, 2015) [6.3]; and Department of Health, Clinical services capability framework companion manual: Termination of pregnancy services (Version 4.3) 1, referring to Queensland Health, *Guide to Informed Decision-making in Health Care* (2nd ed, 2017), which 'documents the broadening approach to informed patient decision-making in Queensland Health and is intended to be contemporaneous with and reflect the national and international ethical, medico-legal and service delivery environment as it evolves and relates to Queensland. It guides good clinical practice within the prevailing legal framework in how to implement the principles of informed decision-making in clinical practice': 3. See further the discussion of 'health facilities and standards of service provision' in Chapter 2 above.

3.178 It is also reflected in the Guide to Good Medical Practice and is the subject of national guidelines.<sup>238</sup> In addition, specific provisions about obtaining consent for terminations, and following facility level approval processes, are included in the clinical guideline on therapeutic terminations.<sup>239</sup>

3.179 Medical and other health practitioners must comply with such guidelines and professional standards.<sup>240</sup> Further, the Commission recommends below that the matters to which a medical practitioner must have regard in considering whether a termination after 22 weeks should be performed include the professional standards and guidelines applicable to the medical practitioner in the performance of terminations.<sup>241</sup>

### **An 'on request' gestational limit of 22 weeks**

3.180 Generally, termination should be treated as a health matter, not a criminal matter. The law should take into account Australia's international human rights obligations in recognising women's decision-making autonomy and should ensure that women are not denied access to sexual and reproductive health services, including termination. The Commission also recognises the concern that a gestational limit can have a negative impact on those women who are seeking a termination but have exceeded the limit.<sup>242</sup>

3.181 However, the Commission recognises that, as the fetus develops, its interests are entitled to greater recognition and protection. This is reflected in sections 292 and 313(1) of the Criminal Code. It is also consistent with the view of the majority of Australians who support a woman's right to choose, but not all of whom consider that this right should be absolute.<sup>243</sup>

<sup>238</sup> See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [3.5], referring to the National Health and Medical Research Council ('NHMRC'), *General Guidelines for Medical Practitioners on Providing Information to Patients* (2004); and NHMRC, *Communicating with Patients: Advice for Medical Practitioners* (2004).

See also, eg, RANZCOG, 'Consent and provision of information to patients in Australia regarding proposed treatment' (C-Gen 2a, July 2016). The RANZCOG statement provides that '[a] patient's informed consent must be obtained before an examination or treatment may be conducted', and provides guidance on competence to consent, consent from children, and duty to inform of risks.

<sup>239</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2] and [4.2]. The clinical guideline provides (at [4.2]) that '[w]here termination of pregnancy has been agreed, informed written consent must be obtained prior to commencement'. It provides guidance on the process of obtaining consent, capacity to consent, adults who lack capacity, and young persons.

<sup>240</sup> Non-compliance may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional: see the discussion of the 'Regulation of health practitioners' in Chapter 2.

<sup>241</sup> See [3.207], Rec 3-3(c) below.

<sup>242</sup> The WHO has observed, for example, that women in such circumstances may seek services from unsafe providers or providers in other jurisdictions: WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) [4.2.1.7], referred to in the overview table on 'legal grounds for abortion' in Appendix C.

<sup>243</sup> See the discussion of 'Community attitudes' in Chapter 2.

3.182 Most terminations are carried out, and are safest, at earlier stages of pregnancy.<sup>244</sup> There are also less frequent situations in which later termination might be necessary or appropriate. Often these situations involve more complex circumstances and higher risk to the pregnant woman.

3.183 For these reasons, the Commission recommends that the draft legislation adopt an on request gestational limit, similar to Victoria, with additional requirements applying after that time. This is a pragmatic approach that recognises community concern about terminations on request without any limits, particularly in later stages of pregnancy, by ensuring that later terminations are subject to additional oversight. It also recognises concerns that, without legislative provision, a medical practitioner may be left in uncertainty as to whether a later termination is lawful.<sup>245</sup>

3.184 The adoption of a gestational limit is also consistent with most other Australian jurisdictions.<sup>246</sup>

3.185 The Commission acknowledges that any limit is, to some extent, arbitrary but considers there is a need to define a point of demarcation between terminations on request and later terminations where further oversight is justified. There is a need to find a workable balance in framing the provisions: although a gestational limit is arbitrary, it provides a greater degree of certainty.

3.186 For a number of reasons, the Commission recommends that the gestational limit be set at 22 weeks gestation.

3.187 First, 22 weeks represents the stage immediately before the 'threshold of viability' under current clinical practice. The threshold of viability for pre-term birth is between 23 weeks zero days and 25 weeks six days gestation and, once reached, may involve the provision of life-sustaining interventions.<sup>247</sup> The relevant clinical guideline provides that:<sup>248</sup>

- At less than 23 weeks, palliative care is recommended.
- At 23 weeks, life sustaining interventions are not usually recommended but might be provided if, after appropriate counselling, the parents make an informed decision or if parental wishes are unknown.

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244 See, eg, Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [7]–[8]; J Oats and S Abraham (eds), *Llewellyn-Jones Fundamentals of Obstetrics and Gynaecology* (Mosby Elsevier, 9th ed, 2010) 106. See also the discussion of the 'incidence of terminations' in Chapter 2 above.

245 See [3.84] above.

246 See *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7–9; *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; *Abortion Law Reform Act 2008* (Vic) ss 4–7; *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3), (7).

247 Viability is primarily determined by age but may be influenced by other factors such as weight or fetal abnormality.

248 Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014) [5.7]. This is generally consistent with international approaches: see the discussion of the 'Stages of fetal development' in Appendix D. As one respondent observed, 22 weeks gestation is regarded as the time immediately 'prior to possible survival': see [3.86].

- At 24 weeks, life sustaining interventions are usually recommended, but palliative care might be provided if, after appropriate counselling, the parents make an informed decision.
- At 25 weeks, life sustaining interventions are recommended and would be provided except in unusual circumstances.

3.188 Second, a limit of 22 weeks aligns with the Clinical Services Capability Framework for Public and Licensed Private Health Facilities (the 'CSCF').<sup>249</sup> Since 2014, the CSCF has required that, '[w]here termination of a live fetus from 22 weeks gestation or more is clinically indicated, the woman is to be referred to a Level six service with ability to provide this service'.<sup>250</sup> Currently, terminations at 22 weeks gestation or more are permitted to be performed only in particular hospitals.<sup>251</sup>

3.189 Third, a limit of 22 weeks aligns with the local facility level approval process adopted at the Royal Brisbane and Women's Hospital, which imposes additional requirements for terminations after 22 weeks gestation.<sup>252</sup> It also accords with the views expressed by the Metro North Hospital and Health Service and AMA Queensland.<sup>253</sup> The Metro North Hospital and Health Service commented, for example, that:<sup>254</sup>

A 22 week pregnancy is currently considered not viable. Whilst this will need review in the future given advances in medical technology, the panel felt that a gestation of 22 weeks or greater, was a point of delineation beyond which increased requirements for termination of pregnancy should be necessary.

3.190 This recognises that terminations after 22 weeks involve greater complexity and higher risk to the woman.

3.191 The Commission considers that a gestational limit earlier than 22 weeks would be unduly restrictive and a potential barrier, particularly to vulnerable and disadvantaged women, and that a gestational limit later than 22 weeks would be out of step with the current clinical framework in Queensland.

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249 Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015), discussed in Chapter 2 above. The CSCF categorises clinical services into six service levels reflecting increasing patient complexity, with level six services being the highest level of service provision. Under the CSCF, termination of pregnancy services are to be provided at the lowest service level that can safely facilitate the care.

250 Information provided by Queensland Health, 15 December 2017; Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015) 2. See also Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [6.1].

251 Information provided by Queensland Health, 15 December 2017.

252 See QLRC Consultation Paper No 76 (2017) [189], referring to Submission 112 to the Parliamentary Committee on the second Bill. The additional requirements for terminations after 22 weeks involve assessment by two specialist practitioners, a psychiatric consultation, and consideration by a hospital ethics committee.

253 Submissions 882 and 885.

254 Submission 882.

3.192 Accordingly, the draft legislation should provide that a medical practitioner may terminate a pregnancy if the woman is not more than 22 weeks pregnant.<sup>255</sup>

3.193 Concerns about potential discrimination and barriers faced by vulnerable and disadvantaged women in making difficult decisions about later termination<sup>256</sup> can be ameliorated by ensuring that the additional ground and consultation requirements triggered when the 22 week gestational limit is reached are not unduly onerous or burdensome.

3.194 The Commission also recognises that for all women across the State at any gestational stage of pregnancy, but especially those in regional and remote areas and at later gestations, access to termination services is heavily influenced by the affordability and availability of the full range of sexual and reproductive health care services. Workforce and resource issues fall outside the scope of the terms of reference, but form part of the context in which the issues for reform have to be considered.

### **Ground to be satisfied for terminations performed after 22 weeks**

3.195 The Commission recommends that the draft legislation provide that, after 22 weeks, a termination may be performed by a medical practitioner only where the specified ground is satisfied.<sup>257</sup> This is consistent with the position in other jurisdictions.<sup>258</sup>

3.196 In determining what should be the grounds for terminations after 22 weeks, the Commission recognises the competing tensions between the need to ensure, on the one hand, that women are not unfairly denied access to health care and that their decision-making autonomy is respected and, on the other, that later terminations are not carried out without due consideration and oversight.

3.197 A number of specific circumstances in which access to lawful termination should be available are identified in international instruments<sup>259</sup> and have been

<sup>255</sup> The draft legislation does not include any express provision about the way in which gestation is to be assessed, given that that this is a matter of clinical practice for determination in the individual circumstances. The Commission recommends that the matters to which a medical practitioner must have regard in considering whether a termination after 22 weeks should be performed include the professional standards and guidelines applicable to the medical practitioner in the performance of terminations: see [3.207] below. At present, this would include the Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) which advises medical practitioners to consider using ultrasound to confirm the gestation and to do so in all cases of second trimester termination procedures: see the discussion of 'Determining gestation' in Chapter 2.

<sup>256</sup> See [3.87]–[3.88] above.

<sup>257</sup> The draft legislation does not include any express requirements about the way in which gestation is to be assessed: see n 255 above.

<sup>258</sup> See, especially, *Abortion Law Reform Act 2008* (Vic) ss 5(1)(a), 7(1)(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(1)(a). Grounds are also imposed in the Northern Territory and Western Australia for the performance of terminations after the specified gestational limits: see *Termination of Pregnancy Law Reform Act 2017* (NT) s 9(b); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a).

<sup>259</sup> United Nations treaty bodies have identified that denying access to termination in these circumstances could infringe the woman's rights to life and health, violate the woman's right to privacy, or amount to cruel, inhuman or degrading treatment: see the discussion of the 'Rights of women' and the overview table on 'Legal grounds for abortion' in Appendix C.

considered above,<sup>260</sup> including where there is a threat to the woman's life or health, in cases of severe fetal abnormality or where the pregnancy is the result of rape.

3.198 One option would be to limit the circumstances in which a later termination may be performed to some or all of those specific circumstances. That might provide a degree of certainty.

3.199 However, the Commission considers that a list of specific grounds would not adequately reflect the complexity and highly individualised nature of the circumstances in which decisions about later terminations arise; and that it would not necessarily provide greater clarity in the law.

3.200 One of the difficulties in framing a list of specific grounds is that the specific circumstances are not necessarily decisive grounds, but represent one or more of several possible factors that may inform a decision about termination.

3.201 The Commission notes RANZCOG's view that:<sup>261</sup>

No specific clinical circumstance should qualify or not qualify a woman for termination of pregnancy. The impact of any particular condition is highly individual and often complex. No list can be complete and becomes highly restrictive in the most complex of circumstances. A list may also be seen as offensive to those affected with specific disabilities.

3.202 Some of these difficulties are apparent when considering the specific grounds that might be included. For example:

- If it is necessary to preserve the woman's life or health — This is a longstanding exception in the criminal law to the offence of procuring a miscarriage, and was supported by many respondents, including a number of those who otherwise considered that termination should be prohibited.<sup>262</sup> Yet, there is a concern that the scope and application of such a ground is unclear and uncertain in practice. In particular, it has been noted that an accepted medical definition of 'serious risk' is lacking for this purpose, leaving the matter to the interpretation of individual medical practitioners.<sup>263</sup> There was also considerable divergence in respondents' views about the proper scope of such a ground.<sup>264</sup>
- If there is a serious or fatal fetal abnormality — Fetal abnormality is often a factor in later terminations. However, the decision whether to terminate is not necessarily based only on the fact of a diagnosis, but is likely to involve a range of medical considerations as well as the woman's own personal

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<sup>260</sup> See [3.116] ff above.

<sup>261</sup> Submission 845 to the Parliamentary Committee on the first Bill and inquiry. This view was supported by a number of respondents to this review: see [3.117] above.

<sup>262</sup> See [3.125] above.

<sup>263</sup> See [3.130] above and, in particular, Submission 794 to the Parliamentary Committee on the first Bill and inquiry quoted at n 174 above.

<sup>264</sup> See [3.127]–[3.129] above.

considerations.<sup>265</sup> To include fetal abnormality as a specific ground would not only be offensive to people with disability, but might suggest that a diagnosis on its own is sufficient reason to terminate without consideration of the individual circumstances.<sup>266</sup>

- If the pregnancy is the result of rape or another coerced or unlawful act — Rape or other coerced sexual acts may be a factor in the termination of a pregnancy, particularly where there is a serious risk to the woman's mental health.<sup>267</sup> However, different people may respond in different ways to such a pregnancy and the decision whether to terminate is likely to encompass both medical and personal considerations and to be highly dependent on the individual circumstances. Respondents have raised competing concerns, for example, about whether continuing such a pregnancy may compound or alleviate a woman's trauma.<sup>268</sup> Further, there is a concern about the possible difficulty and distress of requiring a woman to 'prove' such a ground in order to access a termination.<sup>269</sup>

3.203 Later terminations are especially likely to involve complex medical circumstances, including serious or fatal fetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the fetus is one of a multiple pregnancy; or complex personal circumstances, including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, socio-economic disadvantage, or mental health issues.<sup>270</sup>

3.204 It has also been observed that, where termination is accessible and lawful on broad grounds, unsafe outcomes from termination are reduced.<sup>271</sup>

<sup>265</sup> See, eg, [3.137] above, and Karpin and Savell, above n 186.

<sup>266</sup> See [3.138]–[3.140] above. Although United Nations treaty bodies have urged that lawful access to termination should be available in cases of fetal abnormality, the United Nations Committee on the Rights of Persons with Disabilities has cautioned that termination laws should not involve distinctions based solely on disability: see the discussion of the 'Rights of women', 'Non-discrimination on the basis of disability' and the overview table on 'Legal grounds for abortion' in Appendix C.

<sup>267</sup> The WHO recognises that mental health under the 'health ground' for lawful termination is wide enough to encompass psychological distress or mental suffering caused by coerced sexual acts: see the discussion of the 'Right to health, including sexual and reproductive health and autonomy' and the overview table on 'Legal grounds for abortion' in Appendix C.

<sup>268</sup> See [3.142]–[3.144] above.

<sup>269</sup> See [3.145]–[3.146] above. The WHO has cautioned against requirements for evidence to support such a ground, noting that this can delay and restrict access: see WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) [4.2.1.3], referred to in the overview table on 'legal grounds for abortion' in Appendix C.

<sup>270</sup> See [3.71]–[3.72], [3.82], [3.87]–[3.92] above. See also RANZCOG, 'Late Termination of Pregnancy' (C-Gyn 17A, May 2016) 2 in which it is recognised that there are 'rare but important circumstances' in which later termination may be 'regarded by the managing clinicians and the patient as the most suitable option', including where one fetus of a multiple pregnancy has a serious abnormality and early termination would increase the risks to the other fetus; where a fetal condition is suspected or diagnosed but the prognosis is not apparent until later in pregnancy, such as where there is a cytomegalovirus infection of the fetus; or where a very serious fetal abnormality is not diagnosed until later gestation.

<sup>271</sup> See WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 90, quoted in Appendix C.

3.205 On balance, therefore, the Commission recommends that a single, more broadly expressed ground be adopted to ensure greater discretion to meet the range of individual circumstances that may arise in practice.

3.206 It is also preferable to provide one ground for all terminations after 22 weeks, rather than having different grounds at different stages of pregnancy. This approach leaves assessment of the individual circumstances to the medical practitioner and the woman; the stage of the pregnancy may be only one of several relevant factors.

3.207 Consistently with the approach in Victoria and the Northern Territory,<sup>272</sup> the ground should be that the medical practitioner considers that the termination should, in all the circumstances, be performed, having regard to:

- all relevant medical circumstances;
- the woman's current and future physical, psychological and social circumstances; and
- the professional standards and guidelines that apply to the medical practitioner in relation to the performance of terminations.

3.208 This is generally consistent with current clinical practice.<sup>273</sup>

3.209 The formulation of the test in terms of whether the medical practitioner considers the termination 'should, in all the circumstances, be performed' avoids the use of the word 'appropriate', which might be considered unclear or uncertain. It also adopts the standard of 'consider', as used in the Northern Territory legislation, rather than the standard of 'reasonable belief', which is used in the Victorian legislation.<sup>274</sup>

3.210 The reference to all relevant medical circumstances ensures that consideration is given to the woman's physical and mental health, the medical circumstances of and relating to the fetus and the pregnancy, and the range of medical options and their respective medical risks.

3.211 The reference to the woman's physical, psychological and social circumstances is wide enough to capture the range of relevant considerations that might inform the woman's request, including, for example, the impact of a pregnancy that is the result of rape, safety concerns arising in the context of domestic or family violence, or the combined impact of the woman's age, economic disadvantage and social isolation. It is also consistent with RANZCOG's position that 'a woman's

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<sup>272</sup> See *Abortion Law Reform Act 2008* (Vic) ss 5(1)(a), (2), 7(1)(a), (2); *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 8(1)–(2), 9(b).

<sup>273</sup> See, eg, [3.82], [3.102] above; Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2.2], [4.1] which provides for the complexities specific to the individual case to be considered (such as the gestation of the pregnancy and the woman's medical, social or economic circumstances, mental health and age); RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) Rec 2.

<sup>274</sup> See n 272 above.

physical, social, emotional and psychological needs should be taken into account in the course of decision-making'.<sup>275</sup>

3.212 The reference to applicable professional standards and guidelines confirms the basic requirement for all medical practitioners to act professionally and ethically.

3.213 Whatever the formulation, the imposition of a ground will require the medical practitioner to consider the relevant matters and form an opinion. Some respondents have expressed concern that the imposition of grounds may undermine the woman's decision-making autonomy by requiring others to make a value judgment.<sup>276</sup> The Commission considers, however, that, by framing the ground in the broad terms outlined above, this risk is minimised.<sup>277</sup> This approach also achieves a reasonable balance between concerns about the woman's autonomy and calls for additional oversight for terminations after 22 weeks.

### **Requirement for two medical practitioners to concur for terminations after 22 weeks**

3.214 A legislative requirement for the medical practitioner to consult with one or more other practitioners before a termination may not be strictly necessary, given the current clinical framework.<sup>278</sup>

3.215 However, consistently with its approach in recommending additional requirements for terminations after 22 weeks, the Commission considers that the draft legislation should include a requirement for consultation.

3.216 A legislative requirement recognises that the circumstances are more complicated at later stages of pregnancy, and is consistent with most other Australian jurisdictions.<sup>279</sup>

3.217 The requirement should not be unduly onerous or burdensome. It should reflect the minimum that is required, whilst leaving flexibility for service providers to adopt further measures in practice if deemed appropriate.

3.218 Accordingly, the Commission recommends that the draft legislation require that, before performing a termination after 22 weeks, the medical practitioner must consult with another medical practitioner and both practitioners must consider that

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<sup>275</sup> RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) Rec 2.

<sup>276</sup> See [3.122], [3.152] above. See also [3.115] above.

<sup>277</sup> Medical practice routinely involves the exercise of professional judgment by medical practitioners in providing advice and options to their patients, in a way that puts the patient's care and well-being first and which does not impose the medical practitioner's own moral or religious values on the patient: see generally, eg, AMA, *Code of Ethics* (2016); MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014); RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006).

<sup>278</sup> See Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2] outlined in QLRC Consultation Paper No 76 (2017) [187]; and, eg, [3.82] above.

<sup>279</sup> See *Termination of Pregnancy Law Reform Act 2017* (NT) s 9(a); *Criminal Law Consolidation Act 1935* (SA) s 82A(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(1)(b), (3); *Abortion Law Reform Act 2008* (Vic) ss 5(1)(b), 7(1)(b); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a).

the termination should, in all the circumstances, be performed. This is consistent with the Victorian model.<sup>280</sup>

3.219 It is unnecessary for the legislation to impose additional requirements about the qualifications, expertise or experience of the second medical practitioner. These are matters properly to be determined on a case by case basis in accordance with good medical practice.

3.220 The legislation should not require that the second medical practitioner must examine the woman, or that the consultation must occur in person. Such measures may be good medical practice, and would not be precluded. However, the draft legislation should reflect only the minimum that is required, recognising that, in some areas of the State, such steps may be impractical and could significantly delay or restrict access. In some cases, for example, it might be appropriate for the consultation to occur by telephone or video-conference to facilitate access in regional areas. It would still be necessary for the second medical practitioner to consider all the circumstances in reaching their view on the termination.

3.221 The Commission does not recommend that the draft legislation impose a requirement to consult with, or refer the matter to, a multi-disciplinary committee or panel. This would be too onerous as a mandatory requirement and could adversely impact accessibility, particularly for women living in rural, regional and remote areas<sup>281</sup> who would be travelling, sometimes great distances, to attend one of the limited number of facilities at which terminations after 22 weeks may be performed.

3.222 The Commission acknowledges that many hospitals require referral to a committee, or other forms of consultation, as part of their local facility level approval processes.<sup>282</sup> The proposed legislative provisions would not preclude facilities from continuing to use these more extensive processes. This is properly a matter for clinical practice.

### ***An exception for emergencies***

3.223 Strict compliance with all aspects of the requirements for a termination after 22 weeks may not always be possible in a situation of genuine medical emergency. The situation may not permit sufficient time for the medical practitioner to consult with another medical practitioner or to obtain information about and fully consider all of the woman's relevant medical, physical, psychological and social circumstances.

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<sup>280</sup> See *Abortion Law Reform Act 2008* (Vic) ss 5(1)(b), 7(1)(b).

<sup>281</sup> See [3.167]–[3.171] above. The WHO has recommended that authorisation from hospital authorities should not be required for access to termination, noting that such requirements may amount to a violation of the woman's rights to privacy and non-discrimination in access to health care: see the overview table on 'other requirements or restrictions' in Appendix C.

<sup>282</sup> See Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3.2]; QLRC Consultation Paper No 76 (2017) [187]–[191].

3.224 The legislation in Victoria does not expressly address an emergency situation. Nor does the termination of pregnancy legislation in Tasmania or Western Australia.<sup>283</sup>

3.225 However, the legislation in the Northern Territory includes the following provision for a termination to be lawfully performed in an emergency:<sup>284</sup>

#### **10 Termination of pregnancy where life at risk**

A medical practitioner may perform a termination on a woman in an emergency if the medical practitioner considers the termination is necessary to preserve the life of the woman.

3.226 The grounds only approach taken in South Australia also provides for a termination to be lawfully performed if the medical practitioner 'is of the opinion, formed in good faith, that the termination is immediately necessary to save the life' of the pregnant woman.<sup>285</sup>

3.227 The Commission recommends that the draft legislation include a similar provision. In addition to the woman's life, the provision should extend to the situation in which termination of a fetus in a multiple pregnancy is necessary, in an emergency, to save the life of another unborn child. This will provide a greater degree of certainty for medical practitioners about when a termination may lawfully be performed.

3.228 The emergency provision should apply only in exceptional circumstances in which it is not practicable to comply with all aspects of those requirements because of the medical urgency of the situation.

3.229 Accordingly, the Commission recommends that the provision should be to the general effect that a medical practitioner may, in an emergency, perform a termination on a woman who is more than 22 weeks pregnant if the medical

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283 Note, however, the Criminal Code (Tas) s 178E(2), which provides a defence for a medical practitioner who performs a termination on a woman who is incapable of giving consent if the termination is performed in good faith and with reasonable care and skill, is for the woman's benefit and is reasonable having regard to all the circumstances; and the Criminal Code (WA) s 259 which provides, in similar terms to the Criminal Code (Qld) s 282, a general defence for surgical or medical treatment administered in good faith and with reasonable care and skill to 'an unborn child for the preservation of the mother's life', if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

284 *Termination of Pregnancy Law Reform Act 2017* (NT) s 10. In that jurisdiction, a termination may be performed where the woman is not more than 14 weeks pregnant, if the medical practitioner considers that the termination is 'appropriate in all the circumstances', having regard to specified matters; where the woman is more than 14 weeks pregnant but not more than 23 weeks pregnant, if the medical practitioner has consulted with another medical practitioner and they each consider that the termination is 'appropriate in all the circumstances', having regard to specified matters; and otherwise in an emergency if the medical practitioner considers it is 'necessary to preserve the woman's life': ss 7, 9, 10.

Ordinarily, the termination must be performed by a 'suitably qualified medical practitioner' (defined in s 4 to be an obstetrician or gynaecologist; or a medical practitioner credentialed in the provision of advice, performance of procedures and giving treatment in the area of fertility control). However, the emergency provision in s 10 applies to any 'medical practitioner' (defined in the *Interpretation Act* (NT) s 17 to mean a person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student).

285 *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(b). Other grounds for lawful termination are also specified in s 82A(1), including that the continuation of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated, or that the medical practitioner considers, in good faith, that the termination is immediately necessary to prevent grave injury to the physical or mental health of the pregnant woman.

practitioner considers it is necessary to perform the termination to save the woman's life or the life of another unborn child.

3.230 It is unnecessary for similar provision to be made for a termination performed before 22 weeks since no requirements are recommended for such a termination that would need to be exempted in the case of an emergency.

## APPROVED MEDICAL FACILITIES FOR TERMINATIONS

3.231 As well as specifying that a termination may be performed only by a qualified person, the legislation in some jurisdictions requires that a termination is to be performed at an approved or prescribed medical facility.<sup>286</sup> For example, the legislation in the Australian Capital Territory requires a termination to be performed at an approved medical facility.<sup>287</sup>

3.232 In contrast, the legislation the Northern Territory has removed the former requirement in that jurisdiction for a termination to be performed in a hospital.<sup>288</sup> It was observed that this requirement had led to terminations in the Northern Territory commonly being performed as surgical, rather than medical, terminations.<sup>289</sup>

3.233 Similarly, the Victorian legislation does not include a general requirement for a termination to be performed at an approved medical facility.<sup>290</sup> In considering this issue, the VLRC observed that such a requirement may impact on service patterns and resources and that it 'is important that the law does not restrict the development of best clinical practice for either surgical or medical termination'.<sup>291</sup>

<sup>286</sup> See *Health Act 1993* (ACT) s 82, 83(1), which requires a termination be carried out in a medical facility approved by the Minister; *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a), which requires that 'treatment for the termination' be carried out in a hospital, or a hospital of a class, prescribed by regulation; and *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(b), which requires that, after 20 weeks gestation, the termination be performed in a facility approved by the Minister.

<sup>287</sup> A termination may only be carried out at a medical facility, or part of a medical facility, approved by the Minister *Health Act 1993* (ACT) s 82, 83(1). Failure to comply is an offence, punishable by a fine of up to 50 penalty units, imprisonment for 6 months or both. A medical facility, or part of a medical facility, may be approved by the Minister if it 'is suitable on medical grounds for carrying out abortions': s 83(1). The Minister must not 'unreasonably refuse or delay' a request for approval of a medical facility: s 83(3).

A private member's bill was introduced into the Legislative Assembly on 21 March 2018, but has not yet been debated, which proposes to amend the *Health Act 1993* (ACT) pt 6 div 6.1 to remove the requirement for a medical termination to be performed at an approved medical facility; a surgical termination would still be required to be performed at a medical facility approved by the Minister: *Health (Improving Abortion Access) Amendment Bill 2018* (ACT) cl 5.

<sup>288</sup> *Termination of Pregnancy Law Reform Act 2017* (NT) ss 21–22 (as passed), repealing *Medical Services Act* (NT) s 11. Former s 11 had provided, in part, that it was lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy if the treatment was 'given in a hospital' (a 'hospital' being premises declared by the Minister under s 6(2) of that Act to be a hospital).

<sup>289</sup> Department of Health, 'Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services' (Discussion Paper, Northern Territory Government, 2016) 5.

<sup>290</sup> See *Abortion Law Reform Act 2008* (Vic) s 7(3)–(4), which provides that a registered pharmacist or registered nurse may administer or supply a termination drug to a woman who is more than 24 weeks pregnant only if they are employed or engaged by a hospital and only at the written direction of a registered medical practitioner. However, 'hospital' is defined widely for that provision to mean a public hospital, private hospital or day procedure centre within the meaning of the *Health Services Act 1988* (Vic).

<sup>291</sup> VLRC Report (2008) [8.175], [8.179]. The VLRC recommended against restrictions on where termination procedures may be performed: Rec 7.

3.234 Although the Commission did not seek submissions directly on this issue, some respondents to the review expressed the view that a termination should occur only at a public hospital, and not at a private clinic.<sup>292</sup> Others expressed concern, however, that the availability of both public and private health services is needed to ensure access to termination, including in rural, regional and remote areas.<sup>293</sup>

## Conclusion

3.235 The draft legislation should not require a termination to be performed at an approved medical facility. A requirement of this kind could operate as a barrier to the provision of medical terminations, particularly in rural, remote and regional areas of Queensland.

## CONSEQUENCES OF NON-COMPLIANCE

### Conclusion

3.236 The Commission does not recommend a specific penalty for a medical practitioner's failure to comply with the requirements for a termination under the draft legislation.<sup>294</sup>

3.237 The Commission considers that, in this respect, medical and other health practitioners should be subject to the same professional and legal consequences as those that apply in relation to other medical procedures.<sup>295</sup>

3.238 There is a strong regulatory framework governing registered health practitioners, with potentially serious consequences for unprofessional conduct or professional misconduct, including restriction, suspension or loss of a practitioner's registration.<sup>296</sup>

3.239 The Commission recommends that the draft legislation should provide that in deciding an issue under another Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner performs a termination, or assists another practitioner to perform a termination, other than as authorised.<sup>297</sup>

3.240 This approach is likely to deter non-compliance with the draft legislation.

3.241 The Commission's proposals do not alter the existing laws under which a medical or other health practitioner who administers surgical or medical treatment to

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<sup>292</sup> Eg, Submission 570.

<sup>293</sup> Eg, Submissions 378, 577, 600.

<sup>294</sup> This is consistent with the approach taken in three other Australian jurisdictions: see [3.44], n 64 above. Cf *Criminal Law Consolidation Act 1935* (SA) s 82A(1) at n 63 above.

<sup>295</sup> This is consistent with one of the principles informing the Commission's review, that termination of pregnancy should, in general, be treated as a health issue rather than as a criminal issue: see [1.29] above.

<sup>296</sup> See Health Practitioner Regulation National Law (Queensland) pt 8; *Health Ombudsman Act 2013* (Qld). See the discussion of the 'Regulation of health practitioners' in Chapter 2.

<sup>297</sup> The provision should include a legislative note to refer to the Health Practitioner Regulation National Law (Queensland) and the *Health Ombudsman Act 2013* (Qld).

a person has a duty to exercise reasonable skill and care,<sup>298</sup> and may be civilly<sup>299</sup> or criminally<sup>300</sup> responsible for harm that results from a failure to do so. A medical or other health practitioner who does not obtain the required consent of the patient for a termination may be criminally responsible for assault.<sup>301</sup>

## EXEMPTING THE WOMAN FROM CRIMINAL RESPONSIBILITY

3.242 Pursuant to section 225 of the Criminal Code, it is a crime for a woman to procure her own miscarriage. If section 225 is repealed, and the Criminal Code is amended to include a new offence for an unqualified person to perform or assist in performing a termination, it will be necessary to clarify the criminal responsibility of a woman in relation to the termination of her pregnancy.

3.243 In the Northern Territory, Tasmania and Victoria, the legislation expressly removes the criminal responsibility of a woman who consents to or assists in the termination of her pregnancy.<sup>302</sup> In Tasmania, this protection extends to a woman who performs a termination on herself.<sup>303</sup>

3.244 United Nations treaty bodies have recommended the removal of laws that criminalise and impose punitive measures on women who undergo terminations, observing that such laws undermine women's rights to equality and non-discrimination in sexual and reproductive health.<sup>304</sup>

## Submissions

3.245 In the Consultation Paper, the Commission sought submissions on whether a woman should be criminally responsible for the termination of her pregnancy.<sup>305</sup>

3.246 Most respondents who made a submission on this issue considered that the draft legislation should provide that a woman is not criminally responsible for terminating her pregnancy.

3.247 Those respondents included termination of pregnancy service providers, including Marie Stopes Australia, RANZCOG and AMA Queensland, legal practitioners and academics, human rights law and legal advocacy organisations, health support and advocacy organisations, Children by Choice, the Uniting Church

<sup>298</sup> See generally *Rogers v Whitaker* (1992) 175 CLR 479, 483.

<sup>299</sup> See, eg, *Mules v Ferguson* [2015] QCA 5. See also *Civil Liability Act 2003* (Qld) ch 2 pt 1.

<sup>300</sup> See Criminal Code (Qld) s 288; *Patel v The Queen* (2012) 247 CLR 531.

<sup>301</sup> See, eg, *Marion's Case* (1992) 175 CLR 218, 232, 234; *White v Johnston* (2015) 87 NSWLR 779; and see Criminal Code (Qld) ss 245, 246. See also s 282 as to the defence for surgical operations and medical treatment done 'in good faith and with reasonable care and skill'.

<sup>302</sup> Criminal Code (NT) s 208A(4); *Crimes Act 1958* (Vic) s 65(2).

<sup>303</sup> Criminal Code (Tas) s 178D(1)(b) and *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 8.

<sup>304</sup> See the discussion of the 'Rights of women' and the overview table on the 'Decriminalisation of abortion' in Appendix C.

<sup>305</sup> See QLRC Consultation Paper No 76 (2017) Q-2.

in Australia (Queensland Synod), the Institute for Urban Indigenous Health Ltd and the Women's Bioethics Alliance.<sup>306</sup>

3.248 Some respondents considered that treating a woman as criminally responsible for the termination of her pregnancy is inconsistent with international human rights obligations in relation to women's human rights, including the right to access safe terminations.<sup>307</sup>

3.249 It was also considered to be a barrier to accessing reproductive health services.<sup>308</sup> The Women's Legal Service Queensland submitted that women seek a termination 'for a variety of valid reasons, and they must be able to do so without threat of criminal sanction'.<sup>309</sup>

3.250 A number of respondents considered continuing to impose criminal responsibility on a woman for the termination of her pregnancy is likely to have little deterrent effect and could lead to adverse health consequences for the woman.<sup>310</sup>

3.251 Some respondents considered imposing criminal responsibility on a woman for terminating her pregnancy is a discriminatory and punitive measure.<sup>311</sup> A specialist obstetrician and gynaecologist with more than 40 years' experience commented that '[t]he decision around [termination] is the woman's own ... The notion of "punishment" for abortion belongs to the dubious morality of a long-gone era'.<sup>312</sup>

3.252 The Institute for Urban Indigenous Health Ltd noted that criminal laws disproportionately impact on Aboriginal and Torres Strait Islander women.<sup>313</sup>

3.253 A number of respondents also considered that the removal of a woman's criminal responsibility for terminating her pregnancy was consistent with the policy of removing criminal responsibility from medical practitioners.<sup>314</sup> The Institute for Urban Indigenous Health Ltd commented that 'there is an illogicality to enabling the provision of termination services whilst maintaining penal offences for those ... utilising such services'.<sup>315</sup>

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<sup>306</sup> Eg, Submissions 26, 50, 220, 278, 341, 387, 429, 482, 572, 579, 583, 590, 621, 669, 673, 674, 690, 707, 712, 720, 754, 837, 860, 879, 882, 885, 888.

<sup>307</sup> Eg, Submissions 50, 276, 312, 387, 406, 419, 438, 487, 539, 562, 572, 577, 583, 621, 674, 707, 712, 720, 754.

<sup>308</sup> Eg, Submissions 572, 600, 674, 707.

<sup>309</sup> Submission 720.

<sup>310</sup> Eg, Submissions 50, 104, 312, 387, 452, 487, 579, 707, 720, 754, 879.

<sup>311</sup> Eg, Submissions 220, 487.

<sup>312</sup> Submission 220.

<sup>313</sup> Submission 707.

<sup>314</sup> Eg, Submissions 50, 109, 452, 487, 669, 712, 754.

<sup>315</sup> Submission 707. Marie Stopes Australia also submitted that 'it is unacceptable that women could be criminally responsible for accessing a health service that is covered by Medicare or the PBS and therefore recognised as a legal health service or an approved pharmaceutical product in Australia': Submission 674.

3.254 It was also submitted that providing that a woman is not criminally responsible for the termination of her pregnancy provides clarity and certainty for women, as well as those providing termination of pregnancy services. The Queensland Council for Civil Liberties considered this was especially relevant for medical terminations.<sup>316</sup>

3.255 Some respondents submitted that the retention of a criminal offence for the woman would be inconsistent with the approach in most other Australian jurisdictions; one of the aims of law reform in Queensland should be to better achieve national consistency in this area.<sup>317</sup>

3.256 Some respondents, including the World Federation of Doctors who Respect Human Life—Queensland Branch, considered that the person performing the termination should be criminally responsible, but that the woman should not.<sup>318</sup> Several respondents commented that a woman faced with an unwanted pregnancy needs support, not victimisation.<sup>319</sup>

3.257 Some respondents considered that a woman who procures a termination without the involvement and supervision of a medical practitioner should be criminally responsible for the termination of her pregnancy.<sup>320</sup> A medical practitioner and senior lecturer in general practice, James Cook University, referred to the risk to a woman's health if the termination is not supervised by a medical professional.<sup>321</sup>

3.258 In contrast, a number of respondents, including 40 Days for Life Brisbane Inc., Cherish Life Queensland Inc. and Priceless House and some members of the public, considered that a woman should be criminally responsible for the termination of her pregnancy.<sup>322</sup>

3.259 Some respondents considered that a termination of a pregnancy constitutes 'murder' or an 'unlawful killing',<sup>323</sup> and that the rights of the unborn child should be protected at law.<sup>324</sup> It was also suggested that liberalising termination laws sends the message to the community that termination is acceptable.<sup>325</sup>

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316 Submissions 669, 707.

317 Eg, Submissions 26, 50, 312, 387, 452, 577, 590, 707, 754.

318 Eg, Submissions 165, 169, 231, 240, 268, 433, 437, 495, 515.

319 Eg, Submissions 169, 181, 273, 399, 421, 427A, 437, 509, 517.

320 Eg, Submissions 140, 819. One respondent considered that a woman should be criminally liable for termination after the 'legally allowable number of weeks gestation': Submission 470A.

321 Submission 140.

322 Eg, Submissions 170, 819, 836.

323 Eg, Submissions 44, 65, 76, 138, 148, 154, 186, 226, 327, 335, 336, 352, 353, 424, 434, 441, 444, 491, 492, 498.

324 Eg, Submissions 41, 42, 97, 138, 434, 444, 589, 836.

325 Eg, Submission 407.

3.260 Several respondents considered that a criminal offence should remain as a deterrent to 'backyard' or 'self-administered' terminations.<sup>326</sup> It was also suggested that the current law protects women who are being put under pressure to have a termination.<sup>327</sup>

3.261 Several Church organisations considered that it should remain an offence for a woman to terminate her pregnancy, but that it would rarely be appropriate for the woman to be prosecuted or that it would be appropriate for any penalty imposed to be reduced.<sup>328</sup>

## Conclusion

3.262 International human rights bodies have recognized that criminalisation of termination stigmatizes women.<sup>329</sup> The fact that it is a criminal offence, punishable by seven years imprisonment, for a woman to procure her own miscarriage in Queensland not only has the effect of increasing the uncertainty about the circumstances in which women have a right to lawfully access termination of pregnancy services, but also of increasing their anxiety and preserving the stigma surrounding terminations.<sup>330</sup>

3.263 As explained earlier, generally, termination should be treated as a health issue, not a criminal matter. As a matter of principle, the draft legislation should not only protect a medical practitioner who performs a termination (and a health practitioner who assists in that performance) under the legislation from criminal responsibility for the termination of a woman's pregnancy, but also the woman. This protection, together with the clarification under the draft legislation as to the circumstances in which a woman's pregnancy may be terminated, are intended to increase women's access to safe and lawful termination.

3.264 Accordingly, the draft legislation should provide that, despite any other Act, a woman who consents to, assists in, or performs a termination on herself does not commit an offence.

3.265 The effect of this provision is that a woman could not be convicted of an offence under Queensland law, whether as a principal offender or as a party,

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<sup>326</sup> Eg, Submissions 122, 457, 819, 836.

<sup>327</sup> Eg, Submissions 457, 495, 498, 836.

<sup>328</sup> Eg, Submissions 448, 589.

<sup>329</sup> See, eg, *A, B and C v Ireland* [2010] ECHR, [126] and [162].

<sup>330</sup> Eg, Submission 276, referring to B Major and RH Gramzow, 'Abortion as Stigma: Cognitive and Emotional Implications of Concealment' (1999) 77(4) *Journal of Personality and Social Psychology* 735. This respondent observed that '[t]he maintenance of unclear and uncertain criminal provisions criminalises and stigmatises women and doctors and compromises access to health services'; Submission 486; Submission 487, referring to A Norris et al 'Abortion stigma: A reconceptualization of constituents, causes, and consequences' (2011) 21(3) *Womens Health Issues* and F Hanschmidt et al, 'Abortion Stigma: A Systematic Review (2016) 48(4) *Perspectives on Sexual and Reproductive Health* 169; and Submission 720, referring to 'Stigmatised Meanings of Criminal Abortion Law' in RJ Cook, JN Erdman and BM Dickens (eds), *Abortion Law in Transnational Perspective: Cases and Controversies* (University of Pennsylvania Press, 2014) 14, 35.

including the proposed new ‘unqualified person’ offence<sup>331</sup> or section 313(1) of the Criminal Code.

3.266 An early medical termination may involve the self-administration of a termination drug by the woman. A practical aspect of this reform is that the new provision will ensure that the woman is not criminally responsible for this self-administration.

## TERMINATIONS PERFORMED BY AN UNQUALIFIED PERSON

3.267 If sections 224 to 226 of the Criminal Code are repealed and the recommended new provisions for lawful terminations are introduced,<sup>332</sup> it will be necessary to amend the Criminal Code to provide for the criminal responsibility of a person who performs or assists in the performance of a termination when not qualified to do so under those provisions.

3.268 Most Australian jurisdictions provide that a termination is unlawful unless performed by a medical practitioner.<sup>333</sup> In the Northern Territory, Tasmania and Victoria, it is unlawful for a person other than a medical practitioner to perform a termination.<sup>334</sup>

## Submissions

3.269 Some respondents, including the former Health Services Commissioner, Victoria, a group of health law academics and RANZCOG, submitted that it should continue to be a criminal offence for an unqualified person to perform a termination.<sup>335</sup> The former Health Services Commissioner, Victoria, favoured this approach for consistency with ‘women’s human rights, health and safety’.<sup>336</sup>

## Conclusion

3.270 The Criminal Code should be amended to provide that a person who performs or assists in the performance of a termination, when not qualified to do so under the recommended new provisions for lawful terminations, commits a crime.

3.271 In light of its subject matter, the new offence should be located in Chapter 29 of the Criminal Code (which deals with offences endangering life or health).

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331 See [3.267]–[3.278] below.

332 See Recs 3-1 to 3-5.

333 *Health Act 1993* (ACT) s 81; Criminal Code (NT) s 208A and *Termination of Pregnancy Law Reform Act 2017* (NT) ss 4–10; *Criminal Law Consolidation Act 1995* (SA) s 82A; Criminal Code (Tas) ss 51(1A), 178D and *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; *Crimes Act 1958* (Vic) ss 65–66 and *Abortion Law Reform Act 2008* (Vic) ss 4–5; Criminal Code (WA) s 199.

334 Criminal Code (NT) s 208A; Criminal Code (Tas) s 178D; *Crimes Act 1958* (Vic) s 65. In Tasmania, a termination does not include the supply or procurement of any thing for the purpose of a termination or the administration of drugs used for that purpose by a nurse or midwife acting under the direction of a medical practitioner: Criminal Code (Tas) s 1 (definition of ‘terminate’).

335 See, eg, Submissions 50, 89, 119, 164, 172, 312, 452, 470, 482, 562, 572, 577, 590, 592, 669, 673, 690, 712, 720, 754.

336 Submission 577.

3.272 This new offence continues the current policy under sections 224 and 226 of the Criminal Code to the extent that it applies to a person who is not medically qualified to perform or assist in performing a termination.<sup>337</sup>

3.273 For the purposes of the new offence, an 'unqualified person' should be defined to mean:

- in relation to performing a termination, a person who is not a medical practitioner; and
- in relation to assisting in the performance of a termination, a person who is not a medical practitioner or a nurse, midwife or pharmacist providing the assistance in the practice of their respective professions.

3.274 The definitions of 'termination', 'medical practitioner', 'nurse', 'midwife', 'pharmacist' and 'woman' that apply in respect of the recommended new provisions for lawful terminations should also apply to this offence.<sup>338</sup>

3.275 The main purpose of the new offence is to protect the health, safety and well-being of women by deterring the practice of unregulated or 'backyard' terminations. The offence will apply to a termination performed by an unregistered medical practitioner and to a termination in which a person who is not medically qualified assists in the performance of a termination (for example, by unlawfully administering or supplying a termination drug).

3.276 In accordance with the terms of reference, the draft legislation removes the criminal responsibility of a medical practitioner for performing a termination.<sup>339</sup> A person who is 'qualified' to assist in a termination under the new legislation should also ordinarily be protected from criminal responsibility. However, if a qualified person assists an unqualified person to perform a termination, the general provisions of the Criminal Code which extend criminal responsibility to a person who is a party to an offence will still operate.<sup>340</sup>

3.277 As the new offence is a crime, it will be an indictable offence dealt with in the District Court of Queensland.<sup>341</sup>

3.278 The maximum penalty for the new offence should be seven years imprisonment. The Commission considers this to be an appropriate penalty, given that the mischief to which this offence is addressed is risk to the health of the woman posed by an unqualified person performing or assisting in the performance of a termination. If a termination performed by an unqualified person resulted in a serious

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<sup>337</sup> See, eg, *R v Bayliss v Cullen* (1986) 9 Qld Lawyer Reps 8, 9, in which McGuire DCJ observed that one of the purposes of the proscription of abortion in s 224 appeared to be '[the protection of] the mother, having regard to the grave dangers, which until comparatively recent times, were attendant upon induced abortions'.

<sup>338</sup> See [3.34] and [3.42] above. The term 'medical practitioner' is defined in the *Acts Interpretation Act 1954* (Qld) to mean 'a person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student': *Acts Interpretation Act 1954* (Qld) sch 1 (definition of 'medical practitioner').

<sup>339</sup> See terms of reference, para 1 in Appendix A.

<sup>340</sup> Criminal Code (Qld) ss 7, 8.

<sup>341</sup> Criminal Code (Qld) ss 3(3), 553; *District Court of Queensland Act 1967* (Qld) ss 60, 61.

injury to the woman, that person might be charged with a more serious offence, such as grievous bodily harm.<sup>342</sup>

## RECOMMENDATIONS

### Lawful terminations

**3-1 The Termination of Pregnancy Bill should provide that a medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant.<sup>343</sup>**

*[See Termination of Pregnancy Bill 2018 cl 4]*

**3-2 The Termination of Pregnancy Bill should provide that a medical practitioner may perform a termination on a woman who is more than 22 weeks pregnant if the medical practitioner:**

- (a) considers that, in all the circumstances, the termination should be performed; and**
- (b) has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed.**

*[See Termination of Pregnancy Bill 2018 cl 5(1)]*

**3-3 The Termination of Pregnancy Bill should provide that, in considering whether the termination should, in all the circumstances, be performed, a medical practitioner must have regard to:**

- (a) all relevant medical circumstances;**
- (b) the woman's current and future physical, psychological and social circumstances; and**
- (c) the professional standards and guidelines that apply to the medical practitioner in the performance of the termination.**

*[See Termination of Pregnancy Bill 2018 cl 5(2)]*

<sup>342</sup> See Criminal Code (Qld) s 320 (Grievous bodily harm).

<sup>343</sup> 'Medical practitioner' means 'a person registered under the Health Practitioner Regulation National Law to practise in the medical profession, other than as a student': *Acts Interpretation Act 1954* (Qld). See also Termination of Pregnancy Bill 2018 sch 1 (definitions of 'termination' and 'woman').

**3-4** The Termination of Pregnancy Bill should provide that a medical practitioner may, in an emergency, perform a termination on a woman who is more than 22 weeks pregnant if the medical practitioner considers it is necessary to perform the termination to save the woman's life or the life of another unborn child.

[See *Termination of Pregnancy Bill 2018 cl 5(3)*]

**Registered health practitioners who may assist**

**3-5** The Termination of Pregnancy Bill should provide that:

- (a) A medical practitioner may assist another medical practitioner to perform a termination;
- (b) A nurse, midwife or pharmacist may, in the practice of his or her health profession, assist in the performance of a termination by a medical practitioner;<sup>344</sup>
- (c) However, the provisions in paragraphs (a) and (b) do not apply to a termination that the assisting medical practitioner, nurse, midwife or pharmacist knows, or ought reasonably to know, is not being performed under the provisions in Recommendations 3-1 to 3-4 above.
- (d) A reference in Recommendation 3-5(b) above to assisting in the performance of a termination by a medical practitioner includes dispensing, supplying or administering a termination drug on the medical practitioner's instruction.<sup>345</sup>

[See *Termination of Pregnancy Bill 2018 cl 6*]

**Consequences of non-compliance**

**3-6** The Termination of Pregnancy Bill should provide that, in deciding an issue under an Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner performs a termination, or assists another practitioner to perform a termination, other than as authorised.

[See *Termination of Pregnancy Bill 2018 cl 8(a)-(b)*]

<sup>344</sup> See also Termination of Pregnancy Bill 2018 sch 1 (definitions of 'midwife', 'nurse', 'pharmacist').

<sup>345</sup> A 'termination drug' means 'a drug of a kind used to cause a termination': Termination of Pregnancy Bill 2018 sch 1 (definition of 'termination drug').

**Woman does not commit an offence**

**3-7** The Termination of Pregnancy Bill should provide that, despite any other Act, a woman who consents to, assists in or performs a termination on herself does not commit an offence.

[See *Termination of Pregnancy Bill 2018 cl 9*]

**Terminations performed by an unqualified person**

**3-8** The Criminal Code should be amended to provide that:

- (a) an unqualified person who performs a termination commits a crime; and
- (b) an unqualified person who assists in the performance of a termination commits a crime.<sup>346</sup>

[See *Termination of Pregnancy Bill 2018 cl 21(1)–(3)*]

**3-9** For the purposes of the new offence in Recommendation 3-8 above:

- (a) an ‘unqualified person’ should be defined to mean:
  - (i) in relation to performing a termination, a person who is not a medical practitioner; or
  - (ii) in relation to assisting in the performance of a termination, a person who is not a medical practitioner or a nurse, midwife or pharmacist providing the assistance in the practice of his or her health profession.
- (b) The definitions of ‘pharmacist’, ‘midwife’, ‘nurse’, ‘termination’, ‘termination drug’, and ‘woman’ should be consistent with the definitions that apply under the provisions for lawful terminations in Recommendations 3-1 to 3-5 above.

[See *Termination of Pregnancy Bill 2018 cl 21(4)*]

**3-10** The maximum penalty for the provision in Recommendation 3-8 above should be seven years imprisonment.

[See *Termination of Pregnancy Bill 2018 cl 21(1)–(2)*]

<sup>346</sup>

A reference to an unqualified person assisting in the performance of a termination includes:

- supplying, or procuring the supply of, a termination drug for use in a termination; and
- administering a termination drug.

See *Termination of Pregnancy Bill 2018 cl 21* inserting new s 319A(3).

# Chapter 4

## Conscientious objection

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### INTRODUCTION

4.1 The terms of reference require the Commission to draft legislation to modernise and clarify the law relating to termination in Queensland.<sup>1</sup>

4.2 Some health practitioners may have a conscientious objection to termination. This raises the issues of whether and how the draft legislation should expressly provide for conscientious objection and, if so, whether there should be any circumstances in which that provision does not apply.

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<sup>1</sup>

See terms of reference, paras 2, C in Appendix A.

## RIGHTS AND DUTIES OF HEALTH PRACTITIONERS

4.3 Health practitioners owe a duty of care to their patients. In particular, where there is a doctor-patient relationship, the medical practitioner owes a general duty of care to the patient which requires the practitioner to exercise ‘reasonable care and skill’ in the provision of professional advice and treatment.<sup>2</sup>

4.4 Ethically, a medical practitioner may decline to enter into, or to continue, a therapeutic relationship if an alternative health care provider is available and the situation is not an emergency.<sup>3</sup> In exceptional circumstances, a medical practitioner may also exercise a conscientious objection to particular treatment.<sup>4</sup>

4.5 In this context, the Australian Medical Association (the ‘AMA’) explains that ‘conscientious objection’ is constituted by a medical practitioner’s refusal to provide, or participate in, a lawful treatment or procedure because it conflicts with the practitioner’s ‘personal beliefs and values’ or ‘sincerely-held beliefs and moral concerns’.<sup>5</sup>

### International human rights

4.6 International human rights law recognises the right to ‘freedom of thought, conscience and religion’, including the freedom to manifest a religion or belief either individually ‘or in community with others and in public or private’.<sup>6</sup>

4.7 This right may be limited by legislation to protect others’ fundamental rights and freedoms. It has been observed that a health practitioner’s conscientious objection to termination should be regulated to ensure that it does not impede access to termination services, including by requiring an exception for emergencies and referral to alternative health providers.<sup>7</sup>

<sup>2</sup> Similarly, a hospital emergency department has a general duty to take reasonable care in dealing with persons who present for treatment. See generally *Rogers v Whitaker* (1992) 175 CLR 479, 483; L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) [2.46]–[2.48], [2.86]–[2.88], [7.12]; J McIlwraith and B Madden, *Health Care and the Law* (Lawbook, 6th ed, 2014) [10.55], [10.170]; C Stewart, I Kerridge and M Parker, *The Australian Medico-Legal Handbook* (Elsevier, 2008) [4.2]; LexisNexis, *Halsbury’s Laws of Australia* (at 26 August 2016) 280 Medicine, ‘Professional Negligence’ [280-2000], [280-2025].

<sup>3</sup> AMA, *Code of Ethics* (2016) [2.1.11]–[2.1.12]; MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [3.13]. Where a therapeutic relationship is discontinued, the practitioner must inform the patient and assist in facilitating arrangements for their ongoing care.

<sup>4</sup> AMA, *Position Statement: Conscientious Objection* (2013) [1].

<sup>5</sup> *Ibid* [1]–[3]. The AMA states that a conscientious objection is not based on self-interest or discrimination, and that a refusal may occur ‘in exceptional circumstances, and as a last resort’. In this context, the term ‘participation’ may include indirect actions such as referring a patient to another practitioner who is willing to provide the service. See, in contrast, consideration of the term ‘participate’ at [4.15] below.

‘Conscientious objection’ is not defined under termination legislation in any Australian jurisdiction, but see proposed new s 84A(1) of the *Health Act 1993* (ACT) which defines a ‘conscientious objection’ as a refusal to supply or administer a termination drug, or carry out or assist in carrying out a surgical termination on religious or other conscientious grounds: Health (Improving Abortion Access) Amendment Bill 2018 (ACT) 5.

<sup>6</sup> See the discussion of ‘Freedom of thought, conscience and religion’ in Appendix C.

<sup>7</sup> *Ibid*. See also the overview table on ‘Other requirements or restrictions’ in Appendix C.

## Guidelines about conscientious objection

4.8 Conscientious objection to certain medical treatments is provided for in Australian codes of conduct and ethical standards for medical practitioners and other health practitioners, including nurses, midwives and pharmacists.<sup>8</sup> Generally, they recognise that a health practitioner may decline to provide or participate directly in a treatment to which the practitioner conscientiously objects, and require an objecting practitioner to:

- inform their employer, colleagues and patients of their objection;
- take action to ensure that a patient has alternative care options or that their access to care is not impeded, including by providing information to enable a patient to obtain services elsewhere; and
- provide medically appropriate treatment in an emergency despite their objection.

4.9 RANZCOG acknowledges the right of medical practitioners to hold a conscientious objection to termination, but requires that patients seeking that service be referred elsewhere or informed where and how the service can be obtained.<sup>9</sup>

4.10 In Queensland, the clinical guideline on therapeutic termination of pregnancy (the 'clinical guideline') provides that 'health care professionals may decline to provide termination of pregnancy care on the basis of conscientious objection'. When this occurs, the person has 'a professional responsibility to ensure [that an] appropriate transfer of care occurs within a reasonable time frame for the circumstances'.<sup>10</sup>

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<sup>8</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014), [2.4.6]–[2.4.7], [2.5]; AMA, *Code of Ethics* (2016), [2.1.13], [4.2.3]; AMA, *Position Statement: Conscientious Objection* (2013); AMA, *Position Statement: Ethical Issues in Reproductive Medicine* (2013) [1.7], [2.4.2]; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.4](f), (g), [2.5]; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Nursing and Midwifery Board of Australia, *Code of Conduct for Midwives* (March 2018) [4.4](b); International Confederation of Midwives, *International Code of Ethics for Midwives* (2014) [III](c)–(d); Australian Nursing and Midwifery Federation, *Policy: Conscientious Objection* (November 2017); Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.4](f), (g), [2.5]; Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (February 2017) 12, 18. See generally, as to psychologists and the withdrawal of service: Australian Psychological Society, *Code of Ethics* (2007) B11.

<sup>9</sup> RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) 3, [2.6]; RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.6]. See also FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015), 37–9; International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003) 2.

<sup>10</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3]. The clinical guideline does not define 'health care professional' or 'termination of pregnancy care'.

## LEGISLATING FOR CONSCIENTIOUS OBJECTION TO TERMINATION

4.11 In the Australia Capital Territory, South Australia and Western Australia legislation provides generally that a person is not under a duty (by contract, or by statutory or other legal requirement) to participate in a termination.<sup>11</sup> In the Northern Territory and Victoria, an objecting practitioner must refer a woman to another practitioner who is known not to have a conscientious objection to termination.<sup>12</sup> In Tasmania, the legislation combines these approaches.<sup>13</sup>

### Scope of the conscientious objection provision

4.12 Generally, the conscientious objection provisions apply to registered health practitioners who are participating in, performing or assisting in performing a termination.<sup>14</sup> In Victoria and the Northern Territory, the provision also applies to advising on a proposed termination and in Victoria to directing, authorising or supervising a termination.<sup>15</sup>

4.13 In some jurisdictions, provision for conscientious objection applies generally where a practitioner 'has a conscientious objection to terminations'.<sup>16</sup> In other jurisdictions, it is limited to instances where the practitioner objects to the proposed termination.<sup>17</sup>

4.14 In Western Australia, provision for conscientious objection extends to hospitals, health institutions, other institutions and services.<sup>18</sup>

<sup>11</sup> *Health Act 1993* (ACT) s 84(1); *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2). In the Australian Capital Territory, the legislation uses the phrase 'carry out or assist in carrying out' a termination, and a person is also entitled to 'refuse' to assist in carrying out a termination: s 84(2). In Western Australia, the legislation uses the phrase 'participate in the performance of any abortion': s 334(2).

A similar duty-based model was adopted in the *Health (Abortion Law Reform) Amendment Bill 2016* (Qld): cl 22(1)–(2).

In the Australian Capital Territory, a private member's Bill was introduced into the Legislative Assembly on 21 March 2018, but has not yet been debated, which proposes, among other things, to replace the conscientious objection provision in the *Health Act 1993* (ACT): *Health (Improving Abortion Access) Amendment Bill 2018*.

<sup>12</sup> *Termination of Pregnancy Law Reform Act 2017* (NT) s 11; *Abortion Law Reform Act 2008* (Vic) s 8(1).

<sup>13</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(1), 7(2).

<sup>14</sup> *Health Act 1993* (ACT) s 84(1); *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11(1), 12(1); *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(1); *Abortion Law Reform Act 2008* (Vic) s 8(1); *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

The term 'participate' is used in the legislation in South Australia, Tasmania and Western Australia. The legislation in the Australian Capital Territory uses the phrase 'carry out', and the legislation in the Northern Territory and Victoria uses the term 'perform'.

<sup>15</sup> *Termination of Pregnancy Law Reform Act 2017* (NT) s 11(1); *Abortion Law Reform Act 2008* (Vic) s 8(1). The Victorian approach is also used in relevant guidelines in New South Wales: NSW Health, *Pregnancy-Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) 7.

<sup>16</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(1), 7(2); *Abortion Law Reform Act 2008* (Vic) s 8(1).

<sup>17</sup> *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Termination of Pregnancy Law Reform Act 2017* (NT) s 11(1), 2(a).

<sup>18</sup> *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

4.15 The term ‘participate’ has been described in the United Kingdom<sup>19</sup> and in codes of conduct as referring to ‘direct’ participation in treatment, and as not including ancillary, administrative, managerial or supervisory tasks that might be associated with the treatment.<sup>20</sup>

4.16 The AMA states that ‘participation’ may include ‘indirect actions such as referring the patient to another doctor who will provide the service’.<sup>21</sup>

## A requirement to inform and refer

4.17 In Tasmania, if a woman seeks a termination or advice about the full range of pregnancy options from a medical practitioner who has a conscientious objection, that practitioner is required to give the woman a list of prescribed services that can provide advice, information or counselling on the full range of pregnancy options.<sup>22</sup>

4.18 In Victoria, an objecting health practitioner must inform the woman that they have a conscientious objection to termination, and refer the woman to another registered health practitioner, in the same profession, who the practitioner knows does not have a conscientious objection to termination.<sup>23</sup> It has been suggested that this requirement may be satisfied by directing a woman to a public hospital or family planning service that can provide her with ‘advice and assistance’.<sup>24</sup>

4.19 The requirement in the Northern Territory is similar to that in Victoria. However, the provision applies to a registered medical practitioner and requires that

<sup>19</sup> In England, Scotland and Wales, a person is not under a duty to participate in any treatment authorised by the *Abortion Act 1967* (UK) to which he or she has a conscientious objection: *Abortion Act 1967* (UK) s 4(1).

<sup>20</sup> *Janaway v Salford Health Authority* [1988] 3 All ER 1079, 1082; *Greater Glasgow Health Board v Doogan* [2015] 2 All ER 1, [37]–[38]. The ‘course of treatment’ begins with the inducement of labour and generally ends with the delivery of the fetus and other matter, and includes care connected with the labour and birthing process and any necessary aftercare. It does not include ancillary, administrative, managerial or supervisory tasks that might be associated with the treatment: *Greater Glasgow Health Board v Doogan* [2015] 2 All ER 1, [34], [38].

See more generally, as to the meaning of ‘treatment’, *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800, 828–9 (Lord Diplock), 834–35 (Lord Keith of Kinkel), 837–38 (Lord Roskill).

MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014), [2.4.6]; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Nursing and Midwifery Board of Australia, *Code of Conduct for Midwives* (March 2018) [4.4](b); Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.4](f); Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.4](f).

<sup>21</sup> AMA, *Position Statement: Conscientious Objection* (2013) [1].

<sup>22</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2). See *Reproductive Health (Access to Terminations) Regulations 2013* (Tas) reg 4(1) for the list of prescribed health services. The medical practitioner must also include contact details for each service in the list: reg 4(2).

<sup>23</sup> *Abortion Law Reform Act 2008* (Vic) s 8(1).

<sup>24</sup> See Victoria, *Parliamentary Debates*, Legislative Assembly, 11 September 2008, 3613 (M Morand, Minister for Women’s Affairs); A O’Rourke, L de Crespigny and A Pyman, ‘Abortion and Conscientious Objection: The New Battleground’ (2012) 38(3) *Monash University Law Review* 87, 107–8; R Sifris, ‘Tasmania’s *Reproductive Health (Access to Terminations) Act 2013*: An analysis of the conscientious objection to abortion and the “obligation to refer”’ (2015) 22 *Journal of Law and Medicine* 900, 905–8; cf Victoria, *Parliamentary Debates*, Legislative Council, 10 October 2008, 4261–2 (G Jennings, Minister for Environment and Climate Change).

a referral be made 'within a clinically reasonable time'.<sup>25</sup> Clinical guidelines state that referral may be to another medical practitioner who does not object, or to a facility known to provide terminations.<sup>26</sup>

4.20 A number of jurisdictions include similar referral requirements in guidelines.<sup>27</sup> The New South Wales guidelines require that a woman be 'directed' to another practitioner who does not have an objection but explain that this does not require a written referral.<sup>28</sup> In Queensland, the clinical guideline states that objecting practitioners have a responsibility to ensure that an 'appropriate transfer of care' occurs within a reasonable time.<sup>29</sup>

4.21 Codes of conduct and guidelines state that a practitioner who holds a conscientious objection is to inform their patient and refrain from using their objection to impede access to legal treatments.<sup>30</sup> A practitioner may be required to provide information to enable a patient to see another practitioner or obtain services elsewhere,<sup>31</sup> make an appropriate referral,<sup>32</sup> or ensure that the person has alternative care options<sup>33</sup> or continuity of care.<sup>34</sup>

<sup>25</sup> *Termination of Pregnancy Law Reform Act 2017* (NT) s 11. Clinical guidelines state that a referral must occur within two working days: Northern Territory Government, Department of Health, *Clinical Guidelines for Termination of Pregnancy* (June 2017) 22. The clinical guidelines suggest that this obligation also applies to other health practitioners.

The Northern Territory legislation also requires that, when another health practitioner who is directed to assist in a termination holds a conscientious objection, the medical practitioner who gave the direction must instead direct another practitioner who does not hold a conscientious objection to provide that assistance: *Termination of Pregnancy Law Reform Act 2017* (NT) s 12.

<sup>26</sup> Northern Territory Government, Department of Health, *Clinical Guidelines for Termination of Pregnancy* (June 2017) 22. The practitioner is also required to provide the woman with relevant contact details.

<sup>27</sup> Eg, Women and Newborn Health Service, Western Australia, *Termination of Pregnancy: Information and Legal Obligations for Medical Practitioners* (2007) 10; NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) 7; Parliamentary Committee Report No 33a (2017) [6.3.1] citing ACT Government Health, *Canberra Hospital and Health Services Clinical Guideline—Management of Termination of Pregnancy, Miscarriage or Fetal Death* (4 August 2016) 4.

<sup>28</sup> NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) 7. The guidelines explain that the term 'direct' should be understood as a requirement to 'direct or point to another source, rather than the requirement of a written referral as part of an ongoing working relationship', and that compliance 'may be as simple as directing the woman to another practitioner who they know has no such objection'.

<sup>29</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3].

<sup>30</sup> AMA, *Code of Ethics* (2016) [2.1.13]; MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [2.4.6]; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.4](f); Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.4](f). See also [4.8] ff above.

<sup>31</sup> AMA, *Position Statement: Conscientious Objection* (2013) [6]; RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.6].

<sup>32</sup> RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) 3, [2.6]; FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015), 38-9; International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003) 2.

<sup>33</sup> Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Nursing and Midwifery Board of Australia, *Code of Conduct for Midwives* (March 2018) [4.4](b).

<sup>34</sup> Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (February 2017) 12.

## Circumstances in which conscientious objection does not apply

4.22 In Tasmania, the Northern Territory and Victoria, the legislation states that, despite any conscientious objection, a medical practitioner has a duty to perform a termination in an emergency, if it is necessary to save a pregnant woman's life.<sup>35</sup> In Tasmania, the duty extends to preventing serious physical injury to the woman.<sup>36</sup> In the same circumstances, other health practitioners, such as nurses and midwives have a duty to assist in the performance of a termination.<sup>37</sup>

4.23 In South Australia, the legislation states that a person's conscientious objection does not affect any duty to participate in treatment (which would include, but is not limited to, termination) that is necessary to save the life of a pregnant woman, or to prevent grave injury to her physical or mental health.<sup>38</sup>

4.24 Codes of conduct and guidelines state generally that medical practitioners, nurses and midwives (and other health practitioners) should provide or assist in treatment in an emergency.<sup>39</sup>

4.25 Some guidelines and codes of conduct also provide more generally that practitioners should not use a conscientious objection to 'impede access to treatments that are legal'.<sup>40</sup> For example, RANZCOG states that '[d]octors should not unreasonably refuse to accept referral or provide care; this applies particularly in an emergency or if no other appropriate practitioner is available'.<sup>41</sup>

<sup>35</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(2)–(3); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13(1); *Abortion Law Reform Act 2008* (Vic) s 8(2)–(3). See also proposed new s 84A(2) of the Health Act 1993 (ACT) in similar terms: Health (Improving Abortion Access) Amendment Bill 2018 (ACT) cl 15.

<sup>36</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(2)–(3).

<sup>37</sup> *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(2), (4); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13(2); *Abortion Law Reform Act 2008* (Vic) s 8(2), (4). See also similar requirements for medical and health practitioners in guidelines in other jurisdictions: eg, NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) 7.

<sup>38</sup> *Criminal Law Consolidation Act 1935* (SA) s 82A(6). The provision does not use the term 'emergency'.

<sup>39</sup> AMA, *Code of Ethics* (2016) [2.1.13]; AMA, *Position Statement: Conscientious Objection* (2013) [4]; MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [2.5]; Australian Nursing and Midwifery Federation, *Policy: Conscientious Objection* (November 2017) [3]; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.5]; Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.5]; RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) [2.6]. See also FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015), 39; International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003) 2.

In offering assistance, practitioners take into account matters such as their own safety and skills, the availability of other options, and the impact on other people under their care: MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [2.5]; Australian Nursing and Midwifery Federation, *Policy: Conscientious Objection* (November 2017) [3]; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.5]; Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.5].

<sup>40</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [2.4.6]; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (March 2014) [2.4](f); Pharmacy Board of Australia, *Code of Conduct* (March 2014) [2.4](f). See also AMA, *Code of Ethics* (2016) [2.1.13]; AMA, *Position Statement: Conscientious Objection* (2013) [5].

<sup>41</sup> RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) [2.6].

## Consequences of non-compliance

4.26 The legislation in other jurisdictions does not include a penalty for non-compliance with a requirement related to conscientious objection. However, for registered health practitioners, non-compliance could be the subject of professional disciplinary action.<sup>42</sup>

## CONSULTATION AND SUBMISSIONS

4.27 In the Consultation Paper, the Commission sought submissions on whether there should be provision for conscientious objection in the law relating to termination of pregnancy in Queensland.<sup>43</sup>

4.28 The Commission also asked whether an objecting health practitioner should be obliged to refer or direct a woman to another practitioner or termination service, and whether there should be circumstances in which provision for conscientious objection does not apply, such as an emergency or the absence of another practitioner or service within a reasonable geographic proximity.<sup>44</sup>

## Legislating for conscientious objection to termination of pregnancy

4.29 Of those respondents who addressed the topic of conscientious objection, the majority were in favour of legislative provision for conscientious objection.<sup>45</sup> These respondents included medical practitioners, academics, RANZCOG, the Royal Australasian College of Medical Administrators, AMA Queensland, religious organisations, support and advocacy organisations and members of the public.

4.30 Numerous respondents indicated that they supported the protection of conscientious objection because this approach would be consistent with the recognition of individual rights, particularly the right to freedom of conscience and religion.<sup>46</sup>

4.31 An academic from the School of Law and Justice, University of Southern Queensland considered that where a woman's rights to personal autonomy and

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Similarly, FIGO states that '[p]ractitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients' health and well-being, such as by patients experiencing unwanted pregnancy': FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015) 39.

<sup>42</sup> See the discussion of the 'Regulation of health practitioners' in Chapter 2. See also Clause Notes, Reproductive Health (Access to Terminations) Bill 2013 (Tas) cl 7; Explanatory Note, Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW) sch 1, cl 1.3.

<sup>43</sup> QLRC Consultation Paper No 76 (2017) Q-11.

<sup>44</sup> Ibid Q-12.

<sup>45</sup> Eg, Submissions 4, 20, 21, 26, 27, 31, 32, 35, 36, 42, 48, 49, 50, 53, 55, 56, 59, 60, 61, 63, 65, 66, 67, 70, 71, 73, 74, 75, 84, 88, 89, 97, 101, 102, 108, 111, 118, 119, 127, 137, 138, 140, 143, 144, 145, 161, 162, 164, 166, 194, 220, 231, 233, 234, 237, 244, 248, 276, 278, 315A, 327, 334, 340, 341, 349, 351, 378, 387, 395, 404, 405, 411, 413, 422, 428, 429, 433, 438, 441, 445, 448, 452, 454, 457, 466, 469, 477, 482, 486, 487, 491, 508, 510, 512, 514, 515, 517, 522, 528, 532, 533, 535, 543, 546, 548, 551, 554, 557, 558, 565, 570, 571, 576, 583, 584, 587, 589, 590, 600, 603, 604, 621, 627, 629, 630, 632, 634, 637, 640, 642, 650, 661, 671, 673, 678, 679, 688, 690, 707, 710, 712, 713, 715, 720, 721, 722, 731, 732, 734, 743, 750, 754, 759, 765, 766, 773, 782, 797, 810, 819, 835, 836, 841, 842, 843, 857, 862, 876, 882, 885, 888.

<sup>46</sup> Eg, Submissions 88, 140, 144, 151, 161, 194, 351, 413, 433, 434, 444, 448, 491, 515, 517, 543, 558, 569, 575, 587, 640, 651, 700, 726, 731, 766, 819, 835, 862, 888.

reproductive health conflict with a health practitioner's right to freedom of religion, an 'accommodation that serves both rights and interests' should be found:<sup>47</sup>

Health practitioners are human beings and, despite their occupation, do not surrender their rights to freedom of religion. The belief that the sanctity of human life begins at conception is a deeply and widely held tenet of many religions. Performing or assisting with abortion procedures violates, to their very core, the most fundamental religious, spiritual, and moral beliefs of many people. To such individuals, requiring them to perform or assist with abortion procedures is akin to requiring them to take part in murder.

The principle of freedom of religion demands respect for the sincerely held religious beliefs of individuals. This right is not an absolute right, and can be circumscribed, if necessary, to achieve compelling societal interests. However, whenever possible, reasonable accommodation must be made so that the right is limited only so much as is necessary in order to achieve that compelling societal interest.

4.32 Some respondents submitted that both health practitioners and women should have autonomy and freedom to make choices with regard to termination of pregnancy, and that the freedoms of each should not impact on the other.<sup>48</sup>

4.33 Respondents submitted that health practitioners should be able to provide health care services in accordance with their conscience, beliefs, values, morals or ethics, or more generally that those should be safeguarded; and that practitioners should not be forced to be involved in terminations.<sup>49</sup>

4.34 An academic from the School of Law, University of Notre Dame submitted that:<sup>50</sup>

Conscience is a complex concept. The traditional understanding is that conscience is a law that we do not impose on ourselves, but which holds us to obedience and is unaffected by external control. Acting conscientiously is said to give moral definition to the person. Hence, being coerced to act against conscience damages a person's moral integrity. Refusing to perform an abortion because it does not represent a proportionate response to genuine medical concerns for the patient's life or health is neither irrational nor illegal.

In Australia, doctors do not have a fiduciary duty to their patients. They must, however, respect their patients' autonomous decisions. Whilst the doctor/patient relationship is an unequal one, with doctors being the gatekeepers to abortion, both the doctor and the patient are equal in dignity. As individual persons, the state has no authority to force them to manifest a certain belief, that abortion on

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47 Submission 351.

48 Eg, Submissions 533, 587, 842.

49 Eg, Submissions 75, 84, 86, 88, 94, 102, 111, 123, 137, 138, 151, 166, 194, 220, 231, 233, 237, 270, 278, 283, 341, 376, 395, 404, 411, 413, 422, 436, 494, 508, 512, 515, 517, 532, 548, 557, 600, 603, 609, 627, 679, 690, 710, 713, 715, 722, 734, 761, 807, 842, 843, 855, 857, 881. Also eg, Submissions 279, 522, 773.

It was also observed that if practitioners cannot excuse themselves from participation they may suffer ill-effects, or patients may be adversely affected by a practitioner's unwilling participation: eg, Submissions 107, 108, 411, 468, 535, 551, 700, 722. Also eg, Submission 526.

50 Submission 494.

demand is healthcare, by coerc[ing] them into performing it or facilitating its performance.

4.35 Some respondents observed that health practitioners take an oath to ‘heal and save lives’ or ‘do no harm’, or more generally that they intend to save lives. Some practitioners consider termination to conflict with this position or to be ending a life, and for that reason there should be provision for conscientious objection.<sup>51</sup>

4.36 Respondents also observed that legislative provision for conscientious objection is consistent with current guidelines, codes of conduct and position statements, including, for example, those of RANZCOG and the AMA and the Queensland clinical guideline.<sup>52</sup>

4.37 It was also submitted by several respondents that allowing for conscientious objection will not significantly affect the availability of termination services.<sup>53</sup>

4.38 A number of respondents indicated that they favoured the approach adopted in Victorian legislation because it clarifies the obligations that apply to an objecting practitioner, and assists in addressing barriers to access that might be caused by conscientious objection.<sup>54</sup> Similarly, many respondents supported legislative provision for conscientious objection but submitted that there should also be associated requirements, such as an obligation to refer a woman elsewhere or to assist in an emergency, in order to balance the rights of medical practitioners and women seeking to access services.<sup>55</sup>

4.39 Other respondents, including some medical practitioners, opposed the inclusion of a legislative provision for conscientious objection.<sup>56</sup>

4.40 Some respondents considered that conscientious objection to termination should not be recognised or permitted.<sup>57</sup> It was submitted, by those and some other respondents, that termination should not be treated differently from other medical procedures.<sup>58</sup> Marie Stopes Australia described it as an ‘essential health service’.<sup>59</sup>

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<sup>51</sup> Eg, Submissions 48, 66, 86, 94, 105, 140, 166, 195, 270, 434, 444, 551, 557, 575, 603, 650, 740. Also eg, Submissions 433, 548, 721.

<sup>52</sup> Eg, Submissions 27, 119, 341, 436, 542, 621, 642, 819.

<sup>53</sup> Eg, Submissions 434, 444, 575, 703.

<sup>54</sup> Eg, Submissions 118, 486. Also eg, Submission 378. Other respondents opposed the Victorian approach: eg, Submissions 495, 603, 700.

<sup>55</sup> See generally the discussion at [4.65] ff below. In particular, eg, Submissions 119, 276, 341, 351, 438, 482, 487, 571, 572, 621, 642, 673, 688, 734, 888.

<sup>56</sup> Eg, Submissions 2, 18, 19, 109, 116, 135, 160, 210, 262, 297, 344, 406, 431, 467, 490, 526, 529, 539, 547, 562, 573, 578, 582, 594, 623, 649, 669, 674, 681, 685, 736, 789, 806, 820, 830, 868, 872.

<sup>57</sup> Eg, Submissions 18, 19, 116, 135, 160, 210, 431, 526, 529, 573, 623, 674.

<sup>58</sup> Eg, Submission 529, 863. Also eg, Submissions 19, 116, 681, suggesting that there is no such provision for other medical procedures.

<sup>59</sup> Submission 674.

4.41 It was also submitted that conscientious objection may affect the care provided to patients, and that medical advice and treatment should not be subject to a practitioner's personal beliefs.<sup>60</sup> One respondent submitted that:<sup>61</sup>

All care and advice which medical and nursing practitioners give in relation to pregnancy termination should be based on a clinically-supported approach to a woman's health and well-being in her particular circumstances, rather than their own religious or personal opinions about pregnancy or termination.

4.42 It was observed that conscientious objection may affect the rights of women, including access to services.<sup>62</sup> Several respondents expressed concern that conscientious objection may affect access in regional, rural or remote areas, or impact on women requiring emergency care.<sup>63</sup> Other respondents submitted that conscientious objection should not be permitted in or by public health services.<sup>64</sup>

4.43 Some respondents, including the Sexual Health Society of Queensland and the Women's Abortion Rights Campaign Brisbane submitted that legislative provision might 'increase the legitimacy of "opting out" of abortion provision' or reinforce existing stigma about termination.<sup>65</sup>

4.44 Sustainable Population Australia Inc. (Queensland Branch) submitted that it is unnecessary to include legislative provision for conscientious objection because practitioners are not compelled to provide a specific service.<sup>66</sup>

4.45 Other respondents, including medical practitioners, the Women's Abortion Rights Campaign Brisbane, the Sexual Health Society of Queensland and Pro Choice Queensland, expressed the view that legislative provision is unnecessary because conscientious objection is adequately addressed in existing guidelines, standards and codes of conduct for practitioners.<sup>67</sup>

4.46 The QLS stated that whether guidelines in codes of conduct and ethical standards can be effectively interpreted to impose obligations should be 'carefully considered', and that legislative clarification might be necessary to achieve consistency.<sup>68</sup>

4.47 Some respondents observed that, despite opposition, conscientious objection may be a necessary part of decriminalisation, or is likely to have an ongoing

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<sup>60</sup> Eg, Submissions 18, 116, 135, 160, 573, 623, 806.

<sup>61</sup> Submission 866. Also eg, Submission 116.

<sup>62</sup> Eg, Submission 623, 624, 789.

<sup>63</sup> Eg, Submission 210, 573, 624.

<sup>64</sup> Eg, Submissions 262, 674. Also [4.59]–[4.60], [4.133] below.

<sup>65</sup> Submissions 406, 539, 547, 623. The Sexual Health Society of Queensland suggested that increased legitimacy is evident in other jurisdictions, citing LA Keogh et al, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18: Submission 539.

<sup>66</sup> Submission 500. Also eg, Submission 674.

<sup>67</sup> Eg, Submissions 2, 109, 344, 406, 467, 490, 539, 547, 582, 649, 736, 868, 872. Also eg, Submissions 562, 717, 806.

<sup>68</sup> Submission 879.

role in health care or strong ongoing support.<sup>69</sup> It was observed that forcing practitioners to provide the service may be detrimental to patient well-being.<sup>70</sup> One respondent submitted that if there is legislative provision for conscientious objection, 'appropriate steps should be taken to ensure that the health care of the patient is not compromised'.<sup>71</sup>

4.48 Some respondents who considered that there should not be legislative provision or that guidelines are adequate, including the Queensland Council for Civil Liberties, the Australian Women's Health Network, and Sustainable Population Australia Inc. (Queensland Branch), nonetheless supported a legislative provision in order to allay concerns about imposing a general requirement to participate, provide clarity to practitioners, or protect the rights of women seeking termination by ensuring that objectors are subject to and comply with associated obligations, such as referral.<sup>72</sup>

4.49 Similarly, the Women's Abortion Rights Campaign Brisbane stated that:<sup>73</sup>

it is the countervailing recognition of the responsibility to ensure that pregnant patients' access to abortion care is not unduly impeded by practitioners' existing right to refuse care, that needs protection, above all where the pregnancy threatens the woman's life.

### **Scope of the conscientious objection provision**

4.50 In addressing the topic of legislative provision for conscientious objection, many respondents made submissions relevant to the scope of a legislative provision.

#### ***Who could conscientiously object***

4.51 Some respondents suggested that any person should be able to exercise a conscientious objection to termination.<sup>74</sup> Many other respondents made submissions to the effect that legislative provision for conscientious objection should apply to medical practitioners,<sup>75</sup> or more broadly to medical and other health practitioners (for example, nurses and midwives).<sup>76</sup>

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69 Eg, Submissions 18, 863.

70 Eg, Submission 526.

71 Submission 863.

72 Eg, Submissions 500, 590, 669. Also eg, Submissions 649, 674, 820, 872.

73 Submission 406. Also eg, Submission 547.

74 Eg, Submissions 88, 166, 168, 194, 233, 251, 508, 532, 535, 640, 857.

75 Eg, Submissions 20, 65, 75, 84, 108, 137, 220, 231, 237, 270, 278, 283, 327, 341, 376, 411, 419, 468, 505, 517, 548, 554, 577, 651, 679, 707, 726, 740, 881.

76 Eg, Submissions 26, 27, 32, 36, 50, 66, 89, 102, 111, 118, 119, 127, 138, 140, 143, 144, 145, 162, 164, 244, 248, 249, 284, 334, 349, 351, 375, 387, 404, 405, 422, 429, 433, 438, 445, 452, 455, 469, 482, 491, 500, 504, 510, 512, 522, 533, 551, 557, 572, 583, 584, 587, 589, 600, 603, 621, 629, 630, 632, 637, 642, 661, 678, 688, 690, 700, 710, 712, 713, 721, 722, 734, 754, 759, 761, 766, 797, 807, 810, 835, 836, 841, 842, 843, 855, 888.

4.52 The Presbyterian Church of Queensland submitted that conscientious objection should apply to health practitioners, stating that:<sup>77</sup>

a genuinely secular society which does not privilege the beliefs of one over another should not demand that a patient's freedom of conscience and choice should override a practitioner's. Indeed, it is of benefit to the integrity of health care provision that health care practitioners [be] able to act as self-consciously moral agents.

4.53 The Australian Psychological Society Limited and the Human Rights Law Centre Ltd submitted that the conscientious objection provision should also apply to all health practitioners and counsellors.<sup>78</sup> The Human Rights Law Centre Ltd submitted:<sup>79</sup>

Counsellors may be the first service that a woman contacts for assistance. The religious or moral values of a counsellor, or any other health professional, should not impede a woman from accessing information about her treatment options.

4.54 Some respondents also nominated other categories of people who should be able to conscientiously object, such as allied health personnel, support staff, administrative staff or paramedical workers.<sup>80</sup> Others, including religious organisations, suggested that entities, such as organisations, hospitals, health services, facilities, institutions and corporations, should also be able to exercise a conscientious objection to, or decline involvement in, termination.<sup>81</sup> It was particularly observed that some of these entities may operate on a religious basis or an ethos that is not compatible with termination.<sup>82</sup>

4.55 Other respondents, including Children by Choice and the National Alliance of Abortion and Pregnancy Options Counsellors submitted specifically that conscientious objection should only extend to 'individual practitioners', or to their 'individual involvement' in terminations.<sup>83</sup>

4.56 Respondents opposed the inclusion of other people, such as administrative staff, and of entities involved in the provision of health care.<sup>84</sup> It was submitted that 'conscientious objection should be limited to those directly involved in delivering health services and not those in ancillary positions'.<sup>85</sup> The Public Health Association

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77 Submission 587.

78 Submissions 118, 888.

79 Submission 888. This part of the submission related specifically to a requirement to inform and refer.

80 Eg, Submissions 127, 143, 145, 404, 589, 759, 836, 842.

81 Eg, Submissions 88, 197, 284, 375, 448, 589, 661, 836.

82 Eg, Submissions 284, 448, 589, 661.

83 Eg, Submissions 20, 50, 89, 119, 164, 387, 419, 422, 445, 452, 469, 487, 500, 514, 546, 562, 571, 584, 600, 630, 632, 673, 688, 707, 712, 713, 720, 734, 754, 810.

84 Eg, Submissions 50, 89, 119, 164, 406, 419, 422, 445, 452, 469, 487, 500, 514, 542, 546, 547, 562, 571, 590, 600, 630, 632, 642, 673, 688, 707, 712, 713, 720, 734, 736, 754, 806, 810.

85 Submission 445. Also Submissions 562 (referring to 'direct involvement'), 583, (referring to 'persons involved in decision making about an abortion or the delivery of treatment itself'), 600 (referring to 'individuals closely involved with the proposed treatment'), 712 (referring to practitioners who 'personally perform' terminations), 810 (referring to 'direct participation').

of Australia submitted that, as termination is an individual issue of conscience involving social values, people closely involved with proposed treatment should be able to object, but those engaged in more distant ancillary services and non-individual entities should not.<sup>86</sup> Another respondent observed that current provision for conscientious objection does not include administrative staff or those entities.<sup>87</sup>

4.57 It was also observed that the inclusion of other people or entities might impact on access to services,<sup>88</sup> including for women in regional or remote areas.<sup>89</sup> A group of academics from the Griffith Law School observed that administrative staff and facilities should not act as ‘gatekeepers’, preventing access to willing medical practitioners.<sup>90</sup> The National Alliance of Abortion and Pregnancy Options Counsellors submitted that:<sup>91</sup>

The right to conscientious objection should not extend to administrative staff, services, facilities, organisations and corporate entities. Such an extension would create a power and rights imbalance to the detriment of women and pregnant people. The power imbalance would be so great in this instance that conscientious objection would be escalated to actively impeding a woman or pregnant person’s right to access a full range of healthcare services, a situation that currently exists in many Queensland hospitals, including major metropolitan and regional hospitals.

4.58 The Women’s Abortion Rights Campaign Brisbane also considered a policy response to access, submitting that:<sup>92</sup>

The right to refuse care should not be automatically extended to organisations. It must be possible for policy to be introduced to ensure that Hospital and Health Services establish and provide appropriate services that recruit staff willing to participate in abortion services to meet the healthcare needs of women throughout the State.

4.59 Marie Stopes Australia submitted that public health services such as government funded hospitals should not, despite any affiliation, be able to conscientiously object.<sup>93</sup> A member of the public submitted that conscientious objection by individuals should not be permitted in public hospitals.<sup>94</sup>

4.60 Some respondents, including the Metro North Hospital and Health Service, submitted that public health services should be obliged to offer termination

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86 Submission 600.

87 Submission 590.

88 Eg, Submissions 50, 89, 119, 164, 406, 422, 469, 487, 571, 630, 632, 673, 688, 707, 713.

89 Eg, Submissions 50, 89, 119, 164, 406, 422, 469, 500, 571, 630, 632, 673, 688, 707, 713.

90 Submission 712.

91 Submission 487.

92 Submission 406. Also Submission 547.

93 Submissions 674.

94 Submission 262.

services.<sup>95</sup> Sustainable Population Australia Inc. (Queensland Branch) submitted that public health services should not be permitted to refuse treatment where there is no readily accessible alternative.<sup>96</sup> Some respondents also submitted that it should be the responsibility of those services to ensure that their workforce is not comprised of only practitioners with a conscientious objection.<sup>97</sup>

### **Actions conscientious objection could apply to**

4.61 Respondents used various terms when explaining the proposed scope of the actions to which legislative provision for conscientious objection should apply. For example, many respondents suggested that a conscientious objector should not be required to ‘participate in’,<sup>98</sup> ‘perform’,<sup>99</sup> ‘assist in’,<sup>100</sup> ‘provide’,<sup>101</sup> ‘carry out’,<sup>102</sup> ‘be involved or take part in’<sup>103</sup> or ‘promote’<sup>104</sup> a termination of pregnancy.

4.62 Other respondents also suggested the inclusion of other actions, such as ‘organising’ or ‘preparing a woman for’ a termination,<sup>105</sup> or providing a referral for a woman seeking or contemplating a termination.<sup>106</sup>

4.63 Some respondents suggested a broader approach. The Royal Australian and New Zealand College of Psychiatrists–Queensland Branch suggested that a conscientious objector ‘should be allowed to exclude themselves from treating the

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<sup>95</sup> Eg, Submissions 20, 882. The Metro North Hospital and Health Service submitted that the obligation should apply to ‘those public health services with a CSCF level such that they may offer termination’: Submission 882. Academics from the Faculty of Law, Bond University stated that ‘[r]eproductive justice will inevitably require the support of public health services, ensuring equality of access for women. This is one way to ensure that remote and regional women have access to health practitioners who do not hold conscientious objection to delivery of reproductive health services’ (notes omitted): Submission 445.

<sup>96</sup> Submission 500.

<sup>97</sup> Eg, Submissions 139, 500, 882. The Metro North Hospital and Health Service stated that if all employees were conscientious objectors then, as part of the duty of care to the patient, the service and practitioners would be required to provide ongoing care and support and ensure appropriate referral of the patient to another service: Submission 882.

<sup>98</sup> Eg, Submissions 94, 102, 111, 140, 195, 237, 276, 436, 491, 508, 510, 517, 557, 587, 627, 721, 759, 761, 807, 810, 843, 855.

A medical practitioner and senior lecturer in general practice, James Cook University submitted that ‘participate’ would include performing a surgical termination, counselling about or prescribing medication for termination, or referring a woman for termination services: Submission 140.

Priceless House considered that caring for a woman who has had a termination and experienced complications does not constitute ‘participation’ in a termination: Submission 836.

<sup>99</sup> Eg, Submissions 20, 26, 27, 65, 84, 144, 166, 194, 248, 278, 284, 375, 413, 419, 421, 482, 522, 554, 587, 589, 603, 609, 651, 712, 721, 722, 726, 740, 835, 857, 888.

<sup>100</sup> Eg, Submissions 84, 88, 144, 248, 482, 522, 570, 603, 721, 835, 857, 888.

<sup>101</sup> Eg, Submissions 88, 111, 138, 510, 532, 570, 642, 720, 797, 807. A specialist obstetrician and gynaecologist referred specifically to ‘the direct provision of termination of pregnancy services’: Submission 532.

<sup>102</sup> Eg, Submissions 88, 107, 505, 627. Another respondent referred to ‘conducting’ a termination: Submission 231.

<sup>103</sup> Eg, Submissions 48, 50, 66, 89, 119, 127, 164, 220, 244, 248, 387, 452, 455, 468, 469, 504, 522, 533, 546, 571, 600, 629, 630, 632, 642, 673, 688, 690, 707, 712, 713, 754, 819.

<sup>104</sup> Eg, Submissions 75, 283, 376.

<sup>105</sup> Eg, Submissions 248.

<sup>106</sup> Eg, Submissions 140, 237, 248, 557, 603, 609, 627, 726, 740.

patient'.<sup>107</sup> Other respondents suggested, for example, 'refusing' to terminate, 'opting out' of the procedure, 'withholding reproductive services', or 'relieving a person of any duty' to terminate a pregnancy.<sup>108</sup>

4.64 Another respondent suggested an approach like that in Victoria so that legislative provision for conscientious objection would apply when a practitioner 'is asked to advise a patient about abortion, or perform, direct, authorise or supervise an abortion'.<sup>109</sup>

### A requirement to inform and refer

4.65 Respondents expressed mixed views about whether legislative provision for conscientious objection should include a requirement to inform and refer.

4.66 Many respondents, including members of the public, medical practitioners, Children by Choice, RANZCOG, the former Health Services Commissioner, Victoria and the Human Rights Law Centre Ltd, expressed support for a requirement to the effect that a conscientiously objecting health practitioner should be obliged to inform a woman of their objection and refer or direct her to another practitioner or service.<sup>110</sup>

4.67 In explaining why a requirement to inform and refer is necessary, one respondent stated that:<sup>111</sup>

Patients rely on their health practitioners for knowledge and expertise. They expect to be provided with information about all the options that are available to them, including termination. Patients trust medical professionals to offer the full range of choices available to them.

4.68 It was submitted that a practitioner should not express their own views about termination to others who may not share that view, attempt to dissuade a woman from terminating a pregnancy, or deny a person access to information about lawful health care.<sup>112</sup>

4.69 Some respondents submitted that a requirement to inform and refer would achieve a reasonable balance between a practitioner's right to conscientious objection and the rights of women, particularly their rights to autonomy, health and access to health care.<sup>113</sup>

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<sup>107</sup> Submission 341.

<sup>108</sup> Eg, Submissions 161, 351, 445, 569, 583, 766, 881.

<sup>109</sup> Submission 349. Other respondents expressed more general support for the approach in Victoria: eg, Submissions 118, 276, 378, 486, 572, 577, 590, 782.

<sup>110</sup> Eg, Submissions 2, 4, 18, 19, 20, 21, 26, 45, 50, 55, 59, 60, 61, 63, 67, 70, 71, 73, 74, 89, 101, 108, 118, 119, 135, 138, 142, 164, 172, 220, 276, 284, 302, 341, 344, 349, 375, 387, 405, 406, 419, 421, 422, 429, 438, 445, 452, 454, 467, 469, 482, 486, 487, 500, 514, 526, 529, 542, 546, 547, 571, 572, 577, 579, 583, 590, 600, 604, 621, 629, 630, 632, 637, 642, 649, 662, 669, 671, 673, 674, 681, 688, 707, 712, 717, 720, 734, 754, 782, 797, 810, 820, 863, 872, 882, 885, 888.

<sup>111</sup> Submission 349.

<sup>112</sup> Eg, Submissions 172, 341, 500, 514, 600, 604. Also eg, Submissions 18, 74.

<sup>113</sup> Eg, Submissions 276, 487, 577, 583, 734, 888. Another respondent observed that it is necessary to sufficiently protect the autonomy and reproductive rights of women: Submission 405.

4.70 A number of respondents submitted that a requirement to inform and refer aligns with the position of the other bodies, such as the MBA, the AMA and RANZCOG, and with the clinical guideline.<sup>114</sup>

4.71 AMA Queensland stated that:<sup>115</sup>

If the situation is not an emergency, conscientious objectors should not use their objection to impede access to treatments that are legal or which would impede the patient's access to care and AMA Queensland therefore supports an obligation to refer to a doctor who does not have a conscientious objection. Although this may not always be easy, especially in rural or remote areas, AMA Queensland upholds the view stated in our position statement which says that when exercising a conscientious objection, the doctor must 'take whatever steps are necessary to ensure the patient's access to care is not impeded.'

4.72 It was submitted that a person's religious or personal beliefs should not limit the ability of another person to access quality and timely health care,<sup>116</sup> and that a practitioner is responsible for ensuring a patient can access safe treatment.<sup>117</sup> Conscientious objection may impact on or delay access to services for some women, particularly in regional or remote areas, and a requirement to refer might assist in enabling timely access.<sup>118</sup> However, it was observed that some women may still experience practical barriers to access, such as a need to travel long distances at their own expense, which might be a particular problem for some women, such as those who are young or experiencing domestic violence, or Aboriginal and Torres Strait Islander women.<sup>119</sup>

4.73 The Human Rights Law Centre Ltd submitted that:<sup>120</sup>

Seeking assistance for an unwanted pregnancy can be practically or emotionally difficult for some women. Encountering a doctor with a conscientious objection to abortion can impede timely access to vital health services, particularly in regional and remote locations, which in turn can imperil a woman's physical and psychological health.

<sup>114</sup> Eg, Submissions 50, 119, 276, 341, 387, 467, 482, 500, 579, 590, 712, 720, 754, 810, 885. It was observed that this requirement is 'heavily protested by [individuals and groups opposed to termination] as being 'coercive'', but was submitted that this alignment nonetheless exists: eg, Submissions 50, 89, 164, 469, 590, 630, 632, 712, 754.

The Women's Abortion Rights Campaign Brisbane submitted that the responsibility to ensure access to care is not impeded, which is imposed by codes of conduct, is most in need of protection: Submission 406 at [4.49] above. Also eg, Submission 547.

A few respondents suggested that, in practice, guidelines are not complied with, for example, women are not referred to another practitioner or signposted in a timely manner: eg, Submissions 487, 685.

<sup>115</sup> Submission 885.

<sup>116</sup> Eg, Submission 74.

<sup>117</sup> Eg, Submission 172.

<sup>118</sup> Eg, Submissions 21, 172, 210, 405, 422, 429, 452, 467, 482, 487, 510, 572, 600, 629, 642, 662, 720, 734, 754, 888. A few respondents included consideration of access to appropriate information and advice, so a woman can make an informed and supported decision: Submissions 572, 754.

<sup>119</sup> Eg, Submissions 21, 707. See also [4.132] below, as to Aboriginal and Torres Strait Islander women.

<sup>120</sup> Submission 888.

Health professionals have a right to freedom of thought, conscience and religion, however this must be balanced against the right of women to life, health, autonomy and non-discrimination.

...

Medical practitioners are in a position of power and authority when women seek their assistance. Referral provisions ensure that women receive the treatment and advice they need and that their rights are realised in practice.

4.74 The Australian Psychological Society Limited suggested that, without a requirement to refer, objection by a practitioner could make women feel 'judged and stigmatised, and less able to have their legitimate health care needs met'.<sup>121</sup>

4.75 A number of respondents, including Children by Choice, medical practitioners, the Australian Women's Health Network and AMA Queensland, submitted specifically that it would be appropriate to require a health practitioner who has a conscientious objection to termination of pregnancy to refer a woman to another practitioner who does not have a conscientious objection.<sup>122</sup> Some respondents, including a general practitioner, the Australian Psychological Society Limited and Australian Human Rights, submitted (to similar effect) that the draft legislation should adopt the approach taken in Victoria.<sup>123</sup> It was submitted that the Victorian approach achieves the correct balance in protecting the rights of women and practitioners, and ensures that objecting practitioners are not discriminated against whilst allowing women to access necessary health services.<sup>124</sup>

4.76 Some respondents expressed general support for referral to another practitioner.<sup>125</sup> Some suggested more specifically that, if a practitioner is required to refer a woman to another practitioner, that referral should be to a medical practitioner,<sup>126</sup> or to another health practitioner.<sup>127</sup> Some respondents supported a requirement to refer a woman to an appropriate 'service' or a 'health service that

<sup>121</sup> Submission 118. Also eg, Submission 487.

<sup>122</sup> Eg, Submissions 4, 50, 89, 118, 164, 344, 349, 387, 405, 406, 419, 438, 469, 482, 487, 500, 542, 546, 547, 571, 572, 583, 590, 630, 632, 642, 649, 662, 712, 717, 720, 734, 863, 872, 885, 888. Some of these respondents also expressed support for referral to a service: eg, Submission 590 and see also [4.76] below.

<sup>123</sup> Eg, Submissions 118, 486, 577, 583, 590, 734. The Australian Psychological Society Limited also suggested that this requirement should apply to counsellors: Submission 118, see [4.53] above.

<sup>124</sup> Eg, Submissions 577, 583, 590. However, one respondent observed that, in practice, there were still complaints of medical practitioners attempting to coerce women despite law reform: Submission 577. Women's Health Victoria observed that it is not known in practice whether objecting practitioners are complying with the requirement to inform and refer in the Victorian legislation: Submission 592.

<sup>125</sup> Eg, Submissions 302, 375, 421, 422, 600.

<sup>126</sup> Eg, Submissions 138, 244, 349, 419, 482, 529, 712, 863, 885.

<sup>127</sup> Eg, Submissions 118, 284, 438, 546, 674.

offers abortion'.<sup>128</sup> Health Consumers Queensland Ltd. suggested that referral could be to 'an appropriate, named service provider'.<sup>129</sup>

4.77 Several respondents, including Australian and international academics, suggested that a referral or direction should be to a practitioner or service who would or could provide the services sought by the woman. For example, respondents suggested referral should be to a practitioner who 'will provide' the requested service, 'another willing practitioner', 'a practitioner or service that will be able to meet [the woman's] needs', or 'another practitioner who can safely perform the procedure'.<sup>130</sup>

4.78 It was submitted that a referral should be promptly provided, with some respondents suggesting that it occur 'in a timely manner, without discrimination or delay'.<sup>131</sup> It was also submitted that the referral should be to a practitioner who is geographically proximate to the woman.<sup>132</sup>

4.79 The Women's Abortion Rights Campaign Brisbane suggested that an objecting practitioner should be obliged to 'direct' a woman to another practitioner who will not refuse to provide care, or should 'refer' the woman to that practitioner if a referral is required. It was also suggested that the direction or referral should be 'facilitated' by the objecting practitioner, to minimise any burden on the woman.<sup>133</sup>

4.80 The former Health Services Commissioner, Victoria addressed the use of the word 'referral' in the Victorian legislation, stating that:<sup>134</sup>

some ... activists have [politicised] this section and have provided incorrect information to the effect that doctors who do not want to perform an abortion must refer the women elsewhere for an abortion. This is not the case. The legislation requires the practitioner to refer the woman to another practitioner who does not have such an objection. What happens then is between the woman and the practitioner in accordance with accepted standards of practice.

4.81 On the same point, the Australian Women's Health Network stated that:<sup>135</sup>

The referral stipulated by the [Victorian legislation] is to another health practitioner in the same profession—it is not a direct referral to an abortion service provider. A woman may or may not go on to terminate her pregnancy—the referring doctor cannot reasonably be understood to be a party to, or complicit

<sup>128</sup> Eg, Submissions 341, 422, 438, 542, 546, 590, 669, 674, 754, 863. Most of these respondents supported referral to either a practitioner or a service.

A few respondents suggested that it might be useful if objecting practitioners could access information about other available practitioners or services: eg, Submissions 637, 863.

<sup>129</sup> Submission 119. This respondent and the Atheist Foundation of Australia also suggested that the woman should be referred to patient travel subsidy services, if required. Submissions 119, 642.

<sup>130</sup> Submissions 405, 445, 452, 561, 782.

<sup>131</sup> Eg, Submissions 50, 89, 164, 172, 387, 405, 422, 445, 452, 469, 514, 542, 546, 571, 583, 590, 621, 630, 632, 637, 642, 674, 707, 712, 720, 734, 863.

<sup>132</sup> Eg, Submissions 422, 445, 673, 688, 720, 797.

<sup>133</sup> Submissions 406, 547.

<sup>134</sup> Submission 577. See also Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.4].

<sup>135</sup> Submission 590.

in, a subsequent decision that is the sole province of the patient's subsequent exercise of autonomy in consultation with a referral doctor. The purpose of section 8 [of the *Abortion Law Reform Act 2008 (Vic)*] is to ensure that women receive timely, accurate information from a professional who does not hold an objection to the health service she seeks.

4.82 A few respondents supported a requirement to inform and refer in limited circumstances; for example, emergency, rape, or lack of an alternative practitioner within a reasonable geographic proximity.<sup>136</sup> The Royal Australasian College of Medical Administrators suggested that referral and support to access an alternative provider should be offered if the objecting practitioner is in a location where there is not ready access to alternative providers.<sup>137</sup>

4.83 Other respondents considered that an objecting practitioner should inform a woman of their objection and provide assistance, but did not consider that referral to another practitioner or service should be, or is necessary to be, required. Some suggested that an objecting practitioner could be required to provide a woman with information about obtaining services elsewhere, or to refer a woman to another service that provides information about options for unplanned pregnancy.<sup>138</sup>

4.84 A specialist obstetrician and gynaecologist submitted that:<sup>139</sup>

if a doctor with conscientious objections is consulted by a woman requesting an abortion he/she has an obligation to inform the woman of his/her beliefs, and to make an *effective* referral. The referral does not need to be to a doctor or service performing abortion but can be to a service such as Queensland Family Planning (True Relationships) or Children by Choice, who will provide the woman with information about all her options for an unplanned/unwanted pregnancy, and where to seek help for these. (emphasis in original)

4.85 A group of health law academics preferred a requirement of referral to an equivalent practitioner who does not object, as this is 'a better model to ensure more timely and direct access to a qualified health practitioner who is known not to have a conscientious objection'.<sup>140</sup>

4.86 Many other respondents, including some medical practitioners, religious organisations, Cherish Life Queensland Inc. and the Unborn Children's advocacy

<sup>136</sup> Eg, Submissions 32, 584, 659, 732. Another respondent opposed referral even in these circumstances: Submission 97. An academic from the School of Law and Justice, University of Southern Queensland suggested more generally that an objection by a health practitioner to providing a referral should be reasonably accommodated, but if that is not possible then the women's interests must be prioritised and the practitioner must provide the referral: Submission 351.

<sup>137</sup> Submission 584.

<sup>138</sup> Eg, Submissions 27, 220, 466, 510. One respondent expressed support for the approach taken in Tasmanian legislation: Submission 863.

Some respondents suggested, in addition or as an alternative to a requirement to inform and refer, referral to counselling or support services: eg, Submissions 31, 138, 578, 650, 765.

Other respondents submitted that there should be no obligation, but that referral could be 'recommended' to practitioners, or occur at a practitioner's discretion: eg, Submissions 517, 661, 690.

<sup>139</sup> Submission 220.

<sup>140</sup> Submission 572.

Network, opposed a legislative requirement that an objecting practitioner refer or direct a woman to another practitioner or service.<sup>141</sup>

4.87 It was submitted that to fully recognise and allow for conscientious objection, there should not be a requirement to refer or direct a woman elsewhere.<sup>142</sup> Priceless House submitted that:<sup>143</sup>

A referral is the same as participating. A requirement that a health practitioner has an obligation to refer effectively removes their right to act in accordance with their conscience if they have a conscientious objection to abortion. Nobody should ever be forced to go against their own conscience.

4.88 Numerous respondents submitted that a requirement to refer or direct a woman elsewhere would breach the rights of objecting practitioners (particularly the right to freedom of conscience and religion) and fail to take into account their beliefs. It was observed that practitioners who object to termination would likely also object to referring a woman to another practitioner or service, and submitted that they should not be forced to act against their conscience or beliefs.<sup>144</sup>

4.89 The Roman Catholic Bishops of Queensland stated that:<sup>145</sup>

Compelling a medical practitioner with a conscientious objection to refer a patient to another practitioner who does not have an objection infringes articles 18(1) and (2) of the ICCPR. The objector is being coerced in a way that limits his or her rights; it does so by requiring the health practitioner to provide a referral for purposes to which he or she conscientiously objects on religious or moral grounds and where the health practitioner does not believe a referral is in the best interests of the woman or her child.

4.90 In relation to limitations on the rights of health practitioners, an academic from the School of Law, University of Notre Dame submitted that:<sup>146</sup>

International human rights law limits the manifestation of conscience where it is necessary to preserve public safety, health, morals or order or where it infringes others' rights or freedoms. This balancing act between the rights of the patient and the physician requires further study. That the Council of Europe and others have approved this model, is not justification for it to be applied in Australia. This 'one size fits all' rule is politically expedient, but collectivises the experiences of those affected and is not supported by data. (notes omitted)

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<sup>141</sup> Eg, Submissions 36, 53, 56, 66, 88, 97, 105, 111, 127, 143, 162, 194, 231, 233, 237, 248, 270, 278, 315A, 327, 334, 340, 376, 411, 413, 428, 430, 434, 444, 448, 455, 457, 495, 512, 515, 517, 533, 535, 543, 548, 557, 558, 565, 570, 575, 578, 589, 603, 609, 627, 634, 640, 650, 661, 678, 679, 690, 702, 703, 710, 715, 721, 731, 740, 743, 765, 766, 773, 788, 819, 834, 835, 836, 841, 842, 862.

Several respondents submitted that the approach taken in the Victorian legislation should not be followed: eg, Submissions 162, 340, 495, 841. Others opposed the Tasmanian approach: Submissions 340, 841.

<sup>142</sup> Eg, Submissions 278, 650, 678, 679, 702, 743, 766, 819, 836.

<sup>143</sup> Submission 836.

<sup>144</sup> Eg, Submissions 66, 88, 97, 111, 181, 197, 213, 248, 270, 273, 363, 394, 400, 413, 434, 444, 448, 495, 512, 575, 580, 589, 627, 635, 661, 678, 679, 705, 710, 715, 721, 727, 765, 766, 841, 874.

<sup>145</sup> Submission 448. However, this respondent observed that there is 'an obligation to ensure that the person continues to receive care, advice and assistance'.

<sup>146</sup> Submission 494.

4.91 Another academic from the School of Law, University of Notre Dame submitted that:<sup>147</sup>

A health professional with a conscientious objection who is asked by a patient to perform or refer for abortion should be able to advise that as they have a conscientious objection they do not perform or provide referrals for the procedure. Considering that a health professional who would be willing to perform the procedure could be easily located through other means, it is reasonable to accommodate the conscientious objection that health professionals have to giving referrals for procedures that involve the termination of pregnancy.

4.92 Some respondents also submitted that a requirement to refer or direct a woman elsewhere would have the effect of forcing a practitioner to be involved or cooperate in any subsequent termination, even if that practitioner is not directly responsible for performing the termination.<sup>148</sup> It was suggested that such a requirement would cause a practitioner to be or to feel 'complicit' in the termination, or amount to an endorsement of any subsequent termination.<sup>149</sup> It was also suggested that it might distress or impose an undue burden on health practitioners.<sup>150</sup>

4.93 Cherish Life Queensland Inc. submitted that a referral amounts to a recommendation that treatment should occur, and that a referring practitioner would consider they are complicit in the treatment:<sup>151</sup>

If abortion is totally against one's conscience, to be involved in it in even a minor way such as providing a referral is being complicit in the act. Not every doctor or other medical personnel will take their opposition this far, but for those who believe it is killing another human being; it is completely in accord with their understanding of their duty. ...

A referral is not simply a piece of paper. A doctor who conscientiously believes that abortion destroys another human being will feel bound not to refer on for an abortion as a referral is a recommendation that the procedure be done.

4.94 Another respondent held similar views about referral, stating that:<sup>152</sup>

It is a mark of respect and professional confidence in the other's abilities for a doctor to refer a patient to another practitioner, seeing as the second doctor is acting in lieu of the first. This entrusting of a patient's health and wellbeing is not taken lightly. To refer is to be implicit in the medical treatment that the patient will undergo as a result of that recommendation. If a doctor believes that a procedure is not in the best interests of his patient, or it is one to which he has a conscientious objection, he or she should not be forced to become a part of the process by ensuring that another doctor carries out the procedure in which he or she does not wish to be involved, or does not consider in their professional opinion to be appropriate for the patient's condition.

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147 Submission 721.

148 Eg, Submissions 127, 413, 495, 512, 570, 627, 765.

149 Eg, Submissions 334, 340, 411, 413, 512, 578, 589, 661, 702, 819, 841, 842.

150 Eg, Submissions 494, 535.

151 Submission 819.

152 Submission 842.

4.95 A few respondents observed that some practitioners may believe a termination is not in a patient's best interests and submitted that in those circumstances, because a referral is intended to further a patient's care, it would be inappropriate to refer a woman elsewhere for a termination.<sup>153</sup>

4.96 Respondents also observed that a practitioner's objection does not prevent a woman from seeking a termination or advice about a termination elsewhere, and that referral to a practitioner or service is generally not required. It was submitted that it is the woman's choice or responsibility to locate alternative care, and that it would generally not be difficult for a woman to locate an alternative practitioner or service.<sup>154</sup>

### **Circumstances in which a conscientious objection should not apply**

4.97 Respondents held mixed views about whether there are any circumstances in which provision for conscientious objection should not apply.

4.98 Some respondents expressed the view that there are circumstances, most commonly emergency situations, in which a person's conscientious objection should not apply. It was observed that access is important, with one respondent stating that:<sup>155</sup>

safeguards must be put in place to ensure that recognising a right of conscientious objection does not have the consequence in practice that women are denied adequate access to abortion services and other necessary reproductive health care.

4.99 Other respondents expressed the view that there should not be any circumstances in which a person's conscientious objection would not apply, or where a person is required to take some action despite an objection.<sup>156</sup>

4.100 It was submitted that the inclusion of circumstances in which an objection does not apply would have the effect of removing or inadequately providing for conscientious objection, or would force practitioners to act against their conscience.<sup>157</sup> It was also submitted that this approach would not take into account an objecting practitioner's rights and beliefs, including human rights,<sup>158</sup> and may cause a practitioner to feel pressured or complicit in any resulting act.<sup>159</sup>

4.101 A few respondents supported a requirement to refer a woman elsewhere in particular circumstances.<sup>160</sup>

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<sup>153</sup> Eg, Submissions 248, 428, 634, 841, 842. Also eg, Submissions 237, 773, 819.

<sup>154</sup> Eg, Submissions 66, 111, 231, 411, 430, 434, 444, 565, 575, 603, 634, 661, 678, 721, 724, 773, 836, 862.

<sup>155</sup> Submission 438. Also Submission 429.

<sup>156</sup> Eg, Submissions 65, 75, 84, 86, 97, 105, 111, 127, 137, 140, 231, 234, 237, 248, 270, 334, 430, 434, 444, 448, 457, 468, 508, 512, 515, 535, 554, 558, 575, 578, 589, 661, 679, 721, 766, 773, 862.

<sup>157</sup> Eg, Submissions 127, 270, 334, 515, 554, 721.

<sup>158</sup> Eg, Submissions 84, 88, 127, 334, 413, 448, 558, 578, 589, 661, 679, 766, 862.

<sup>159</sup> Eg, Submissions 494, 508, 578.

<sup>160</sup> See [4.82] above and [4.135] below.

## Emergency

4.102 Numerous respondents, including health practitioners, RANZCOG, legal academics and support and advocacy organisations, submitted that any provision for conscientious objection should not apply in emergency situations.<sup>161</sup>

4.103 It was observed that, if provision for conscientious objection is able to apply in emergency situations, this would directly impact on the health of women<sup>162</sup> or be a barrier to accessing safe termination services.<sup>163</sup> Respondents submitted that a pregnant woman's life, or safety and well-being, should be prioritised over the beliefs of an objecting practitioner.<sup>164</sup>

4.104 AMA Queensland and RANZCOG expressed support for the AMA's position regarding conscientious objection in an emergency, which specifies that medical practitioners should provide treatment in an emergency even if it conflicts with their personal beliefs and values. Fair Agenda observed that an exception in emergency situations would be consistent with the AMA's position.<sup>165</sup>

4.105 The QLS observed that the guidelines in codes of conduct and ethical standards:<sup>166</sup>

may place special requirements on health practitioners in circumstances of emergencies and locations with access to a limited number of health care providers who are qualified to perform terminations to ensure that the doctor's first duty of best patient care is paramount. Whether this can be truly effective in the interpretation of various guidelines should be very carefully considered and it may require legislative clarification to set consistent benchmarks.

4.106 Some respondents, including The Royal Australian and New Zealand College of Psychiatrists–Queensland Branch, the Human Rights Law Centre Ltd, and a legal academic, suggested that an emergency exception would reasonably balance or accommodate the rights of health practitioners to freedom of conscience and the rights of women, particularly their rights to health and timely access to health care services.<sup>167</sup>

<sup>161</sup> Eg, Submissions 18, 20, 21, 26, 35, 42, 45, 50, 53, 55, 59, 60, 61, 63, 67, 70, 71, 73, 74, 89, 101, 118, 119, 164, 172, 220, 244, 276, 315A, 341, 344, 349, 351, 387, 405, 406, 419, 422, 429, 445, 452, 454, 469, 482, 487, 510, 514, 526, 542, 543, 546, 547, 562, 571, 572, 577, 583, 590, 600, 604, 629, 630, 632, 637, 642, 649, 669, 671, 673, 702, 707, 712, 717, 720, 734, 754, 765, 782, 810, 836, 842, 863, 872, 888.

The Metro North Hospital and Health Service stated that 'the law should provide clarity for situations where a health care provider may have a conscientious objection to a procedure but at the same time has a duty of care to the patient who needs acute and critical care during or following the procedure': Submission 882.

<sup>162</sup> Eg, Submission 18.

<sup>163</sup> Eg, Submissions 669, 734.

<sup>164</sup> Eg, Submissions 50, 89, 118, 164, 419, 422, 452, 469, 571, 630, 632, 673, 707, 712, 720, 754. Other respondents stated that the pregnant woman's life must be prioritised over that of the unborn fetus: Submissions 649, 872.

<sup>165</sup> Submissions 482, 542, 885. Also eg, Submission 810 and see also [4.8] above.

<sup>166</sup> Submission 879.

<sup>167</sup> Eg, Submissions 341, 351, 734, 888. As to Submission 351, see also [4.122] below.

4.107 The Australian Psychological Society Limited and Australian Lawyers for Human Rights submitted that the draft legislation in Queensland should take a similar approach to the legislation in Victoria, which provides generally that a doctor or nurse has a duty to perform or assist in performing a termination in an emergency, if it is necessary to preserve a pregnant woman's life.<sup>168</sup> Australian Lawyers for Human Rights submitted that this approach appropriately balances the rights of objecting professionals with the rights of women to health and bodily autonomy.<sup>169</sup>

4.108 The Human Rights Law Centre Ltd submitted more generally that a duty to perform or assist in a termination in an emergency should be imposed on practitioners.<sup>170</sup> A specialist obstetrician and gynaecologist and a group of health law academics submitted that medical practitioners and nurses should be 'required' or 'obliged' to perform or assist in performing a termination in emergency circumstances.<sup>171</sup>

4.109 However, AMA Queensland cautioned that not all registered medical practitioners possess the skills and training to perform a termination. They observed that the Victorian approach might have the effect that a practitioner is exposed to liability for not performing a procedure for which they are not trained, or that is outside their scope of practice. AMA Queensland recommended that:<sup>172</sup>

any potential legislation should reflect that despite any conscientious objection to abortion, only a registered medical practitioner who has the necessary skills and training to safely perform a termination of pregnancy is under a duty to do so. If they do not have these skills or training, in an emergency they should be obligated to urgently refer or otherwise assist the patient to a registered medical practitioner who has these skills and training, where the termination is necessary to preserve the life of the pregnant woman.

4.110 Respondents had differing views about the scope of any provision for emergencies. Some respondents submitted that provision for conscientious objection should not apply only where a woman's life is at risk, with some clarifying that the risk should be 'serious' or 'immediate'.<sup>173</sup> Others considered that this should also extend to circumstances involving risk to the woman's physical and/or mental health.<sup>174</sup>

4.111 An academic from the School of Law, University of Notre Dame observed that '[w]hilst an imminent threat to life is a clinical judgment, based on objective facts,

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168 Eg, Submissions 118, 583. Support was also expressed for the Tasmanian provision, as it pertains to preserving a woman's life: Submission 429.

169 Submission 583.

170 Submission 888. Specifically, it was suggested that there should be a duty to perform or assist in cases of medical emergency, where necessary to save a woman's life or prevent serious physical harm. RANZCOG also referred to a duty to perform in similar circumstances, but did not suggest a specific provision: Submission 482.

171 Submissions 220, 572, 583.

172 Submission 885.

173 Eg, Submissions 26, 42, 55, 118, 119, 220, 341, 351, 406, 429, 445, 482, 526, 543, 547, 572, 583, 600, 642, 671, 702, 707, 717, 782, 836, 842, 888.

174 Eg, Submissions 26, 119, 341, 351, 406, 445, 482, 526, 547, 572, 583, 642, 707, 888.

preserving [a woman's] physical or mental health involves subjective factors and is open to interpretation'.<sup>175</sup>

4.112 Several respondents submitted that an emergency would arise in only limited or rare circumstances.<sup>176</sup> Some observed that it should be left to the health practitioner caring for the woman to determine if the particular circumstances constitute an emergency.<sup>177</sup>

4.113 A few respondents specified that any exception to conscientious objection pertaining to emergency circumstances should apply only where there is no equivalent practitioner to act in the place of the objecting practitioner.<sup>178</sup>

4.114 Other respondents, including members of the public, medical practitioners, and the Unborn Children's advocacy Network, submitted that the application of the conscientious objection provision should not be limited or excluded in emergency circumstances.<sup>179</sup> A few respondents expressed the view that, even in an emergency, a practitioner should not be required to participate in or facilitate a termination against their conscience.<sup>180</sup>

4.115 Several respondents explained that, in their view, this approach would not adequately consider a health practitioner's beliefs and right to object, or would force practitioners to act against their conscience.<sup>181</sup> Others observed that it could place 'pressure' on an objecting practitioner.<sup>182</sup> An academic from the School of Law, University of Notre Dame submitted that:<sup>183</sup>

A law or policy that requires a health professional to perform or assist with [a termination], even in circumstances where the woman's life is endangered,

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<sup>175</sup> Submission 494. It was stated that, for example, it is unclear whether living in a remote area could be interpreted to satisfy this requirement.

It has been suggested that an exception for emergency circumstances (particularly one that extended to a woman's health) might involve 'ambiguity' or be 'open to interpretation, and ... liable to being progressively broadened over time': Parliamentary Committee Report No 33a (2017) [6.4.3], citing Submission 863 to the Parliamentary Committee on the second Bill.

The Castan Centre for Human Rights Law stated that '[i]t 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': Submission 276, citing C Fiala and JH Arthur, 'Dishonourable Disobedience—Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman—Psychosomatic Gynaecology and Obstetrics* 12, 14.

<sup>176</sup> Eg, Submissions 49, 220, 233, 237, 411, 413, 428, 491, 671, 717. Some (but not all) of these respondents expressed opposition to an exception on the ground of emergency.

<sup>177</sup> Eg, Submissions 53, 576.

<sup>178</sup> Eg, Submissions 55, 233. Also eg, Submissions 244, 406, 547, 797, 836. The Women's Abortion Rights Campaign Brisbane submitted that '[t]he right to refuse care should not apply where the woman's health or life would be at risk from the delay of referral to another provider': Submission 406, see also Submission 547.

<sup>179</sup> Eg, Submissions 4, 56, 66, 105, 127, 140, 194, 237, 248, 334, 340, 428, 430, 434, 444, 448, 457, 468, 508, 512, 515, 517, 528, 535, 548, 554, 558, 565, 575, 578, 589, 603, 640, 650, 661, 678, 715, 721, 731, 732, 835.

<sup>180</sup> Eg, Submissions 237, 589.

<sup>181</sup> Eg, Submissions 66, 127, 334, 448, 512, 515, 558, 565, 578, 603, 650, 715, 721, 819. Also eg, Submissions 589, 661.

<sup>182</sup> Eg, Submissions 512, 565, 578.

<sup>183</sup> Submission 721.

involves requiring them to participate in a procedure that many conscientious objectors understand involves killing a child. A law or policy that requires a person to engage in conduct that they understand involves killing one person in order to save the life or health of another is unacceptable especially when other health professionals can be made available who do not have a conscientious objection.

4.116 Some respondents observed that an emergency termination is uncommon.<sup>184</sup> A few respondents submitted that, regardless of the circumstances, there will always be some ‘uncertainty’ and people ‘must not be forced to play God and choose who dies’.<sup>185</sup> Another respondent stated that ‘[a]ny argument centred around a medical practitioner’s obligation to preserve life would be spurious, given that the unborn child is being killed’.<sup>186</sup>

4.117 Some respondents observed generally that in the case of an emergency, and particularly where a woman’s life is at risk, an objecting practitioner would give priority to the woman’s life and health and provide necessary treatment.<sup>187</sup> It was also submitted that, in instances where, without a termination, both the woman and unborn child would not survive, conscientious objection is not raised and ethical issues do not preclude a doctor from providing treatment.<sup>188</sup> It was suggested that, on this basis, an exception for emergency circumstances may not be required.<sup>189</sup>

### ***Geographic proximity***

4.118 A number of respondents, including members of the public, health practitioners, legal academics and the Australian Association of Social Workers (Qld), submitted that any provision for conscientious objection should not apply in the absence of an alternative practitioner or termination of pregnancy service within a reasonable geographic proximity.<sup>190</sup> A few respondents submitted more broadly that there may be no accessible alternative due to geographic, financial, logistical or confidentiality-related considerations.<sup>191</sup>

4.119 It was observed by respondents that, in regional and remote settings, conscientious objection might operate as a barrier to accessing termination

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184 Eg, Submissions 237, 413, 428. Cherish Life Queensland Inc. observed that, where a pregnant woman’s life is endangered, this might be able to be handled in a way that does not involve terminating the pregnancy. They stated that ‘the choice between the mother and the child’s life is hardly ever necessary, so it would seem unnecessary to make a law to cover the rare cases’: Submission 819.

185 Submissions 434, 444, 575.

186 Submission 528.

187 Eg, Submissions 138, 457, 466, 548, 634.

188 Eg, Submission 841.

189 Eg, Submission 841. Other respondents suggested that objecting practitioners should follow existing procedures for situations in which there is an ethical issue, or that emergency situations may already be addressed by the current law: eg, Submissions 743, 750.

190 Eg, Submissions 18, 21, 26, 45, 59, 60, 61, 63, 67, 70, 71, 73, 74, 101, 315A, 351, 405, 406, 445, 454, 510, 514, 526, 546, 547, 585, 604, 629, 637, 669, 712, 720, 797.

191 Eg, Submissions 351, 514.

services,<sup>192</sup> even if there were a requirement to refer the woman elsewhere.<sup>193</sup> It was submitted that enabling access to safe and affordable termination services (including when there is no alternative service within a reasonable geographic proximity) should override any refusal of care based upon conscientious objection.<sup>194</sup>

4.120 Another respondent stated that:<sup>195</sup>

All Australians should have the same access to healthcare and allowing conscientious objection in remote settings and other such instances in which there are limited resources and professionals available would prevent equitable access to necessary health resources.

4.121 It was also submitted that conscientious objection should not apply where a delay in access could place the woman's health or life at risk.<sup>196</sup>

4.122 An academic from the School of Law and Justice, University of Southern Queensland observed that it is not always possible to reconcile and accommodate competing interests and submitted that, where this is not possible, the interests of a patient must be prioritised:<sup>197</sup>

There are some circumstances where the religious beliefs of some health practitioners that abortion is immoral cannot be reasonably accommodated. These circumstances include situations where there is a medical emergency threatening the life or health of the woman, or where there is no reasonably accessible alternative to the health practitioner (geographically, financially, or logistically).

In situations where reasonable accommodation is not possible, health practitioners must put the interests of their patients ahead of their personal moral and religious beliefs and take part in the abortion procedures. In these situations, the provision for conscientious objection should not apply.

4.123 As previously noted, the QLS observed, in relation to guidelines in codes of conduct and ethical standards, that legislative clarification might be required to achieve consistency.<sup>198</sup>

4.124 One respondent suggested specifically that provision for conscientious objection should not apply where there is no alternative within a stated distance, such

<sup>192</sup> Eg, Submissions 21, 445, 669, 882, 888.

<sup>193</sup> Eg, Submission 276. This respondent observed that an obligation to refer may be 'of little practical utility should a woman not be in a position to travel'.

<sup>194</sup> Eg, Submissions 344, 445, 669.

<sup>195</sup> Submission 18.

<sup>196</sup> Eg, Submissions 406, 547.

One respondent, the former Health Services Commissioner, Victoria, submitted that provision for conscientious objection should not apply in an emergency, and that the term 'emergency' should include the situation that there is no other practitioner or service within a reasonable geographic proximity: Submission 577. An academic from the School of Law, University of Notre Dame queried whether living in a remote area could be interpreted as a situation in which termination is necessary to preserve life, or physical or mental health: Submission 494.

<sup>197</sup> Submission 351. Cf Submission 494 at [4.90] above.

<sup>198</sup> Submission 879 at [4.105] above.

as 100 kilometres.<sup>199</sup> Others suggested more generally that the provision should not apply where there is no 'geographically proximate practitioner',<sup>200</sup> where there is no 'reasonably accessible alternative',<sup>201</sup> or where geographic distance prevents timely access to services.<sup>202</sup>

4.125 One respondent considered that provision for conscientious objection should not apply in the absence of an alternative practitioner or service, but observed that, in some instances, other options such as telemedicine might provide a simple and safe alternative.<sup>203</sup> Similarly, another respondent suggested that conscientious objection should be limited where there is no alternative pathway.<sup>204</sup>

4.126 Other respondents, including health practitioners, religious organisations and support and advocacy groups, did not support the limitation or exclusion of conscientious objection where there is no alternative practitioner or service within a reasonable geographic proximity.<sup>205</sup>

4.127 Some respondents considered that the absence of a proximate alternative is not a sufficient ground on which to override a health practitioner's conscientious objection.<sup>206</sup> Others observed that it could place 'pressure' on an objecting practitioner.<sup>207</sup>

4.128 Respondents also considered that requiring an objecting practitioner to act in the absence of any alternative would not give adequate consideration to a health practitioner's rights and beliefs, or would force practitioners to act against their conscience.<sup>208</sup> A member of the public observed that '[m]edical practitioners in rural areas have equal rights to conscientious objection'.<sup>209</sup>

4.129 It was also submitted that it is not uncommon for people residing in rural areas to be required to travel or consider other options to access more significant medical care,<sup>210</sup> and one respondent stated that '[i]t is not reasonable to expect a medical practitioner to act grossly outside of their conscience to make the

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199 Submission 21.

200 Submission 445.

201 Submission 351. Similar suggestions were made in Submissions 546, 797.

202 Eg, Submission 26. The Women's Abortion Rights Campaign Brisbane submitted that care should not be refused if there is a risk to the woman's life or health arising from the delay of being referred to another provider: Submission 406.

203 Submission 454.

204 Submission 438.

205 Eg, Submissions 4, 42, 50, 56, 66, 89, 97, 105, 119, 127, 138, 140, 164, 172, 194, 248, 278, 327, 334, 340, 419, 428, 430, 434, 444, 448, 457, 468, 469, 508, 512, 515, 517, 528, 535, 543, 548, 554, 565, 571, 575, 578, 587, 589, 590, 603, 605, 630, 632, 640, 650, 661, 673, 678, 703, 713, 715, 721, 731, 732, 819, 835, 842.

206 Eg, Submissions 430, 678, 703.

207 Eg, Submissions 512, 565, 578.

208 Eg, Submissions 66, 270, 327, 334, 448, 512, 515, 558, 565, 578, 589, 627, 650, 661, 703, 715, 721.

209 Submission 327.

210 Eg, Submissions 270, 411, 428, 678.

procurement of an abortion more convenient for another person'.<sup>211</sup> However, other respondents observed that some women may not be in a position to travel.<sup>212</sup>

4.130 Several respondents suggested that alternative solutions could be considered.<sup>213</sup> Some expressed concern that if practitioners were forced to provide services, this may be a disincentive to doctors otherwise willing to work in remote areas.<sup>214</sup> Respondents suggested that alternatives might include transporting women to services or reimbursing their travel costs,<sup>215</sup> or that options such as telemedicine receive greater support.<sup>216</sup>

4.131 Several respondents submitted that 'health services should ensure that their patients' access to lawful procedures is not limited or removed due to conscientious objection' and that 'these matters are best dealt with using policies and clinical guidelines'.<sup>217</sup> The National Alliance of Abortion and Pregnancy Options Counsellors stated that:<sup>218</sup>

In non-emergency situations, including those where geographic isolation is a barrier to abortion access, NAAPOC believes it is incumbent upon Queensland Health, and Hospital and Health Services, to develop guidelines to facilitate abortion access so that the actions of a conscientious objector do not otherwise delay or prevent a woman or pregnant person from accessing their lawful reproductive choice of termination of pregnancy. For example, developing clear and timely referral pathways between hospitals and Hospital and Health Services, and establishing public-private partnerships between hospitals and private termination of pregnancy clinics.

4.132 The Institute for Urban Indigenous Health Ltd supported the use of policies and guidelines relating to access to services, however also observed that it is necessary to ensure that Aboriginal and Torres Strait Islander women do not experience unfair and inequitable barriers to accessing reproductive services.<sup>219</sup>

4.133 Some respondents considered the role of public health services. Sustainable Population Australia Inc. (Queensland Branch) stated that '[p]ublic hospitals and clinics should not be permitted to refuse treatment, where there is no readily accessible alternative service. It is their responsibility to ensure that staffing enables abortion access'.<sup>220</sup> Academics from the Faculty of Law, Bond University

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211 Submission 678.

212 Eg, Submissions 276.

213 Eg, Submissions 50, 89, 119, 138, 164, 172, 419, 422, 438, 452, 469, 571, 590, 630, 632, 673, 690, 707, 713.

214 Eg, Submissions 690, 819, 842.

215 Eg, Submission 119, 138, 690. Another respondent also suggested, more generally, that Queensland Health should facilitate access: Submission 172.

216 Eg, Submissions 438, 454.

217 Eg, Submissions 50, 89, 164, 422, 438, 452, 469, 487, 500, 571, 590, 630, 632, 673, 707, 712, 713.

218 Submission 487.

219 Submission 707.

220 Submission 500. The Metro North Hospital and Health Service made a similar point: Submission 882.

explained that support from public health services is important to ensure equality of access, and is a way of ensuring access for women in regional or remote areas.<sup>221</sup>

4.134 Some respondents suggested (in relation to rural or remote areas, but also more generally) that hospitals should ensure adequate staffing for terminations, or that health service districts should provide accessible termination services.<sup>222</sup> Similarly, it was submitted that practitioners should not be able to refuse to undertake training in termination of pregnancy, as lack of education could place people at risk.<sup>223</sup>

4.135 Several respondents observed that a referral requirement may assist.<sup>224</sup>

### Consequences of non-compliance

4.136 Some respondents suggested that legislative provision for conscientious objection should impose a penalty for some behaviours. For example, it was suggested that practitioners should be prohibited from or penalised for unsolicited expressions of their religious or personal views, attempting to coerce, influence or dissuade a woman contemplating a termination on the basis of their personal views, intimidating, obstructing or being disrespectful to a woman, or refusing to refer a woman elsewhere.<sup>225</sup>

4.137 Other respondents submitted that practitioners should not be penalised for refusing to be involved in or facilitate a termination,<sup>226</sup> or more generally protected from repercussions or legal action.<sup>227</sup>

4.138 A number of respondents, including support and advocacy organisations, also suggested that practitioners who have a conscientious objection to termination should be required to publicly disclose or advertise to their patients their position, for example by signage or on their website, or to have this noted on their registration.<sup>228</sup> It was submitted that this will ‘allow them to practice as they chose while at the same time prioritising women’s right to timely and supportive information and care’, and

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221 Submission 445.

222 Eg, Submissions 139, 220, 882.

223 Eg, Submission 526.

224 Eg, Submissions 419, 452, 642, 888. Several respondents submitted that the second practitioner should be ‘reasonably close by, so that the patient would not be burdened unnecessarily’ or, more generally, should be accessible: eg, Submissions 673, 797.

Fair Agenda stated that ‘health services and providers should ensure that their patients’ access to, and knowledge of their ability to access, lawful procedures is not limited or removed due to conscientious objection’: Submission 542. Young Queenslanders for the Right to Choose stated that a practitioner should ensure a patient is not completely unable to access services and has another available option, suggesting that this could be achieved through referral, or by medical and clinical guidelines: Submission 419.

225 Eg, Submission 18, 172, 421, 529, 674. Also eg, Submissions 116, 514, 820.

226 Eg, Submissions 48, 102, 138, 237, 375, 428, 722.

227 Eg, Submissions 234, 477, 505, 551. Also eg, Submission 140.

228 Eg, Submissions 20, 50, 89, 164, 421, 469, 487, 514, 542, 571, 577, 590, 629, 630, 632, 673, 712, 754. Some respondents also suggested that practitioners should be required to advise their employer (or potential employer) of their objection: eg, Submissions 20, 510. As to public disclosure, see also Parliamentary Committee Report No 33a (2017) [6.4.5].

would enable women to ‘make informed choices regarding the services they access’.<sup>229</sup>

## CONCLUSION

### Legislating for conscientious objection to termination

4.139 The Commission recommends that the draft legislation deal with the consequences of a health practitioner’s conscientious objection to termination.

4.140 The recommended conscientious objection provision recognises that health practitioners have, and may exercise, the right to freedom of thought, conscience and religion, but balances that right against the rights of women, particularly the right to health, including sexual and reproductive health and autonomy.

4.141 The Commission recommends a similar approach to that taken in Victoria and the Northern Territory. The inclusion of a positive requirement for an objecting health practitioner to inform and refer or transfer the care of a woman to another practitioner or provider who does not have a conscientious objection will facilitate the woman’s access to termination services.<sup>230</sup> It may reduce barriers to access, including for women who live in a rural, regional or remote area or are from a culturally and linguistically diverse background.

4.142 The Commission’s recommended approach is generally consistent with the clinical guideline in Queensland, and with the codes of conduct and guidelines that apply to registered health practitioners.<sup>231</sup> For example, the AMA requires objecting medical practitioners to take ‘whatever steps are necessary’ to ensure that a patient’s access to care is not impeded, and to provide treatment in an emergency.<sup>232</sup> RANZCOG states that there is a ‘professional responsibility to inform patients where and how abortion services can be obtained’.<sup>233</sup>

229 Eg, Submissions 50, 89, 164, 469, 487, 542, 590, 629, 630, 632, 712, 754.

230 See the discussion of ‘Accessibility and availability’ in Chapter 2 and of ‘Access to health services, including abortion services’ in Appendix C.

231 See generally [4.8]–[4.10] above.

232 AMA, *Position Statement: Conscientious Objection* (2013) [6]. See also AMA, *Code of Ethics* (2016) [2.1.13]; FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women’s Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015), 38–9.

Nurses and midwives are required to inform a person of their objection and ‘ensure the person has alternative care options’: Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Nursing and Midwifery Board of Australia, *Code of Conduct for Midwives* (March 2018) [4.4](b).

233 RANZCOG, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016) [4.6]. RANZCOG also states generally that a practitioner should arrange ongoing care with another suitable practitioner if the therapy required by a patient conflicts with the doctor’s belief or value system, and that a practitioner who wishes to discontinue care must make an appropriate referral and communicate relevant information (with consent) to the new practitioner: RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) [2.6].

## Scope of the conscientious objection provision

4.143 The conscientious objection provision in the draft legislation should apply to registered health practitioners. This is consistent with the application of the other provisions of the draft legislation to medical and other health practitioners.<sup>234</sup>

4.144 Non-compliance by a practitioner may be dealt with under the regulatory framework for registered health practitioners.<sup>235</sup>

4.145 The conscientious objection provision should apply to a registered health practitioner who is asked by a person to perform or assist in performing a termination, or to decide whether a termination should be performed on a woman who is more than 22 weeks pregnant.

4.146 It should also apply to a registered health practitioner who is requested to advise about the performance of a termination; for example, a general practitioner. This is necessary to ensure that the provision will apply to a registered health practitioner who may not be qualified to perform or assist in a termination, but who may be approached in the first instance by a woman seeking a termination. The inclusion of advice will ensure that a woman's initial attempts to access lawful termination are not impeded.

4.147 To minimise potential barriers to access, the conscientious objection provision should not extend to administrative, managerial or other tasks ancillary to the provision of termination services.

4.148 It should only apply in relation to a registered health practitioner's objection to performing the termination that is contemplated by a woman. Some practitioners may have a conscientious objection to termination in particular circumstances,<sup>236</sup> and should not be required to refer a woman elsewhere when those circumstances do not apply. That outcome may result in delays in access to services.

4.149 The conscientious objection provision should not apply to a counsellor who is not a registered health practitioner, or to others who are not directly involved in the provision of services; for example, administrative staff at a hospital. Given that these persons are not subject to regulation by national boards under the Health Practitioner Regulation National Law (Queensland), it would be difficult to monitor compliance and to impose consequences for non-compliance. If the provision applied more broadly, it might increase the likelihood of conscientious objection becoming a barrier to accessing services. The provision also should not extend to hospitals, institutions or services, as the right to freedom of thought, conscience and religion is a personal and individual right.

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234 See Rec 3-5 above.

235 See [4.174]–[4.176] below, and see generally Health Practitioner Regulation National Law (Queensland) pt 8; *Health Ombudsman Act 2013* (Qld).

236 For example, a practitioner may object to termination after a particular gestation.

## A requirement to inform and refer

4.150 The conscientious objection provision in the draft legislation should include a requirement to inform and refer. This approach balances the right to freedom of conscience with other individual rights, achieves consistency with current codes of conduct and guidelines, and assists in enabling access to services.<sup>237</sup>

4.151 This requirement should apply to a registered health practitioner who is asked to perform or assist in performing a termination, decide whether a termination should be performed after 22 weeks, or advise about the performance of a termination, if that practitioner has a conscientious objection to the performance of the contemplated termination. A request might be made by a woman considering a termination; for example, a woman may ask that a medical practitioner perform a termination. A request might also be made by a registered health practitioner to another practitioner; for example, a medical practitioner may ask for assistance from a nurse.

4.152 A registered health practitioner should be required to disclose their objection to the person who made the request. In the examples given above, disclosure would be required by the practitioner to the woman seeking a termination, and by the nurse to the medical practitioner seeking assistance in performing a termination.

4.153 If a woman requests a practitioner to perform a termination on her, or give her advice about performing a termination on her, the practitioner should be required to refer her elsewhere or transfer her care. Pursuant to the *Acts Interpretation Act 1954*, that would be required to be done ‘as soon as possible’.<sup>238</sup>

4.154 Some respondents have expressed significant concerns about the inclusion of a requirement to inform and refer. The Commission notes that health practitioners have the right to provide services according to their conscience and beliefs. Women also have the right to health and health care. There is a need to ensure that women’s access to lawful termination services is not impeded. The inclusion of a requirement to inform and refer or transfer care represents an appropriate limitation on the rights of health practitioners, which is necessary to adequately protect the rights of women.

4.155 This requirement to inform and refer or transfer care is generally consistent with codes of conduct and guidelines for health practitioners, which require a practitioner to offer information or alternatives, or to make a referral. It is also consistent with the Queensland clinical guideline.<sup>239</sup>

4.156 The requirement in the draft legislation should include two referral or transfer pathways. The first pathway should be referral or transfer of care to another registered health practitioner who, in the objecting practitioner’s belief, can provide the requested service and does not have a conscientious objection to the performance of the termination. If a woman requests that a termination be performed, a referral or transfer would generally be to a suitable registered medical practitioner;

<sup>237</sup> See also [4.140]–[4.142] above.

<sup>238</sup> See *Acts Interpretation Act 1954* (Qld) s 38(4), which provides that ‘[i]f no time is provided or allowed for doing anything, the thing is to be done as soon as possible, and as often as the relevant occasion happens’.

<sup>239</sup> See [4.21] above.

in some instances, such as a request for termination at a later gestation, the referral may be to a specialist medical practitioner. A request for advice about the performance of a termination might also be referred or transferred to another suitable practitioner.

4.157 The second pathway should be referral or transfer of care to a health service provider at which, in the objecting practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination. For example, a woman who requests a termination could be referred or transferred to a health service provider known to offer suitable termination services. A woman who requests advice about termination could also be referred or transferred to a service relevant to women's reproductive health, or to appropriate counselling.<sup>240</sup>

4.158 The result will be that a woman is referred or transferred to a practitioner (either directly or through referral to a health service provider) who can provide her with the requested service, ensuring that her attempts to access termination are not impeded in the first instance.

4.159 Some health practitioners may consider that referring a woman elsewhere or transferring her care would make them 'complicit' in any subsequent termination. A referral does not necessarily mean that a termination will take place, but enables a woman to access a practitioner who can offer her a range of options, including termination.<sup>241</sup>

4.160 The Commission is aware that the term 'refer' can have a particular meaning for health practitioners. For medical practitioners, 'referral' generally involves the partial transfer of responsibility for a patient's care for a defined time and particular purpose. Good medical practice involves ensuring that the second practitioner is qualified, and communicating sufficient information about the patient and the necessary treatment to enable their continuing care.<sup>242</sup>

4.161 The clinical guideline requires an objecting practitioner to ensure that there is an 'appropriate transfer of care'.<sup>243</sup> For example, objecting practitioners in some health services have an 'obligation of care' to ensure that there is 'handover' of a

<sup>240</sup> With respect to counselling, the referral would need to be to a counselling provider, or counselling service that employed a provider, who is a registered health practitioner.

<sup>241</sup> See generally Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.4]. Also eg, Evidence to the Parliamentary Committee, 1 August 2016, 49 (Dr A Klose, Queensland Baptists); Submissions 762, 773, 800 and 1216 to the Parliamentary Committee on the first Bill and Inquiry; Submissions 811, 1030 and 1040 to the Parliamentary Committee on the second Bill; A O'Rourke, L de Crespigny and A Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87, 107–8; and R Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An analysis of the conscientious objection to abortion and the "obligation to refer"' (2015) 22 *Journal of Law and Medicine* 900, 908–9. As to the intent of a referral Eg, Evidence to the Parliamentary Committee, 4 August 2016, 17 (Dr G Gardner); 28 October 2016, 29 (Prof M Permezel, President, RANZCOG).

The International Federation of Gynecology and Obstetrics has expressly stated that '[r]eferral for services does not constitute participation in any procedures agreed upon between patients and the practitioners to whom they are referred': FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (October 2015), 39.

<sup>242</sup> MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) [4.3].

<sup>243</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3].

patient to another staff member in the same discipline who can, without delay, take over the care of the patient.<sup>244</sup> Policies or requirements may vary between services.

4.162 The Commission has taken into account that some registered medical and health practitioners who object to termination are not comfortable with providing a referral of this nature to a woman seeking a termination, or transferring a woman's care elsewhere. The Commission also notes that in many instances such a referral or transfer is unlikely to be required because most terminations occur at an earlier gestation,<sup>245</sup> and many early terminations could be performed by a general practitioner or a health service provider.

4.163 The terms 'refer' and 'transfer of care' should not be defined. It will be for the objecting practitioner to determine how to appropriately refer a woman to another practitioner or service, and how and when to transfer a woman's care.

4.164 An example of a referral could be giving a woman enough information to contact an alternative practitioner or health service provider about obtaining the requested service (for example, their name and contact details), or providing a written referral to another medical practitioner (for example, an obstetrician).

4.165 Where it is not practicable for a woman to make the arrangements to see another doctor, it might be appropriate for an objecting practitioner to make the necessary arrangements on her behalf. For example, in a hospital, the woman's care could be transferred to another equivalent practitioner.

4.166 Whether to publicly identify as having a conscientious objection to termination (for example, by placing a sign at their premises or on their website), and how to locate a practitioner or service to which a woman can be referred or transferred, are matters for individual health practitioners.<sup>246</sup>

## **Circumstances in which conscientious objection does not apply**

### ***Emergency***

4.167 The draft legislation should generally recognise and accommodate the conscientious objection of a registered health practitioner, but should not exempt a practitioner from taking steps that might be required in emergency circumstances.

4.168 This approach achieves a balanced outcome, giving effect to the conscientious objection of registered health practitioners in the majority of instances

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<sup>244</sup> Information provided by Queensland Health, 23 February 2018.

<sup>245</sup> See the discussion of 'The incidence of terminations' in Queensland in Chapter 2.

<sup>246</sup> Policies and guidelines for some practitioners, including medical practitioners and nurses, require that an objecting practitioner inform their employer, or prospective employer, of their conscientious objection.

The AMA policy states that a practitioner should also discuss with their employer how they can practice in accordance with their beliefs, without compromising patient care or burdening colleagues. The Australian Nursing and Midwifery Federation policy states that practitioners have a responsibility to inform their employer at the time of accepting employment in a position where their objection may arise, and that people should 'give serious consideration to avoiding employment positions where they can foresee that a situation of conscientious objection may arise with relative frequency'. These policies also provide that a person should not be subject to discrimination or treated unfairly because of their conscientious objection. See AMA, *Position Statement: Conscientious Objection* (2013); Australian Nursing and Midwifery Federation, *Policy: Conscientious Objection* (November 2017).

but recognising that in an emergency it may be necessary for a practitioner to perform or assist in performing a termination despite their objection.

4.169 The draft legislation should adopt an approach similar to the South Australian legislation. This approach has the advantage of not affecting the performance of any existing obligations. The imposition of a positive duty to act in an emergency would be difficult to monitor and enforce, and would impose a duty that some doctors could not comply with, for example due to lack of training.

4.170 Accordingly, the draft legislation should provide that the conscientious objection provision does not limit any duty of a registered health practitioner to provide a service (including performing or assisting in performing a termination on a woman) in an emergency.

4.171 This provision should refer to 'emergency' circumstances, because an objecting practitioner could otherwise be required to act in serious, but non-urgent, circumstances.<sup>247</sup> The term 'emergency' should not be defined, as this is properly a matter for clinical practice. The South Australian approach of referring to specific circumstances, such as preserving a woman's life or health, could have the effect of limiting any other existing responsibility or obligation of registered health practitioners.

### ***Geographic proximity***

4.172 In Queensland, the accessibility of practitioners and services is likely to be different in different areas of the State. Women in rural, regional or remote areas may experience particular difficulties in accessing a practitioner or termination service, and in accessing an alternative if the first is unable to provide assistance due to conscientious objection or for another reason.

4.173 The lack of another practitioner or termination service within a reasonable geographic proximity is a service delivery and access issue, and a lack of alternatives where a practitioner has a conscientious objection represents only part of that issue. The draft legislation is not the most suitable means to deal with this matter. Other initiatives may assist in improving access to services.

### **Consequences of non-compliance**

4.174 As discussed in Chapter 3,<sup>248</sup> there are a range of professional and legal consequences that apply in relation to medical procedures. These include the potential for action to be taken under the regulatory framework governing registered medical and other health practitioners, and civil or criminal liability.

4.175 Consistently with its position about compliance with the requirements for a lawful termination under the draft legislation,<sup>249</sup> the Commission does not

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247 In non-urgent circumstances, a practitioner would be required to comply with the requirement to refer the woman elsewhere: see [4.150] ff above.

248 See the discussion of 'Consequences of non-compliance' in Chapter 3.

249 See Rec 3-6 above.

recommend a specific penalty for a registered health practitioner's failure to comply with the conscientious objection provision.

4.176 However, a failure to comply with the draft legislation may constitute behaviour for which action may be taken under the Health Practitioner Regulation National Law (Queensland) or the *Health Ombudsman Act 2013*. The Commission recommends that the draft legislation should provide that, in deciding an issue under those Acts about a registered health practitioner's professional conduct, regard may be had to whether the practitioner has complied with the conscientious objection provision.<sup>250</sup>

## RECOMMENDATIONS

### 4-1 The Termination of Pregnancy Bill should provide that:

- (a) a registered health practitioner who:
  - (i) is asked by a person to:
    - (A) perform a termination on a woman; or
    - (B) assist in the performance of a termination on a woman; or
    - (C) make a decision in accordance with the provision in Recommendation 3-2 above whether a termination should be performed on a woman; or
    - (D) advise the person about the performance of a termination on a woman; and
  - (ii) has a conscientious objection to the performance of the termination;
- (b) is required to:
  - (i) disclose their conscientious objection to the person; and
  - (ii) if the request was made by a woman for the practitioner to perform a termination on the woman, or to advise the woman about the performance of a termination on her, refer the woman, or transfer her care, to:

<sup>250</sup>

The provision should include a legislative note to refer to the Health Practitioner Regulation National Law (Queensland) and the *Health Ombudsman Act 2013* (Qld).

- (A) another registered health practitioner who, in the first practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of the termination; or
- (B) a health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.

[See *Termination of Pregnancy Bill 2018 cl 7(1)–(3)*]

- 4-2 The Termination of Pregnancy Bill should provide that the provision in Recommendation 4-1 above does not limit any duty owed by a registered health practitioner to provide a service in an emergency.

[See *Termination of Pregnancy Bill 2018 cl 7(4)*]

- 4-3 The Termination of Pregnancy Bill should provide that, in deciding an issue under an Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner contravenes the provisions in Recommendations 4-1 or 4-2 above.

[See *Termination of Pregnancy Bill 2018 cl 8(c)*]



# Chapter 5

## Safe access zones

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### INTRODUCTION

5.1 There is evidence that people who oppose termination of pregnancy sometimes engage in activities including protesting, holding prayer vigils, or providing ‘footpath counselling’,<sup>1</sup> at or near premises at which a service of performing terminations on women is provided (‘termination services premises’);<sup>2</sup> and that such behaviour may impact on the safety, privacy and well-being of women who are accessing those premises and of service providers.<sup>3</sup>

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<sup>1</sup> ‘Footpath counselling’ (also referred to as ‘sidewalk counselling’) may include conduct such as handing out information, telling women entering the clinic that there is an alternative to termination, praying or proselytising. Footpath counsellors view themselves as providing support, assistance or an alternative to women and are generally opposed to terminations: see, eg, Evidence to the Parliamentary Committee, 27 October 2016, 24, 28 (A Duff, State Vice-President, Australian Family Association). See also [5.60]–[5.61] below.

<sup>2</sup> Information provided by Queensland Police Service, 5 April 2018. See also [5.65]–[5.68] and [5.70] below.

<sup>3</sup> See Parliamentary Committee Report No 33a (2017) 37–38, referring to Submissions 112, 702, 812, 1014, 1032 and 1267 to the Parliamentary Committee on the second Bill. See also [5.72] below.

5.2 Planned protest activity may be the subject of a permit issued by the Queensland Police Service.<sup>4</sup> Such permits, which are issued on a case by case basis, have been used on a number of occasions to permit protest activity at or near termination services premises.<sup>5</sup>

5.3 There is a range of existing laws that address harassing, intimidating and other behaviour.<sup>6</sup> However, their applicability to the behaviour of persons at or near termination services premises is dependent on the precise facts of each case.

5.4 ‘Safe access zone’ legislation, which specifically deals with harassing, intimidating and other behaviour at or near termination services premises, has been introduced in the Australian Capital Territory, New South Wales, Northern Territory, Tasmania and Victoria.<sup>7</sup> This follows similar legislation enacted in parts of Canada.<sup>8</sup>

5.5 United Nations treaty bodies have observed that measures should be taken to prevent violence, harassment and obstruction of women seeking access to termination services and facilities. The United Nations Special Rapporteur on the

<sup>4</sup> The *Peaceful Assembly Act 1992* (Qld) sets out a process for organisers to give notice to police and local authorities of proposed assemblies in public places: see further the discussion of ‘freedom of political communication and peaceful assembly’ in this Chapter.

<sup>5</sup> Eg, from 14 February to 25 March 2018, the organisation 40 Days for Life Brisbane held a prayer vigil near the Marie Stopes clinic at Bowen Hills, Brisbane. See further [5.62] below. Eight protest applications have been made and granted since 2010. Of those, three were for 40 Days for Life protests outside the Marie Stopes Bowen Hills Clinic. The remainder were for protest marches that commenced at or near clinics providing termination services (particularly Salisbury, Greenslopes and Bowen Hills) and ceased at Parliament House: Information provided by Queensland Police Service, 5 April 2018.

<sup>6</sup> See the discussion of ‘General laws addressing harassing, intimidating, obstructing or other behaviour’ in this Chapter.

<sup>7</sup> See *Health Act 1993* (ACT) pt 6, div 6.2 (ss 85–87), as inserted by the *Health (Patient Privacy) Amendment Act 2015* (ACT) (commenced on 22 March 2016); *Public Health Act 2010* (NSW) pt 6A (ss 98A–98F), as inserted by the *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018* (NSW) (commenced on 15 June 2018); *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3 (ss 14–16) (commenced on 1 July 2017); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9 (commenced on 12 February 2014); *Public Health and Wellbeing Act 2008* (Vic) pt 9A (ss 185A–185H), as inserted by the *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) (commenced on 2 May 2016).

<sup>8</sup> Safe access zone legislation was first enacted in British Columbia in 1996 and has since been enacted in Newfoundland and Labrador, Quebec, Ontario and, most recently, Alberta: *Access to Abortion Services Act*, RSBC 1996, c 1; *Access to Abortion Services Act*, SNL 2016, c A–1.02; *An Act Respecting Health Services and Social Services*, CQLR c S–4.2, ss 9.2, 16.1 and 531.0.1; *Safe Access to Abortion Services Act*, SO 2017, c 19; *Protecting Choice for Women Accessing Health Care Act*, SA 2018, c P-26.83A.

Legislation to address this situation has also been enacted in the United States of America. At the federal level, see the *Freedom of Access to Clinic Entrances (FACE) Act of 1994*, 18 USC §248. A number of States have also enacted various laws to protect access to termination of pregnancy services: see Guttmacher Institute, *Protecting Access to Clinics* (25 June 2018) <<https://www.guttmacher.org/state-policy/explore/protecting-access-clinics>>.

In the United Kingdom, the Home Office announced a review on harassment and intimidation near abortion clinics, including consideration of whether existing laws for protection against harassment or intimidation are sufficient, or whether new police and civil measures are necessary: Rt Hon Amber Rudd MP, Home Secretary, ‘Review into harassment and intimidation near abortion clinics’ (Media statement, 26 November 2017) <<https://www.gov.uk/government/news/review-into-harassment-and-intimidation-near-abortion-clinics>>. An Inquiry into this topic was undertaken by the Home Affairs Committee in 2017: UK Parliament, Home Affairs Committee, ‘Harassment and intimidation near abortion clinics’ <<https://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/inquiries/parliament-2017/abortion-clinic-inquiry-17-19/>>.

right to health has also observed that measures should be taken to protect termination service providers from harassment and violence.<sup>9</sup>

## GENERAL LAWS ADDRESSING HARASSING, INTIMIDATING, OBSTRUCTING OR OTHER BEHAVIOUR

### Queensland

5.6 Harassing, intimidating, or obstructing behaviour that affects women or service providers who are entering or leaving termination services premises may be addressed by existing laws.

5.7 In particular, a person commits a public nuisance offence if they behave in a disorderly, offensive, threatening or violent way that interferes, or is likely to interfere, with the peaceful passage through or enjoyment of a public place by a member of the public.<sup>10</sup>

5.8 Police also have the power to give a move on direction to a person in a public place,<sup>11</sup> including if the police officer reasonably suspects the person's behaviour has been disorderly, indecent, offensive, or threatening to someone entering, at or leaving the place; or if the person's behaviour or presence is or has been:<sup>12</sup>

- causing anxiety to a person entering, at or leaving the place, reasonably arising in all the circumstances; or
- interfering with trade or business at the place by unnecessarily obstructing, hindering or impeding someone entering, at or leaving the place.<sup>13</sup>

<sup>9</sup> See the discussion of 'Access to health services, including abortion services' in Appendix C.

<sup>10</sup> *Summary Offences Act 2005* (Qld) s 6. The maximum penalty is 10 penalty units or 6 months imprisonment. Local laws may also apply: see, eg, QLRC Consultation Paper No 76 (2017) n 318, referring to *Local Law No 4 (Local Government Controlled Areas, Facilities and Roads) 2011* s 5(1); *Subordinate Local Law No 4 (Local Government Controlled Areas, Facilities and Roads) 2011* s 5(1), sch 1 column 2.

<sup>11</sup> Police have issued move on directions in relation to protest activities outside abortion clinics in Queensland. Between 2013 and 2016, one male was issued approximately eight move on directions and charged once with disobeying a move on direction. A second male who was in the company of the first male on three occasions was also issued a move on direction for each instance: Information provided by Queensland Police Service, 5 April 2018.

A 'public place' means: a place to which members of the public have access as of right, whether or not on payment of a fee and whether or not access to the place may be restricted at particular times or for particular purposes (eg, a road, park or beach); or a place declared under another Act to be a public place for any law conferring powers or imposing functions on police officers; or a part of a place that the occupier of the place allows members of the public to enter, but only while the place is ordinarily open to members of the public (eg, a cinema complex, shop, restaurant or racecourse); or a place that is a public place under another Act. A move on direction can also be given in other prescribed places: *Police Powers and Responsibilities Act 2000* (Qld) ss 3 sch 6 (definition of 'prescribed place' and 'public place'), 44. However, move-on directions do not apply to an authorised public assembly under the *Peaceful Assembly Act 1992* (Qld): s 45.

<sup>12</sup> *Police Powers and Responsibilities Act 2000* (Qld) ss 46, 47. A move on direction can only be given to a person at or near the public place if the person's behaviour has or had the effect mentioned, in the part of the public place at or near where the person then is: ss 46(2), 47(2).

<sup>13</sup> This applies to premises used for trade or business only if the occupier of the premises complains about the person's behaviour or presence: *Police Powers and Responsibilities Act 2000* (Qld) s 47(3).

5.9 Directions must be reasonable in the circumstances and can include a direction to leave the area in a specified direction to a certain distance and for a period of up to 24 hours.<sup>14</sup> Failure to comply with a move on direction without a reasonable excuse is an offence.<sup>15</sup>

5.10 Unlawfully entering or remaining on business premises, such as a private health clinic that provides termination services, may constitute trespass.<sup>16</sup>

5.11 More generally, conduct that amounts to harassment may constitute the crime of unlawfully stalking another person.<sup>17</sup>

5.12 'Unlawful stalking' means conduct that is:<sup>18</sup>

- (a) intentionally directed at a person (the stalked person);<sup>19</sup> and
- (b) engaged in on any 1 occasion if the conduct is protracted or on more than 1 occasion;<sup>20</sup> and
- (c) consisting of 1 or more acts of the following, or a similar, type—
  - (i) following, loitering near, watching or approaching a person;
  - (ii) contacting a person in any way, including, for example, by telephone, mail, fax, email or through the use of any technology;
  - (iii) loitering near, watching, approaching or entering a place where a person lives, works or visits;
  - (iv) leaving offensive material where it will be found by, given to or brought to the attention of, a person;
  - (v) giving offensive material to a person, directly or indirectly;

<sup>14</sup> As to the use of these powers, see further QPS, *Operational Procedures Manual* (Issue 64, 25 May 2018) [13.23]. Generally, the officer must provide the people directed to move on with reasons for giving the direction. A direction that interferes with the right of peaceful assembly must not be given unless it is reasonably necessary in the interests of public safety, public order or the protection of the rights and freedoms of others: *Police Powers and Responsibilities Act 2000* (Qld) s 48.

<sup>15</sup> *Police Powers and Responsibilities Act 2000* (Qld) s 791. The maximum penalty is 40 penalty units. It may be a reasonable excuse that the officer failed to provide reasons for the direction, or that the direction was not reasonable in the circumstances.

<sup>16</sup> See, eg, *Preston v Parker* [2010] QDC 264, in which a person who opposed termination of pregnancy was convicted of trespass under s 11(2) of the *Summary Offences Act 2005* (Qld) for unlawfully remaining in a place used for a business purpose. In this case, the person sat on the front steps of a premises at which termination services were provided to deter or prevent people from accessing a termination, and refused to move following a request by police.

<sup>17</sup> Criminal Code (Qld) s 359E(1).

<sup>18</sup> Criminal Code (Qld) s 359B. See also ss 359C and 359D.

<sup>19</sup> It is immaterial whether the person doing the unlawful stalking intends that the stalked person be aware the conduct is directed at the stalked person; or has a mistaken belief about the identity of the person at whom the conduct is intentionally directed. It is also immaterial whether the conduct directed at the stalked person consists of conduct carried out in relation to another person or property of another person: Criminal Code (Qld) s 359C(1), (2).

<sup>20</sup> It is immaterial whether the conduct throughout the occasion on which the conduct is protracted, or the conduct on each of a number of occasions, consists of the same or different acts: Criminal Code (Qld) s 359C(3).

- (vi) an intimidating, harassing or threatening act against a person, whether or not involving violence or a threat of violence;
  - (vii) an act of violence,<sup>21</sup> or a threat of violence, against, or against property of, anyone, including the defendant; and
- (d) that—
- (i) would cause the stalked person apprehension or fear, reasonably arising in all the circumstances,<sup>22</sup> of violence to, or against property of, the stalked person or another person;<sup>23</sup> or
  - (ii) causes detriment,<sup>24</sup> reasonably arising in all the circumstances, to the stalked person or another person. (notes added)

5.13 A person who unlawfully stalks another person is liable to a maximum penalty of imprisonment for 5 years or, in particular circumstances, 7 or 10 years.<sup>25</sup>

5.14 Whether the person is found guilty or not guilty or the prosecution ends in another way, if the presiding judge or magistrate considers it desirable, the judge or magistrate may constitute the court to consider whether a restraining order should be made against the person.<sup>26</sup>

5.15 In the context of a ‘relevant relationship’,<sup>27</sup> the court may make a domestic violence order to stop threats or acts of domestic violence against a person.<sup>28</sup> This

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21 ‘Violence’ does not include any force or impact within the limits of what is acceptable as incidental to social interaction or to life in the community. Further, ‘violence’ against a person includes an act depriving a person of liberty; and against property includes an act of damaging, destroying, removing, using or interfering with the property: Criminal Code (Qld) s 359A (definition of ‘violence’).

22 ‘Circumstances’ means the alleged stalker’s circumstances; the circumstances of the stalked person known, foreseen or reasonably foreseeable by the alleged stalker; the circumstances surrounding the unlawful stalking; and any other relevant circumstances: Criminal Code (Qld) s 359A (definition of ‘circumstances’).

23 It is immaterial whether the person doing the unlawful stalking intended to cause the apprehension or fear, or the detriment. Further, it is immaterial whether the apprehension or fear, or the violence is actually caused: Criminal Code (Qld) s 359C(4), (5).

24 ‘Detriment’ includes apprehension or fear of violence to, or against property of, the stalked person or another person; serious mental, psychological or emotional harm; prevention or hindrance from doing an act a person is lawfully entitled to do; and compulsion to do an act a person is lawfully entitled to abstain from doing: Criminal Code (Qld) s 359A (definition of ‘detriment’).

25 Criminal Code (Qld) s 359E(2)–(4).

26 Criminal Code (Qld) s 359F.

27 A ‘relevant relationship’ includes an intimate personal relationship (such as a partner, whether married, engaged, in a de facto or dating relationship), a family relationship (such as a parent, child or other relative) or an informal care relationship (where one person is dependent on the other person for help in an activity of daily living): *Domestic and Family Violence Protection Act 2012* (Qld) pt 2, div 3 (ss 13–20).

28 *Domestic and Family Violence Protection Act 2012* (Qld) ss 26, 27, 37, 44. A ‘court’ includes: if an application is made to a Magistrates Court, the Magistrates Court; if an application is made to a magistrate, the magistrate; or if a court convicts a person of a domestic violence offence, the court that convicts the person: *Domestic and Family Violence Protection Act 2012* (Qld) s 6 (definition of ‘court’).

could apply in circumstances where a woman's partner or family member is harassing her in relation to a termination.<sup>29</sup>

## Commonwealth

5.16 The *Criminal Code Act 1995* (Cth) includes offences in relation to the use of telecommunications and the postal service to make threats or to menace, harass or cause offence.<sup>30</sup> This is of relevance to communications made by post, phone or email, or on websites or other social media platforms, such as Facebook and Twitter.

## SAFE ACCESS ZONE LEGISLATION IN OTHER AUSTRALIAN JURISDICTIONS

### Purpose, scope and content of safe access zone legislation

5.17 The purpose of safe access zone legislation is to protect the safety and well-being, and respect the privacy and dignity, of people accessing termination services premises, as well as employees and others who need to access those premises in the course of their duties and responsibilities.<sup>31</sup>

5.18 Although the provisions vary between jurisdictions, the legislation commonly prohibits a range of behaviour such as harassing, intimidating or obstructing a person from obtaining or performing a termination in a safe access zone.

### Establishment of safe access zones

5.19 In effect, the legislation in the Northern Territory, New South Wales, Tasmania and Victoria automatically establishes that a safe access zone is the area within 150 metres around termination services premises.<sup>32</sup> The precise wording of these provisions varies.

5.20 In Tasmania and Victoria, safe access zone is defined to mean 'an area within a radius of 150 metres' from termination services premises. In relation to how this is measured, the Victorian government explained that:<sup>33</sup>

<sup>29</sup> 'Domestic violence' means behaviour by a person towards another person that is abusive (including physically or sexually abusive, emotionally or psychologically abusive or economically abusive), or coercive, or in any other way controls or dominates the other person and causes them to fear for their safety or well-being or that of someone else. Emotional or psychological abuse means behaviour by a person towards another person that torments, intimidates, harasses or is offensive to the other person: *Domestic and Family Violence Protection Act 2012* (Qld) ss 8, 11.

<sup>30</sup> See, eg, *Criminal Code Act 1995* (Cth) ss 471.11, 471.12, 474.15, 474.16 and 474.17.

<sup>31</sup> See, eg, *Public Health and Wellbeing Act 2008* (Vic) ss 185A and 185C.

<sup>32</sup> *Public Health Act 2010* (NSW) s 98A (definition of 'safe access zone'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definition of 'safe access zone'); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'access zone'); *Public Health and Wellbeing Act 2008* (Vic) s 185B(1) (definition of 'safe access zone').

<sup>33</sup> Victoria State Government, Health and Human Services, 'Safe Access Zones around Abortion Clinics: Information for stakeholders' (April 2016).

The 150 metre safe access zone will be measured from the perimeter of the land where the premises providing abortions is situated. This is the case even if the health service has more than one building on the land where it is situated. For a clinic in a shopping centre or similar multi-use complex, the 150 metre safe access zone is measured from the boundary of the clinic land—rather than being measured from the perimeter of the entire complex.

5.21 Similarly, in the Northern Territory, a safe access zone is defined to mean the area within the boundary of termination services premises and within 150 metres outside the boundary.<sup>34</sup>

5.22 In New South Wales, a safe access zone means the premises of a reproductive health clinic at which abortions are provided, and the area within 150 metres of any part of the premises of a reproductive health clinic at which abortions are provided, or a pedestrian access point to a building that houses a reproductive health clinic at which terminations are provided.<sup>35</sup>

5.23 In contrast, the legislation in the Australian Capital Territory provides that the Minister must declare that an area around a medical facility approved by the Minister to perform terminations (an ‘approved medical facility’) is a ‘protected area’.<sup>36</sup> In making the declaration, the Minister must be satisfied that the area declared is:<sup>37</sup>

- not less than 50 metres at any point from the approved medical facility; and
- sufficient to ensure privacy and unimpeded access for anyone entering, trying to enter or leaving an approved medical facility; but
- no bigger than necessary to ensure that outcome.

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<sup>34</sup> See also Northern Territory, *Parliamentary Debates*, 15 February 2017, 840 (N Fyles, Minister for Health), in which it was explained that:

It is intended that the outer part of safe access zones be measured from the boundaries of premises delineated on property titles, leases or declarations. A boundary may be an external land perimeter, whether fenced or not, or a physical attribute such as a wall, but will be consistent with the outer perimeter, and should not be measured from any specific entry point of a building within the boundaries.

<sup>35</sup> *Public Health Act 2010* (NSW) s 98A (definitions of ‘reproductive health clinic’ and ‘safe access zone’).

<sup>36</sup> *Health Act 1993* (ACT) ss 85(1) (definitions of ‘approved medical facility’ and ‘protected area’), 86(1). An ‘approved medical facility’ is a medical facility (or part of a medical facility) approved by the Minister under s 83 as suitable on medical grounds for carrying out terminations.

<sup>37</sup> *Health Act 1993* (ACT) s 86(2). See, eg, *Health (Protected Area) Declaration 2016 (No 2)* (ACT) (Disallowable instrument DI2016–58).

## Prohibited behaviour

5.24 The legislation in the Australian Capital Territory, Northern Territory, New South Wales, Tasmania and Victoria prohibits certain behaviour in a safe access zone.<sup>38</sup>

5.25 Prohibited behaviour includes:<sup>39</sup>

- besetting (Tasmania, Victoria, New South Wales),<sup>40</sup> harassing, hindering, intimidating, interfering with, threatening or obstructing a person (Tasmania) by any means (Victoria, New South Wales), that is intended to stop the person (Australian Capital Territory) or that may result in deterring the person (Northern Territory) from entering or leaving premises where terminations are performed, or from having or providing a termination at the premises;
- interfering with or impeding a footpath, road or vehicle, without reasonable excuse, in relation to premises at which termination services are provided (Victoria, New South Wales), or footpath interference in relation to terminations (Tasmania), or obstructing or blocking a footpath or road without reasonable excuse (New South Wales);
- acts that can be seen or heard by a person in the premises and that are intended to stop a person (Australian Capital Territory), or that may result in deterring a person (Northern Territory) from entering or leaving the premises, or from having or performing a termination at the premises;
- communicating by any means in relation to terminations in a manner that is able to be seen or heard by a person accessing, attempting to access, or

<sup>38</sup> The legislation in the Australian Capital Territory, Northern Territory, Tasmania and Victoria makes it an offence to engage in 'prohibited conduct' (Northern Territory) or 'prohibited behaviour' (Australian Capital Territory, Tasmania and Victoria) in a safe access zone: *Health Act 1993* (ACT) s 87(1); *Termination of Pregnancy Law Reform Act 2017* (NT) s 14; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(2); *Public Health and Wellbeing Act 2008* (Vic) s 185D. In the Northern Territory, a person commits the offence if the person intentionally engages in prohibited conduct, the prohibited conduct occurs in a safe access zone and the person is reckless in relation to that circumstance: *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(1). The Act expressly states that it is not an offence if the person engaging in prohibited conduct is a police officer acting in the duties of law enforcement, or a person employed at premises for performing terminations, and the conduct is reasonable in the circumstances: s 14(2).

Cf: In New South Wales, the legislation provides for separate offences in relation to interfering with access of persons to reproductive health clinics, causing actual or potential distress or anxiety to persons in safe access zones and capturing and distributing visual data of persons in safe access zones: *Public Health Act 2010* (NSW) ss 98C, 98D, 98E.

<sup>39</sup> *Health Act 1993* (ACT) s 85(1) (definition of 'prohibited behaviour'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(4) (definition of 'prohibited conduct'); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'prohibited behaviour'); *Public Health and Wellbeing Act 2008* (Vic) s 185B(1) (definition of 'prohibited behaviour'). Cf: *Public Health Act 2010* (NSW) ss 98C, 98D, 98E.

<sup>40</sup> 'Watching and besetting' means to attend or be near any place in numbers or in a manner calculated to intimidate a person in that place; or to obstruct the entrance or exit; or to lead to a breach of the peace. The watching must be such as would amount to a nuisance at common law: LexisNexis, *Encyclopaedic Australian Legal Dictionary* (at 26 June 2018), referring to *Re Van der Lubbe* (1949) 49 SR (NSW) 309.

leaving a premises at which termination services are provided and is reasonably likely to cause distress or anxiety (Victoria, New South Wales);<sup>41</sup>

- a protest in relation to terminations (Australian Capital Territory, Tasmania) by any means (Australian Capital Territory), or that is able to be seen or heard by a person accessing, or attempting to access, premises at which termination services are provided (Tasmania);
- intentionally capturing visual data (Australian Capital Territory, New South Wales)<sup>42</sup> or recording by any means (Northern Territory, Tasmania, Victoria) a person accessing or attempting to access premises at which termination services are provided without that person's consent;<sup>43</sup> or
- any other prescribed behaviour (Tasmania).

5.26 In contrast with other jurisdictions, the offence in the Australian Capital Territory is limited to prohibited behaviour that occurs during the 'protected period' (between 7 am and 6 pm on each day the facility is open).<sup>44</sup>

5.27 The following penalties are prescribed:<sup>45</sup>

- a maximum fine of 25 penalty units (\$3 750) (Australian Capital Territory);
- a maximum fine of 50 penalty units (\$5 500) or imprisonment for 6 months for a first offence, or both; or 100 penalty units (\$11 000) or imprisonment for 12 months, or both, for a second or subsequent offence (New South Wales);
- a maximum fine of 100 penalty units (\$15 400) or imprisonment for 12 months (Northern Territory);

<sup>41</sup> However, this does not apply to an employee or other person who provides services at premises at which termination services are provided: *Public Health and Wellbeing Act 2008* (Vic) s 185B(2); *Public Health Act 2010* (NSW) s 98D(2).

<sup>42</sup> A person 'captures visual data' of another person if the person captures moving or still images of the other person by a camera or any other means in such a way that a recording is made of the images, or the images are capable of being transmitted in real time with or without retention or storage in a physical or electronic form, or the images are otherwise capable of being distributed: *Health Act 1993* (ACT) s 85(1) (definition of 'capture visual data'); *Public Health Act 2010* (NSW) s 98E (definition of 'capture visual data').

<sup>43</sup> In Victoria, this is not an offence unless also done 'without reasonable excuse': *Public Health and Wellbeing Act 2008* (Vic) s 185B(1) (definition of 'prohibited behaviour', para (d)). News organisations filming legitimate news stories outside a health service, or a clinic undertaking a recording of its premises for security purposes would constitute 'reasonable excuses' for the purposes of the legislation: Victoria State Government, Health and Human Services, 'Safe Access Zones Around Abortion Clinics: Information for Stakeholders' (April 2016) 2. The Tasmanian legislation states that a law enforcement officer is not guilty of engaging in prohibited behaviour within an access zone by intentionally recording, by any means, a person accessing or attempting to access premises at which termination services are provided without that person's consent if, at the time of making the recording, the officer was acting in the course of his or her duties and their conduct was reasonable for the performance of those duties: *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(3). The New South Wales legislation also provides some express exceptions in relation to this and other offences: see n 49 below.

<sup>44</sup> Or any other period declared by the Minister: *Health Act 1993* (ACT) s 85(2) (definition of 'protected period').

<sup>45</sup> *Health Act 1993* (ACT) s 87(1) and *Legislation Act 2001* (ACT) s 133; *Public Health Act 2010* (NSW) ss 98C-98D and *Crimes (Sentencing Procedure) Act 1999* (NSW) s 17; *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(1); *Penalty Units Act* (NT) s 6(1) and *Penalty Units Regulations* (NT); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(2) and *Penalty Units and Other Penalties Act 1987* (Tas) ss 4, 4A; *Public Health and Wellbeing Act 2008* (Vic) s 185D and *Monetary Units Act 2004* (Vic) s 5.

- a maximum fine of 75 penalty units (\$11 925) or imprisonment for a term not exceeding 12 months, or both (Tasmania);
- a maximum fine of 120 penalty units (\$19 343) or imprisonment for a term not exceeding 12 months (Victoria).

5.28 In each jurisdiction, it is also an offence to publish or distribute a recording of another person entering or leaving, or trying to enter or leave, termination services premises, unless the recorded person has given their consent (Australian Capital Territory, Northern Territory, Tasmania, Victoria),<sup>46</sup> or the person publishing the recording has a reasonable excuse (Northern Territory, Victoria).<sup>47</sup>

5.29 This offence is intended to prohibit the deliberate filming or recording of people who are accessing termination services premises.<sup>48</sup> It is not intended to prohibit other recordings.<sup>49</sup>

5.30 The prescribed penalty for this offence is the same as for engaging in prohibited behaviour,<sup>50</sup> except in the Australian Capital Territory where a person is liable to a maximum fine of 50 penalty units (\$7500), imprisonment for six months, or both.<sup>51</sup>

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<sup>46</sup> *Health Act 1993* (ACT) s 87(2), (3); *Public Health Act 2010* (NSW) s 98E; *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(1); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(4); *Public Health and Wellbeing Act 2008* (Vic) s 185E.

A person commits this offence only if: the recording is made with the intention of stopping a person from having or performing a termination (Australian Capital Territory); the recording is published intentionally and made recklessly (Northern Territory); or the recording contains particulars likely to lead to the identification of that other person (Victoria, New South Wales).

<sup>47</sup> *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(3); *Public Health and Wellbeing Act 2008* (Vic) s 185E. In the Northern Territory, it is not an offence if the recording is published to a person who is authorised under a law in force in the Territory to receive the information in the recording: s 15(2).

<sup>48</sup> See, eg, Victoria, *Parliamentary Debates*, Legislative Assembly, 22 October 2015, 3974 (J Hennessy), in which it was explained that the purpose of this offence is:

To protect the privacy of persons accessing premises at which abortions are provided and to protect them from intimidatory conduct currently engaged in by some persons through taking recordings with the explicit or implicit threat of publicly exposing individuals who access lawful abortions or provide those health services.

<sup>49</sup> In Victoria, the offence applies if the recording is published or distributed 'without reasonable excuse'. In the Northern Territory, the offence of publishing a recording is expressed not to apply 'if the recording is published to a person who is authorised under a law in force in the Territory to receive the information in the recording', and it is a defence to a prosecution for this offence if the defendant has a reasonable excuse. In New South Wales, the offence does not apply to: the operation of a security camera, for security reasons only, by or on behalf of a person operating a reproductive health clinic at which abortions are provided, or premises adjacent to or near such a reproductive health clinic at which abortions are provided, or premises adjacent to or near such a reproductive health clinic; a person employed or contracted to provide services at the reproductive health clinic; a person otherwise acting for or on behalf of a person operating a reproductive health clinic (but only if the visual data is provided either to the person operating the clinic or to a police officer); or a police officer acting in the course of their duties, if their conduct is reasonable in the circumstances for the performance of those duties; or a person who has another reasonable excuse. In the Australian Capital Territory, it states in the Explanatory Notes to the Health (Patient Privacy) Amendment Bill 2015 (ACT) [at 6] that:

It is not the intention of the Bill to create an offence for accredited media to take footage of the building for reporting, nor for members of the public to commit an offence by taking a photograph of the area for any genuine purpose not related to the services offered in the facility.

<sup>50</sup> See [5.27] above.

<sup>51</sup> *Health Act 1993* (ACT) s 87(2) and *Legislation Act 2001* (ACT) s 133.

## FREEDOM OF POLITICAL COMMUNICATION AND PEACEFUL ASSEMBLY

5.31 Freedom of expression is protected under international human rights law, but it can legitimately be limited by legislation that is necessary and proportionate to protect others' fundamental rights, including rights to privacy and health.<sup>52</sup>

5.32 The Australian Constitution does not expressly protect a right to 'freedom of speech'.<sup>53</sup> However, the High Court has recognised an implied freedom of political communication as a necessary part of the system of representative and responsible government established by the Constitution. The freedom is not absolute, but operates as a limit on the exercise of legislative power to impede the freedom.<sup>54</sup>

5.33 Legislation may place some restrictions on the free expression of political communication, including peaceful protest, provided they are reasonably appropriate and adapted to serve a legitimate purpose in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government.<sup>55</sup>

5.34 In other jurisdictions that have introduced safe access zone provisions, they have been considered reasonable and justified to serve a legitimate purpose.<sup>56</sup>

5.35 The constitutional validity of safe access zone legislation in Australia has not yet been considered by the High Court. There are currently two matters before the High Court in relation to whether certain provisions of the safe access zone legislation in Victoria and Tasmania impermissibly burden the implied freedom of political communication.<sup>57</sup>

5.36 Safe access zone provisions in other jurisdictions also restrict freedom of assembly.<sup>58</sup>

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52 See the discussion of 'Freedom of opinion and expression' in Appendix C.

53 Some States have introduced rights legislation protecting, among other things, the freedom of expression: see *Human Rights Act 2004* (ACT) s 16; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 15. No such legislation has been introduced in Queensland.

54 *Brown v Tasmania* (2017) 349 ALR 398; *McCloy v New South Wales* (2015) 257 CLR 178; *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.

55 *Brown v Tasmania* (2017) 349 ALR 398, in which a majority of the High Court (Kiefel CJ, Bell and Keane JJ; Gageler and Nettle JJ agreeing) held that particular legislative provisions prohibiting environmental protests on forestry land, or on business access areas in relation to forestry land, were invalid because they impermissibly burdened the implied freedom of political communication.

56 See, eg, the Statement of Compatibility for the Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (Vic) in Victoria, *Parliamentary Debates*, Legislative Council, 19 August 2015, 2543 at 2544:

Impeding access, or intrusively interfering, with individuals as they access lawful health services is both an infringement of privacy and an obstruction of public health. This limitation reasonably restricts the right in order to achieve its purpose.

57 High Court Bulletin [2018] HCAB 5 (27 June 2018) 22, referring to *Clubb v Edwards* (M46/2018) and *Preston v Avery* (H2/2018). The matters will be heard together, or sequentially: *Attorney-General for the State of Victoria v Clubb*; *Clubb v Edwards*; *Preston v Avery* [2018] HCATrans 60 (23 March 2018).

58 There is a statutory right to freedom of assembly in the Australian Capital Territory and Victoria: *Human Rights Act 2004* (ACT) s 15; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 16. See further Explanatory Statement, Health (Patient Privacy) Amendment Bill 2015 (ACT); and the Statement of Compatibility for the Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (Vic) in Victoria, *Parliamentary Debates*, Legislative Council, 19 August 2015, 2543, in which it was stated at 2544 that:

5.37 In Queensland, a person's right to assemble peacefully with others in a public place is recognised in the *Peaceful Assembly Act 1992*.<sup>59</sup> This right may be subject only to restrictions that are necessary and reasonable in a democratic society in the interests of public safety, public order, or the protection of the rights and freedoms of other persons.<sup>60</sup>

5.38 The *Peaceful Assembly Act 1992* provides for organisers of proposed assemblies in public places to give a notice of intention to hold an assembly to the police or local authority (the 'relevant authority').<sup>61</sup>

5.39 If the relevant authority does not oppose the holding of a public assembly, a permission notice may be given in writing. The permission notice may specify conditions to which the giving of the notice is subject, provided that the condition relates to a matter concerning public safety, the maintenance of public order or the protection of the rights and freedoms of persons.<sup>62</sup>

5.40 Once a public assembly is taken to be approved, it becomes an 'authorised public assembly' and, consequently, participants in it are given legal immunity.<sup>63</sup>

5.41 If the relevant authority opposes the holding of the public assembly, they may apply to a Magistrates Court for an order refusing to authorise the holding of the assembly.<sup>64</sup> However, before applying for such an order, the Act requires the relevant authority to have had regard to the objects of the Act, to have formed the opinion, on

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Preserving order in public places, and protecting the rights of others from infringement, will support the reasonable limitation of this right. I submit that this limitation is reasonable and justified, in that it does not prohibit assembly or association, but rather prohibits a set of behaviours that infringe on the rights of others.

In New South Wales, Part 4 of the *Summary Offences Act 1988* sets out a process for public assemblies to become authorised, similar to the Queensland provisions. Section 98F(2) of the *Public Health Act 2010* (NSW) provides that the safe access zone provisions apply despite anything to the contrary in Part 4 of the *Summary Offences Act 1988* (NSW). However, section 98F(1) states that the safe access zone provisions do not apply so as to prohibit conduct occurring in or around a church or other building ordinarily used for religious worship or outside Parliament House in Macquarie Street, Sydney or to prohibit the carrying out of any survey or opinion poll by or with the authority of a candidate, or the distribution of any handbill or leaflet by or with the authority of a candidate, during the course of a Commonwealth, State or local government election, referendum or plebiscite.

<sup>59</sup> *Peaceful Assembly Act 1992* (Qld) ss 2(1)(a), 5(1). One of the purposes of this Act is to ensure, so far as it is appropriate to do so, that persons may exercise the right to participate in public assemblies: s 2(1)(b).

<sup>60</sup> *Peaceful Assembly Act 1992* (Qld) ss 2, 5. This reflects the position under international human rights law. For example, see Article 21 of the International Covenant on Civil and Political Rights, which states:

The right of peaceful assembly shall be recognized. No restrictions may be placed on the exercise of this right other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others.

<sup>61</sup> The notice must comply with the requirements in s 9 of the *Peaceful Assembly Act 1992* (Qld).

<sup>62</sup> *Peaceful Assembly Act 1992* (Qld) ss 10, 11.

<sup>63</sup> *Peaceful Assembly Act 1992* (Qld) ss 6, 7, 10. A person who participates in an authorised public assembly does not, merely because of the participation, incur any civil or criminal liability because of the obstruction of a public place, provided that the assembly is peaceful and held in accordance with any relevant particulars and conditions specified in the approval.

<sup>64</sup> *Peaceful Assembly Act 1992* (Qld) s 12. This applies if the assembly notice was given to the relevant authority not less than five business days before the day specified in the notice for the public assembly. If less than five business days is given, the organiser may apply to the Magistrates Court for an order authorising the holding of the assembly: s 14.

reasonable grounds, that if the assembly were to be held, it would interfere with public safety, public order, or the rights and freedoms of others. The Act also requires the relevant authority to engage in consultation with interested parties and a mediation process.<sup>65</sup>

## CONSULTATION AND SUBMISSIONS

### A new general offence for protecting women and service providers

5.42 In the Consultation Paper, the Commission asked whether it should be unlawful to harass, intimidate or obstruct.<sup>66</sup>

- a woman who is considering, or who has undergone, a termination; or
- a person who performs or assists, or who has performed or assisted in performing, a termination.

5.43 Many respondents simply replied in the affirmative to this general question, without giving reasons.<sup>67</sup>

5.44 Most of the respondents who gave reasons clearly contemplated that harassing, intimidating and obstructing behaviour should be unlawful in the context of a woman *seeking* or *accessing* a termination.<sup>68</sup>

5.45 A few respondents specifically stated that safe access zone provisions should be introduced to make the harassment, intimidation or obstruction of women and service providers unlawful.<sup>69</sup>

5.46 One respondent, an academic from the TC Beirne School of Law, University of Queensland, stated that existing offences (such as stalking or, in the context of a 'relevant' relationship, laws governing domestic and family violence) should ordinarily apply, but that 'in other circumstances it should be an offence to harass, intimidate or obstruct within an exclusion zone'.<sup>70</sup>

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<sup>65</sup> *Peaceful Assembly Act 1992* (Qld) s 13.

<sup>66</sup> QLRC Consultation Paper No 76 (2017) Q-14.

<sup>67</sup> Eg, Submissions 50, 61, 89, 118, 119, 164, 297, 482, 529, 539, 562, 577, 582, 584, 590, 630, 632, 720, 882, 885.

<sup>68</sup> Eg, Submissions 21, 116, 341, 438, 583, 600, 671, 674, 810, 879. True Relationships and Reproductive Health commented that 'patients should be able to access the service free from judgement, harassment, intimidation or harm': Submission 671. The Women's Electoral Lobby (NSW) stated that:

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: Submission 810.

QLS stated that it:

supports measures, including legislative measures, which protect a woman who is seeking or who has accessed termination services from harassment, intimidation or shame, and from behaviour or action which attempts to obstruct a woman from accessing health care services related to terminating a pregnancy: Submission 879.

<sup>69</sup> Eg, Submissions 422, 429, 454, 542, 671, 672.

<sup>70</sup> Submission 429.

5.47 A number of respondents considered that existing criminal laws provide adequate protections against harassing, intimidating or obstructing behaviours.<sup>71</sup>

5.48 Some queried whether it is necessary to make a law limited to these specific circumstances.<sup>72</sup> One respondent observed generally that:<sup>73</sup>

harassment and intimidation are not permissible under the law as it currently stands. There is no need to create a separate offence of the same nature dealing specifically with the provision of abortion services. Particularly given the absence or evidence that harassment, intimidation or obstruction is occurring, laws of this kind, or in the nature of exclusion zones, should not be enacted.

5.49 A number of respondents considered that any legal protections against harassment, intimidation or obstruction should apply equally to everyone.<sup>74</sup> A member of the public stated:<sup>75</sup>

It is currently unlawful to harass, intimidate or obstruct people... If the law is insufficient then it should be amended for *everyone* not just those considering, undergoing, or [who] have undergone an abortion or [who are] involved with abortions. Specific laws should not be introduced for one sector of the community to prevent harassment, intimidation or obstruction. The same laws should be available to all persons not just surrounding the circumstances of abortion. (emphasis in original)

5.50 Some respondents expressed concern that terms such as 'harassment' and 'intimidation' are ambiguous.<sup>76</sup>

5.51 A few respondents commented that any offence provision would need to carefully and clearly define terms such as 'harassment' and 'intimidation',<sup>77</sup> and that they should not be determined subjectively.<sup>78</sup> A lawyer specialising in criminal law observed generally that:<sup>79</sup>

The discussion paper contemplates the creation of new criminal offences, the boundaries of which would be uncertain. Some of the language employed obscures clarity. For example, if you ask people whether they deplore bullying, harassment, or intimidation, they will likely respond in furious agreement. It is often much less easy to reach broad agreement about whether a particular action is or is not bullying, etc. Laws constructed around such generalities tend to have unintended, unjust consequences.

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71 Eg, Submissions 430, 433, 434, 444, 448, 515, 535, 575, 599A, 608, 627, 634, 650, 760, 819, 836.

72 Eg, Submissions 127, 407, 410, 434, 608, 659. Some respondents commented that this is a 'loaded question', which wrongly suggests that 'a woman seeking an abortion needs protection greater than any other person simply going about some lawful activity which people might find objectionable': eg, Submissions 434 and 575.

73 Submission 608.

74 Eg, Submissions 127, 226, 353, 407, 410, 434, 605, 608, 659, 678.

75 Submission 659.

76 Eg, Submissions 32, 65, 122, 127, 234, 263, 399, 420, 528, 661, 678, 731, 760, 862.

77 Eg, Submissions 234, 399, 661, 678.

78 Eg, Submissions 528, 558, 678.

79 Submission 880.

5.52 Only one respondent expressly suggested that a general offence provision is preferable to the introduction of safe access zone provisions:<sup>80</sup>

Safe and unhindered access to all medical facilities is a fundamental right of all citizens. Despite the attractiveness of imposing a safe access zone, this would simply create an arbitrary boundary. A boundary will be interpreted as allowing harassment, intimidation and obstruction at the edge of the boundary. A better approach would be to create an offence which captures the harassment, intimidation and obstruction of patients everywhere.

5.53 Another respondent commented generally that:<sup>81</sup>

the privacy of the woman who has undergone a termination of pregnancy should be protected by law, including harassing or disclosing information on social media.

5.54 However, no respondents provided any evidence or referred to any examples of a woman or a service provider being harassed in relation to terminations other than in the context of the behaviours or activities of pro-life supporters outside abortion clinics.<sup>82</sup>

5.55 Some respondents expressed concern that women may be pressured by their partners or parents to terminate a pregnancy.<sup>83</sup>

### Safe access zone provisions

5.56 In the Consultation Paper, the Commission asked whether there should be provision for safe access zones in the area around termination services premises.<sup>84</sup>

5.57 Responses to this question were mixed.

5.58 Many respondents, including pregnancy support and advocacy services, Church organisations, medical and legal practitioners, academics and advocacy organisations, submitted that safe access zone provisions are unnecessary and should not be introduced in Queensland.

5.59 A number of those respondents considered that existing laws are sufficient to address harassing, intimidating or obstructing behaviour at or near termination

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80 Submission 109.

81 Submission 138.

82 However, one respondent noted that 'services in addition to traditional abortion clinics are also subjected to intimidating practice by anti-choice protesters', including services provided by Children by Choice (including training events and conferences) and GP medical abortion providers: Submission 806.

83 Eg, Submission 162, in which a member of the public commented that:

It should be unlawful to obstruct, intimidate, or harass a person considering an abortion. It certainly should not be unlawful to offer to help or encourage a person to continue with a pregnancy. So many young women are under pressure from family or boyfriend to have an abortion, when they are very reluctant to do so.

84 QLRC Consultation Paper No 76 (2017) Q-15.

services premises,<sup>85</sup> and that behaviour that is currently lawful, such as peaceful protest or 'sidewalk counselling', should not be prohibited.<sup>86</sup>

5.60 Several respondents, including some who have participated in protests or sidewalk counselling, submitted that people at or near termination services premises do not engage in harassing, intimidating or obstructing behaviour. Rather, they are offering people who are seeking a termination 'an alternative', or providing support or assistance that may be beneficial, in a non-harassing way.<sup>87</sup>

5.61 A member of the public submitted:<sup>88</sup>

My experience in being a footpath presence as a pro-lifer is that it has always been a peaceful and prayerful gathering, nothing else. The strategy of a footpath presence is that if a woman is seeking a termination of pregnancy... or her partner or support person approaches the footpath presence for support or opinion or advice, then it is provided respectfully and without judgement or prejudice. No attempt is made by the footpath presence to engage or offer advice without it being requested.

5.62 A few respondents noted that some protests or prayer vigils are conducted pursuant to permits issued by the Queensland Police Service, such as the 40 Days for Life campaign that was held outside the Marie Stopes clinic in Bowen Hills earlier this year.<sup>89</sup>

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<sup>85</sup> Eg, Submissions 105, 108, 140, 155, 165, 168, 237, 343, 376, 400, 411, 413, 448, 483, 530, 544, 580, 608, 743, 769, 836, 842. Those respondents referred to a range of existing laws, including the public nuisance offence under the *Summary Offences Act 2005* (Qld), police move-on powers, or in more extreme cases the offence of unlawful stalking. BAQ commented that:

In general the Association does not support the imposition of new criminal offence provisions where there is little or no evidence that the existing provisions are inadequate or lacking in some way: Submission 878.

<sup>86</sup> Eg, Submissions 111, 168, 169, 204, 214, 237, 240, 278, 310, 311, 343, 367, 413, 466, 483, 565, 640, 655, 769, 826. Some respondents considered that there is a lack of evidence that people entering or leaving termination services premises are unsafe, or that people at or near those services are causing harm: eg, Submissions 168, 367, 413, 494, 522, 556, 570, 650, 661, 678, 748, 836. An academic from the School of Law, University of Notre Dame stated that 'there is only a weak case for safe access laws outside abortion clinics', given the absence of empirical evidence of the effect of protesters and sidewalk counsellors: Submission 494. Many respondents considered that, if behaviours such as protest or communications in relation to terminations are prohibited, safe access zone provisions would undermine freedom of speech: see [5.84] ff below.

<sup>87</sup> Eg, Submissions 23, 161, 196, 277, 328, 367, 407, 483, 528, 557, 678, 740, 759, 765.

<sup>88</sup> Submission 367. One respondent similarly stated that people 'who engage in this type of activity are motivated by the concern for both the baby and the mother and by saving lives': Submission 407. 40 Days for Life Brisbane Inc. observed that 'the volunteers outside the abortion centre provide real choice and options for women who may believe that abortion is their only choice': Submission 170.

<sup>89</sup> Eg, Submissions 170, 556, 819. See further 40 Days for Life, 'Mission' (2018) <<https://40daysforlife.com/mission/>>:

40 Days for Life is a community-based campaign that ... puts into action a desire to cooperate with God in the carrying out of His plan for the end of abortion ...

Those respondents noted that participants were required to sign a 'statement of peace' stating that, among other things, they would not 'obstruct the driveways or sidewalk while standing in the public right of way' or 'threaten, physically contact, or verbally abuse [Marie Stopes] employees, volunteers, or customers': 40 Days for Life, 'Statement of Peace' (2018) <<http://40dfl.net/statement-of-peace/>>. Such requirements are consistent with the types of conditions usually imposed on a permit: Information provided by Queensland Police Service, 5 April 2018.

5.63 The Unborn Children's advocacy Network noted that safe access zone provisions would conflict with the right to peaceful assembly.<sup>90</sup>

5.64 In contrast, many respondents, including health, support and advocacy organisations, medical practitioners and termination of pregnancy services, human rights law and legal advocacy organisations, domestic and family violence and sexual assault support services, legal practitioners and academics, submitted that safe access zone provisions should be introduced to protect the safety and well-being, and preserve the privacy and dignity, of women and service providers.

5.65 A number of those respondents, including Australian Lawyers for Human Rights, the Uniting Church in Australia, Queensland Synod, Marie Stopes Australia and Children by Choice, considered that safe access zone provisions are necessary to address the ongoing behaviours of pro-life supporters at or near termination services premises.<sup>91</sup>

5.66 Sustainable Population Australia Inc. (Queensland Branch) commented that:<sup>92</sup>

Sadly, the propensity for certain groups within society to target people seeking or providing abortions raises the need for specific prohibitions.

5.67 Australian Lawyers for Human Rights noted that:<sup>93</sup>

Women seeking abortions and staff working at clinics providing reproductive services report routinely experiencing harassment and intimidation from anti-abortion protesters outside the clinics.

5.68 The Uniting Church in Australia, Queensland Synod commented that:<sup>94</sup>

women or staff of clinics have, in the past, been attacked verbally and even physically when entering or leaving the building. People who strongly oppose termination of pregnancy at times conduct intrusive campaigns targeting specific clinics. They stand on the footpath and demonstrate using protest signs which may contain graphic images, and/or speaking to or shouting at people entering and leaving the premises. This may be termed 'footpath counselling' by the protestors, but may be very confronting, frightening, intrusive and confusing for

<sup>90</sup> Submission 105. See the discussion of 'Freedom of political communication and peaceful assembly' in this Chapter.

<sup>91</sup> Eg, Submissions 50, 89, 164, 172, 419, 422, 475, 487, 500, 542, 571, 583, 590, 629, 630, 632, 637, 673, 674, 690, 707, 712, 734, 754, 888.

<sup>92</sup> Submission 500.

<sup>93</sup> Submission 583. Children by Choice similarly observed that:

Most providers of pregnancy termination services have extensive experience with opponents of abortion being obstructive, abusive and violent toward patients, their support people, staff and passers-by: Submission 50.

Submission 50 was endorsed and supported by a number of other respondents, including Health Consumers Queensland Ltd., the National Foundation for Australian Women Ltd, White Ribbon Australia, and a group of academics from Griffith Law School: Submissions 89, 119, 164, 454, 469, 562, 592, 630, 632, 683, 712, 883.

Marie Stopes Australia reported that 'verbal abuse, mainly religious in nature' is commonly experienced by staff or patients at or near its Queensland clinics: Information provided by Marie Stopes Australia, 29 March 2018.

<sup>94</sup> Submission 690.

women who are entering or leaving the premises before or after termination of pregnancy.

5.69 The Castan Centre for Human Rights Law submitted, based on research it has undertaken in Victoria, that:<sup>95</sup>

Anti-abortion protesters frequently describe themselves as sidewalk counsellors seeking to render assistance to women. This characterisation differs markedly from what we heard from interviewees who spoke of the protesters' unwelcome intrusions into the personal space of patients and staff. (note omitted)

5.70 In reference to the prayer vigil held outside one of their clinics in Brisbane, Marie Stopes Australia observed that having to walk past the prayer vigil participants and hear their religious messages 'disturbs and traumatises some women'.<sup>96</sup> This respondent also observed:<sup>97</sup>

the majority of women and their support people who attend the clinic are visibly frustrated and angry that they are subject to this type of behaviour when accessing an essential health service. Many comment that they know they would not be subject to this type of harassment when accessing other health services in Qld or this type of health service in other parts of Australia. Regardless of the woman's reaction, this translates into a small delay in women being able to access services as often [staff] need time to calm (both the angry and upset women) or reassure women they are safe when in the clinic.

5.71 A number of respondents considered that the behaviours or presence of pro-life supporters at or near termination services premises is harassing, shaming, intimidating or distressing.<sup>98</sup> A group of legal academics from the Griffith University Law School observed:<sup>99</sup>

It is clear that communications with opponents of abortion at clinics which offer terminations of pregnancy can be experienced as distressing, frightening and harassing by pregnant people seeking terminations of pregnancy. Opponents of abortion should not be allowed to cause undue distress to pregnant persons seeking termination procedures.

<sup>95</sup> Submission 276. This respondent gave some examples of the conduct of anti-abortion protestors, which included: approaching, following or walking alongside people approaching clinic premises; dispensing brochures or plastic fetal 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; and preventing patients from exiting their cars or obstructing clinic entrances.

<sup>96</sup> Information provided by Marie Stopes Australia, 29 March 2018. This respondent noted that, due to the location of prayer vigil participants on a narrow street, 'footpath access is restricted'. It also noted that 'even where the groups "pray" this is loud and usually focused on the "soul" and "salvation" of staff and women'. It further noted that, while prayer vigil participants are 'mainly peaceful and are typically not physically aggressive ... the larger groups by their sheer number are threatening to staff and patients'.

<sup>97</sup> Information provided by Marie Stopes Australia, 29 March 2018.

<sup>98</sup> Eg, Submissions 50, 341, 419, 421, 438, 583, 681, 712, 883, 888. A few respondents considered that such behaviours may be a barrier to women accessing such services, cause women to delay medical care or follow-up, or discourage medical practitioners from providing these services: eg, Submissions 18, 883, 888.

<sup>99</sup> Submission 712. The Australian Psychological Society Limited similarly observed that:

Safe access zones ensure that women will not be shamed, intimidated, frightened or obstructed when accessing a health clinic of their choosing ... Such behaviour may impact on the safety, privacy and wellbeing of women who are accessing those premises and of service providers: Submission 118.

5.72 Some respondents, including the Australian Association of Social Workers (Qld), the Human Rights Law Centre Ltd and Reproductive Choice Australia, submitted that such behaviours may significantly impact on the health and well-being of women and staff.<sup>100</sup>

5.73 A few respondents, including domestic and family violence and sexual assault support services, noted that such behaviours may particularly impact already vulnerable women at a sensitive time.<sup>101</sup>

5.74 Women's Legal Service Queensland submitted that:<sup>102</sup>

Women who have experienced domestic violence, reproductive coercion and sexual assault have often experienced significant trauma associated with the physical, emotional and psychological abuse of the perpetrator. It is unacceptable that women and pregnant people should have to risk being further traumatised or made to feel unsafe by the actions of protestors whilst accessing health services for a termination, particularly when the choice to terminate a pregnancy was made due to ongoing safety concerns within the context of a violent relationship.

5.75 The Institute for Urban Indigenous Health Ltd submitted that:<sup>103</sup>

Termination of pregnancy is a sensitive and highly personal subject, with issues of access and confidentiality particularly pronounced for [Aboriginal and Torres Strait Islander] women. In our experience, a patient's decision to access a termination service is difficult and considered. Anti-abortion behaviours in proximity to termination services compound the difficulty, angst and trauma for Aboriginal and Torres Strait Islander women and their partners or other support persons.

5.76 Many respondents, including Australian Lawyers for Human Rights and White Ribbon Australia, considered that safe access zone provisions are necessary to support women's sexual and reproductive health rights, including their right to access termination services with privacy and dignity.<sup>104</sup>

5.77 A member of the public observed that:<sup>105</sup>

Everyone accessing health care is entitled to confidentiality and privacy. Safe access zones would assist in ensuring those health rights.

5.78 Women's Abortion Rights Campaign Brisbane stated:<sup>106</sup>

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100 Eg, Submissions 118, 276, 312, 341, 378, 487, 542, 592, 888.

101 Eg, Submissions 312, 707, 720.

102 Submission 720.

103 Submission 707.

104 Eg, Submissions 312, 349, 406, 452, 547, 572, 583, 830, 883.

105 Submission 172.

106 Submission 406. Also eg, Submission 349, in which a member of the NSW Parliament similarly stated that:

In recognising that the right to make decisions about reproduction without coercion means women should be able to access abortion in safe healthcare settings, and that this remains controversial in some segments of society that are opposed to abortion in all or most circumstances, we argue that it is necessary to offer special protection to women who are or may be seeking abortion at healthcare facilities that provide it.

5.79 A number of respondents, including AMA Queensland, also considered that safe access zone provisions are necessary to protect the rights of staff, including their right to a safe workplace.<sup>107</sup>

5.80 QLS observed that existing laws are ‘unlikely to provide adequate protection’, as they only address some of the unwanted behaviours exhibited at or near termination services premises.<sup>108</sup>

5.81 Several respondents submitted that safe access zone provisions have been effective in curtailing this behaviour in other jurisdictions.<sup>109</sup> Fair Agenda referred to the experience of a doctor who provides termination services in different Australian jurisdictions, who stated that:<sup>110</sup>

There is a marked difference between places that have safe access zones and those that don’t. Since the zones were implemented in Victoria in 2016, the experience of entering our Maroondah clinic has changed. Where once staff and patients were yelled at and had graphic images thrust at them that are designed to misinform and manipulate, they are now able to attend the clinic in peace...

5.82 Some respondents considered that existing laws have not been effective in restraining the behaviour of pro-life supporters at or near termination services premises. A number of respondents specifically endorsed the principle that safe access zone provisions are necessary to stop the harm before it occurs.<sup>111</sup> White Ribbon Australia submitted that safe access zones:<sup>112</sup>

act as a necessary prevention mechanism rather than merely responding to the harm that may result from harassment, intimidation or obstruction.

5.83 A number of respondents also considered that safe access zone provisions should be introduced for consistency with the majority of other Australian jurisdictions.<sup>113</sup>

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Termination or pregnancy is a medical and health issue, and patients should be afforded the same medical privacy for this as for any other health matter ... Exclusion zones must be established outside all reproductive health facilities to enable women and all people needing reproductive health care to access abortion and related health services in safety, dignity and medical privacy.

107 Eg, Submissions 312, 387, 406, 419, 452, 487, 539, 547, 712, 720, 885.

108 Submission 879.

109 Eg, Submissions 118, 276, 378, 542, 590, 592.

110 Submission 542.

111 Eg, Submissions 50, 89, 119, 406, 475, 590, 629, 632, 642, 707, 712, 754, 883.

112 Submission 883.

113 Eg, Submissions 50, 89, 119, 406, 452, 469, 475, 539, 542, 571, 590, 629, 632, 754, 810, 883, 888.

### ***Freedom of speech***

5.84 Many respondents considered that safe access zone provisions undermine freedom of speech.<sup>114</sup>

5.85 One respondent stated that safe access zone provisions would:<sup>115</sup>

impede freedom of speech which is an integral part of our democratic society. Peaceful non-obstructive protest should not be outlawed as far as it does not impede another individual's personal freedom.

5.86 Women's Forum Australia stated that:<sup>116</sup>

the ability for people to engage in peaceful protests or to freely engage in debate on political and moral issues is an intrinsic part of every Australian's implied right to freedom of political communication. In a democratic society, and on an issue like abortion which has such a profound impact on women, it is critical to uphold the rights of women to both express and have access to all views and perspectives on the perceived advantages or harms of abortion.

5.87 Some respondents, including legal academics, submitted that safe access zone provisions may be unconstitutional for unduly limiting the implied freedom of political communication.<sup>117</sup>

5.88 BAQ also noted that there is some uncertainty as to the constitutional validity of safe access zone provisions in other Australian jurisdictions, which are yet to be tested in the High Court. This respondent noted that 'concerns for [women and service providers] must be balanced with the rights of others to protest', and that the provisions 'which prohibit acts of protest ... are difficult to accept in a state where civil liberties including the right to protest are valued highly'. It concluded that:<sup>118</sup>

The Association does not support a new statutory regime where legitimate political protest is restricted in certain areas and in relation to certain issues.

5.89 However, many respondents, including Australian Lawyers for Human Rights, the Human Rights Law Centre Ltd, the Queensland Council for Civil Liberties, and the QLS, considered that safe access zone provisions do not impose an undue burden on the freedom of political communication, but can be appropriately tailored

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114 Eg, Submissions 42, 76, 108, 111, 127, 168, 169, 237, 244, 288, 328, 334, 343, 346, 363, 407, 413, 434, 483, 491, 527, 603, 703, 759, 766, 788, 799, 841, 842. Some respondents also considered that safe access zone provisions could undermine freedom of religion, particularly if prayer is a prohibited behaviour: eg, Submissions 339, 603, 627, 759 and 841.

115 Submission 111. Another respondent similarly stated that:

Queenslanders deserve the right to peaceful objection. Citizens should be permitted to hold signs, offer leaflets, pray, or in other ways express their beliefs and seek to influence people considering a termination or part of providing terminations. Such behaviour should never extend to violence or aggression: Submission 169.

116 Submission 769.

117 Eg, Submissions 122, 168, 494, 842.

118 Submission 878.

to achieve the legitimate purpose of ensuring that people have access to lawful health services in safety, without harassment, and with privacy and dignity.<sup>119</sup>

5.90 The Human Rights Law Centre Ltd stated that:<sup>120</sup>

Sensible and proportionate safe access zones, enacted for a legitimate purpose of protecting women from violence, harassment, surveillance and obstruction when trying to access a health service, do not unreasonably restrict freedom of expression. Overseas courts have noted that free speech rights do not extend to entitling people to a captive audience. When people cannot simply walk away, there is a greater imperative for protection of the rights of the audience. There is also a greater imperative in relation to abortion and other reproductive health care, given the intensely private and personal nature of the services for women. (note omitted)

5.91 The Queensland Council for Civil Liberties expressed the view that safe access zone provisions:<sup>121</sup>

can be clearly distinguished from laws against protesting outside say a forest or a mine. People visiting these clinics are engaged in a deeply personal, private and no doubt emotionally stressful activity. This justifies giving them some level of protection, whilst still allowing those with strong views on this topic a fairly wide opportunity to express their views on the topic.

5.92 One respondent considered that:<sup>122</sup>

A patient seeking treatment is in a situation of special vulnerability, and any hindrance to their lawful medical treatment is not a political expression but rather a personal attack.

5.93 Australian Lawyers for Human Rights submitted that safe access zone provisions are 'essential to protecting and promoting the human rights and safety of women and girls and the staff who care for them'. This respondent noted that behaviour such as protests or prayer vigils are 'just as harmful to women and girls seeking treatment' and clearly infringes a woman's 'right to privacy and dignity when accessing health services'. It explained that the right to freedom of speech is not an unqualified right:<sup>123</sup>

UN human rights bodies as well as courts in similar countries such as America and Canada have all found that sensible measures to ensure safe access to women's health services do not unreasonably limit the rights to freedom of expression and assembly. ...

Under international law and [in] most jurisdictions, the right to freedom of speech has never been an unqualified right. By contrast, access to safe and legal abortion services, in accordance with human rights standards, is part of a State's

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119 Eg, Submissions 50, 89, 119, 406, 469, 475, 482, 486, 539, 583, 590, 629, 630, 632, 669, 712, 734, 879, 888.

120 Submission 888.

121 Submission 669. This respondent also submitted that 'demonstrations and "footpath counselling" provide unnecessary stress on those visiting a facility', and stated that 'any counselling should be offered by health practitioners'.

122 Submission 109.

123 Submission 583.

obligations to eliminate discrimination against women and girls, and to ensure their right to health and other fundamental human rights.

Claims that safe access zones interfere with freedom of speech or religion misunderstand the very concrete terms, standards and norms enshrined in international human rights law, particularly the interdependent and indivisible nature of *all* human rights. (emphasis in original)

5.94 Australian Lawyers for Human Rights also noted that ‘safe access zones do not deny groups or individuals the opportunity to express their views’ generally.<sup>124</sup> RANZCOG similarly observed that safe access zones:<sup>125</sup>

do not prevent those who oppose termination of pregnancy from holding such views. People remain free to express their views, just not in a place that prevents women from exercising their right to privacy and reproductive health care.

5.95 QLS submitted that it:<sup>126</sup>

supports additional measures which promote the ability of women, support persons and health care staff to safely access these facilities. QLS suggests that in relation to ensuring safe and dignified access to health care, and to respecting freedom of political communication as they relate to premises which perform termination services, a fair balance may exist with the introduction of an appropriate access zone. We advise that the description of any offence ought to be carefully constructed to ensure that the intention of protecting patients and healthcare practitioners is appropriately restrained to facilities which carry out termination and related services.

### Establishment of safe access zones

5.96 In the Consultation Paper, the Commission asked whether, if safe access zone provisions are introduced in Queensland, they should:<sup>127</sup>

- automatically establish an area around the premises as a safe access zone. If so, what should the area be; or
- 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.

5.97 Most respondents considered that safe access zone provisions should automatically establish safe access zones around premises that provide termination services.<sup>128</sup>

<sup>124</sup> Submission 583. Two other respondents similarly noted that ‘people opposed to abortion have plenty of opportunity to influence public opinion’ and the political process, through other avenues: Submissions 547, 830.

<sup>125</sup> Submission 482.

<sup>126</sup> Submission 879.

<sup>127</sup> QLRC Consultation Paper No 76 (2017) Q-16.

<sup>128</sup> Eg, Submissions 50, 89, 118, 119, 164, 210, 220, 387, 406, 419, 422, 487, 490, 500, 510, 542, 562, 582, 583, 590, 600, 629, 630, 632, 673, 674, 720, 754, 830, 868, 879, 888.

5.98 Many noted that this is consistent with the majority of other Australian jurisdictions that have introduced safe access zone legislation.<sup>129</sup> A number of respondents also considered that the automatic establishment of safe access zones provides legal certainty.<sup>130</sup>

5.99 Some respondents considered that requiring safe access zones to be established by Ministerial declaration creates an unnecessary administrative hurdle,<sup>131</sup> and may undermine the purpose of safe access zones.<sup>132</sup> A number of respondents also expressed concern that the establishment of safe access zones should not be left to political will.<sup>133</sup>

5.100 A few respondents suggested a combined approach. They considered that the safe access zone provisions should automatically establish a safe access zone around termination services premises and also empower the Minister to make a declaration to extend the area if necessary to ensure the safety of women and staff.<sup>134</sup>

5.101 The Public Health Association of Australia preferred the automatic establishment of safe access zones ‘because every premises should be covered at all times—not merely at ministerial discretion—while it is operating as a provider of the relevant services’. However, this respondent also considered that:<sup>135</sup>

Legislation might usefully [allow] for the making of specific declarations relating to any given safe access zone so as to take into account local physical circumstances, consistent with the objectives of the law.

5.102 There were differing views as to what the area of a safe access zone should be, with responses ranging from 5 metres to 5 kilometres around termination services premises.

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129 Eg, Submissions 419, 542, 546, 572, 577, 583, 590, 629, 642, 674, 707, 712, 720, 810, 879.

130 Eg, Submissions 674, 707. The Institute for Urban Indigenous Health Ltd commented that ‘a fixed area ... provides clarity and certainty for women and the public’: Submission 707.

131 Eg, Submissions 118, 406, 547, 592, 669, 830. The Women’s Abortion Rights Campaign Brisbane observed that empowering the responsible Minister to establish safe access zones by declaration ‘causes unnecessary administrative and organisational hurdles to the establishment of safe access zones’: Submission 406. The Queensland Council for Civil Liberties noted that leaving the establishment of safe access zones to Ministerial declaration may result in unnecessary delay: Submission 669. Women’s Health Victoria observed that:

by relying on Ministerial discretion, the issue of safe access will be drawn out and ultimately left unresolved, subject to a change of Ministers, etc. It will effectively be up to women and health professionals to continuously advocate for safe access on a case by case basis, creating inefficiencies and costs to business as well as government: Submission 592.

132 Eg, Submissions 592, 888. Women’s Health Victoria commented that ‘relying on Ministerial discretion to determine which abortion-providing GPs are covered by protective areas on a case by case basis provides a disincentive to GPs to provide these services’; and ‘undermines the principle that women, no matter where they live, should be able to access common, safe and legal health services without experiencing obstruction, harassment or intimidation’: Submission 592.

133 Eg, Submissions 135, 406, 438, 547, 600, 888. The Human Rights Law Centre Ltd commented:

Given the sensitive and highly politicised nature of abortion, there may be strong political and other factors weighing against creating a protected area by Ministerial declaration, which could undermine the intent of the law: Submission 888.

134 Eg, Submissions 429, 487, 863, 882.

135 Submission 600.

5.103 However, many respondents, including health, support and advocacy organisations, medical practitioners and services who provide termination of pregnancy services, psychologists, legal practitioners and academics expressed support for an area of 150 metres,<sup>136</sup> which is consistent with safe access zone provisions in other Australian jurisdictions.<sup>137</sup>

### Prohibited behaviour

5.104 In the Consultation Paper, the Commission asked:<sup>138</sup>

- what behaviour should be prohibited in a safe access zone;
- whether the prohibition on behaviour in a safe access zone should apply only during a particular time period; and
- whether it should be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, termination services premises, unless the recorded person has given their consent.

5.105 The majority of respondents who supported the introduction of safe access zone provisions considered that behaviour, such as harassing, intimidating, interfering with, threatening or obstructing a person, should be prohibited in a safe access zone.

5.106 However, there were differing views on whether acts or communications in relation to terminations should also be prohibited.

5.107 Some respondents considered that behaviour, such as displaying posters, handing out leaflets, or approaching and speaking to women about termination, should be prohibited in a safe access zone.<sup>139</sup>

5.108 A number of respondents expressed a preference for the prohibition of behaviour in the same, or similar, terms as the Victorian legislation. In particular, those respondents considered that the legislation should prohibit communicating about termination, where the communication is reasonably likely to cause distress or anxiety.<sup>140</sup>

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<sup>136</sup> Eg, Submissions 50, 89, 118, 119, 164, 422, 452, 454, 500, 510, 511, 542, 572, 598, 623, 630, 632, 674, 879.

<sup>137</sup> Eg, Submissions 50, 89, 164, 629, 630, 632, 707, 712. Some respondents also noted that an area of 50 metres was initially declared in the Australian Capital Territory, but proved to be insufficient to provide adequate protection to patients and staff and was expanded to 150 metres: eg, Submissions 50, 542, 577.

<sup>138</sup> QLRC Consultation Paper No 76 (2017) Q-17, Q-18 and Q-19.

<sup>139</sup> Eg, Submissions 2, 70, 116, 421, 467, 526, 532, 584, 637, 649, 690, 863, 872. Some of those respondents considered that such behaviours may be harassing, stigmatising, impinge on people's privacy and dignity when they are accessing health care, may deter people from accessing services or may cause distress or anxiety.

<sup>140</sup> Eg, Submissions 50, 89, 118, 164, 387, 422, 487, 490, 539, 562, 577, 582, 590, 630, 632, 637, 673, 707, 712, 720, 879.

5.109 In contrast, a number of respondents considered that behaviour such as peaceful protest, prayer vigils, offering ‘support’, or expressing views about alternatives to abortion should not be prohibited.<sup>141</sup>

5.110 The majority of respondents considered that, if introduced, the prohibition on behaviour in a safe access zone should apply at all times.<sup>142</sup> A number of respondents, including the QLS and the Human Rights Law Centre Ltd, considered that this is the simplest and most pragmatic approach, which provides legal certainty.<sup>143</sup> Some respondents noted that this approach is consistent with the majority of other jurisdictions that have safe access zone provisions.<sup>144</sup> Several respondents, including medical practitioners, also noted that it is necessary to protect the safety of patients and staff after hours.<sup>145</sup>

5.111 In addition, the majority of respondents considered that it should be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, termination services premises, unless the recorded person has given their consent.<sup>146</sup>

5.112 Many of those respondents considered that such an offence would protect the privacy of patients and staff of termination services, and the medical confidentiality of people accessing terminations.<sup>147</sup>

5.113 A number of respondents considered that conduct such as filming or photographing a woman accessing termination services and publishing or distributing such recordings, is used as a form of intimidation and harassment.<sup>148</sup>

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<sup>141</sup> Eg, Submissions 122, 140, 150, 231, 374, 427, 428. As previously noted, many respondents considered that, if such behaviours are prohibited, it would undermine freedom of speech and peaceful assembly: see [5.84] above.

<sup>142</sup> Eg, Submissions 50, 89, 101, 118, 119, 158, 164, 210, 220, 249, 297, 387, 406, 419, 422, 429, 438, 487, 526, 539, 542, 546, 571, 577, 582, 583, 590, 629, 630, 632, 637, 669, 671, 673, 674, 707, 712, 720, 810, 863, 879, 882, 885, 888.

<sup>143</sup> Eg, Submissions 50, 89, 119, 438, 514, 542, 546, 577, 600, 630, 632, 637, 671, 707, 712, 720, 879, 888. One respondent noted that ‘if the prohibition is limited to a particular time period, it is likely to be more complex and difficult to enforce it’: Submission 438.

<sup>144</sup> Eg, Submissions 50, 89, 119, 419, 422, 487, 542, 590, 630, 632, 707, 712.

<sup>145</sup> Eg, Submissions 406, 487, 542, 571, 577, 590, 600, 637, 720, 810, 830, 863. One medical practitioner observed that ‘there may be circumstances when patients [or] staff may access the service facility outside the normal hours of opening’: Submission 637.

<sup>146</sup> Eg, Submissions 26, 50, 89, 164, 118, 119, 140, 164, 210, 297, 344, 387, 406, 419, 422, 429, 436, 438, 445, 454, 467, 487, 490, 510, 511, 514, 532, 542, 546, 547, 562, 571, 572, 577, 583, 589, 590, 598, 600, 630, 632, 650, 661, 669, 671, 673, 674, 690, 712, 720, 754, 810, 819, 830, 872, 879, 882, 885, 888.

<sup>147</sup> Eg, Submissions 18, 21, 140, 210, 262, 312, 387, 419, 422, 429, 438, 487, 490, 535, 542, 546, 583, 589, 590, 600, 629, 661, 669, 673, 674, 690, 712, 754, 810. One member of the public stated that ‘people have a right to privacy, particularly in sensitive issues such as healthcare’: Submission 18. A medical practitioner similarly commented that ‘everyone has the right to confidentiality in their health care’: Submission 140.

<sup>148</sup> Eg, Submissions 21, 50, 344, 438, 454, 467, 514, 583, 600, 629, 690, 707. A member of the public noted that conduct such as filming or photographing ‘is part of efforts to intimidate and harass women seeking an abortion and the employees of the abortion provider’: Submission 344. Another respondent similarly stated that ‘conduct of this kind is an invasion of the person’s privacy, usually aimed at embarrassing, shaming or intimidating them’: Submission 438.

5.114 Women's Abortion Rights Campaign Brisbane noted that:<sup>149</sup>

Video and audio recordings as well as stills can and have been used for public harassment and intimidation campaigns.

5.115 The National Alliance of Abortion and Pregnancy Options Counsellors also observed that:<sup>150</sup>

Technology-facilitated abuse is increasingly common in our society and there is international evidence that this strategy is being adopted by anti-abortion opponents to harass patients and/or staff outside termination clinics.

5.116 Some respondents considered that this type of conduct causes distress and anxiety to staff or patients, and may discourage or deter people from accessing or providing termination services.<sup>151</sup>

5.117 The Australian Psychological Society Limited considered that the inclusion of this offence:<sup>152</sup>

will prevent individuals or groups from seeking to shame, stigmatise, humiliate or cause distress to women by publishing images of them accessing premises providing abortions online.

5.118 Several respondents considered that the violation of privacy may particularly impact already vulnerable women, including women who are experiencing domestic and family violence,<sup>153</sup> Aboriginal and Torres Strait Islander women,<sup>154</sup> women in rural, regional and remote communities,<sup>155</sup> and women of culturally and linguistically diverse backgrounds.<sup>156</sup>

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149 Submission 406. A number of respondents, including Children by Choice, gave evidence of this type of conduct occurring at or near termination services premises: eg, Submissions 50, 89, 119, 164, 406, 577, 630, 632.

150 Submission 487.

151 Eg, Submissions 21, 312, 467, 514, 674, 754.

152 Submission 118.

153 Eg, Submissions 312, 546, 720. One respondent submitted that:

Women and pregnant persons accessing abortion services should be ensured privacy. This is of particular relevance for victims of domestic and family violence, sexual assault, or reproductive coercion, where the pregnant person has needed to keep their abortion confidential for their own safety: Submission 546.

154 The Institute for Urban Indigenous Health Ltd submitted:

In many Aboriginal and Torres Strait Islander communities and cultures, reproductive health and associated services are 'women's business'. The recording or publishing of Aboriginal and Torres Strait Islander women utilising reproductive health and termination of pregnancy services risks the dissemination of women's business to males, and additionally is also culturally objectionable.

The possibility of photography or recording of Aboriginal and Torres Strait Islander women in proximity to reproductive health and [termination of pregnancy] services risks women being 'shamed' and disinclined to access the service: Submission 707.

155 The former Health Services Commissioner, Victoria noted that:

Photographs of clients accessing abortion facilities have been taken by some protesters and have caused distress. This is particularly so in small towns where health privacy is extremely sensitive because everyone knows everyone: Submission 577.

156 The Centre Against Sexual Violence Inc. commented that:

## CONCLUSION

### A new general offence for protecting women and service providers

5.119 The draft legislation should not introduce a new general offence provision which makes it unlawful to harass a woman who is considering, or who has undergone, a termination; or a person who performs or assists, or who has performed or assisted in performing, a termination.

5.120 There is already a significant body of law dealing broadly with harassment, including the Criminal Code offence of unlawful stalking, the civil protection order scheme in the *Domestic and Family Violence Protection Act 2012* and the Criminal Code (Cth) offences relating to the use of telecommunications and the postal service to make threats or to menace, harass or cause offence.<sup>157</sup>

5.121 The Commission is conscious of the need for laws to keep up with the use of rapidly advancing technologies to engage in harassing behaviours.<sup>158</sup> However, it is unable to determine the extent to which existing laws are able to be used effectively in the context of the harassment of women or service providers in relation to terminations. In the absence of evidence suggesting that addressing harassment in this context is a clear problem in practice (beyond that which can be addressed by safe access zone legislation), the introduction of a specific offence or civil regime is not warranted.

### Safe access zone provisions

5.122 The draft legislation should include safe access zone provisions.

5.123 Termination of pregnancy is an issue about which many people have strongly held views. There is a history of ongoing activities by people who are opposed to terminations at or near termination services premises in Queensland. This is likely to continue in future.

5.124 The draft legislation broadens the lawful authority for performing terminations in Queensland. Women are entitled to access health services for terminations without interference and with privacy and dignity.

5.125 To the extent that safe access zone provisions prohibit certain conduct (such as protest or communications in relation to terminations) at or near termination services premises, they restrict the implied freedom of political communication and

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Women have a right to privacy protections for any medical treatment they choose to engage in including termination of pregnancy. Violation of a woman's privacy could have significant impacts for women particularly for women of culturally diverse backgrounds. We believe that this behaviour would act as a serious deterrent for women to be able to access a safe and legal termination: Submission 312.

<sup>157</sup> See the discussion of 'General laws addressing harassing, intimidating, obstructing or other behaviour' in this Chapter.

<sup>158</sup> The Commission notes, for example, that the Law Commission of England and Wales has recently been asked to review the laws around offensive communications and assess whether they provide the right protection to victims online: Law Commission of England and Wales, 'Government asks law commission to look at trolling laws' (6 February 2018) <<https://www.lawcom.gov.uk/government-asks-law-commission-to-look-at-trolling-laws/>>.

the right to peaceful assembly. However, neither the freedom of political communication nor the right of peaceful assembly is absolute.

5.126 Legislation may place some restrictions on the free expression of political communication, including peaceful protest, provided they are reasonably appropriate and adapted to serve a legitimate purpose in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government. Similarly, the right of peaceful assembly may be subject to restrictions that are necessary and reasonable in a democratic society in the interests of public safety, public order, or the protection of the rights and freedoms of other persons.<sup>159</sup>

5.127 The right to protest must be balanced with other rights and freedoms. They include a right to sexual and reproductive health and rights to privacy and personal autonomy.<sup>160</sup>

5.128 The draft legislation should provide that the purpose of the safe access zone provisions is to protect the safety and well-being and respect the privacy and dignity of persons accessing services provided at termination services premises and employees and others who need to access those premises in the course of their duties and responsibilities.

5.129 While existing laws, including public nuisance offences, may address some types of harassing, threatening or obstructing behaviour at or near termination services premises, they can only be enforced after the harmful behaviour has occurred.<sup>161</sup> Safe access zone provisions are intended to promote public safety and public order and will provide a simple and effective mechanism for the protection of women and service providers. Similar provisions appear to have been effective in curtailing harassing and intimidating conduct at or near termination services premises in other jurisdictions.<sup>162</sup>

5.130 Existing laws also do not adequately address the full range of behaviours engaged in by people who oppose terminations at or near termination services premises. Safe access zone provisions recognise that termination of pregnancy is a sensitive and personal issue. Although 'sidewalk counsellors' may view their behaviours as harmless, their presence at or near termination services premises interferes with the privacy and dignity of individuals who are accessing lawful terminations.<sup>163</sup>

5.131 In the past, some of the activities held at or near termination services premises, including prayer vigils and protests, have been authorised public

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<sup>159</sup> See the discussion of 'Freedom of political communication and peaceful assembly' in this Chapter.

<sup>160</sup> See further the discussion of 'rights of women' in Appendix C.

<sup>161</sup> See the discussion of 'General laws addressing harassing, intimidating, obstructing or other behaviour' in this Chapter, in relation to relevant summary offences and police powers to give move on directions (noting that such directions are temporary and may apply for a period of up to 24 hours).

<sup>162</sup> See [5.79] above.

<sup>163</sup> See [5.60] ff above; Information provided by Marie Stopes Australia, 29 March 2018.

assemblies under the *Peaceful Assembly Act 1992*.<sup>164</sup> It is intended that the safe access zone provisions will override the operation of the *Peaceful Assembly Act 1992* in relation to such activities. It would undermine the purpose of safe access zone provisions if, for example, an organiser of a protest in relation to terminations could hold an authorised public assembly in a safe access zone.

5.132 The safe access zone provisions are tailored to prohibit conduct that infringes the rights of other individuals at the time and place they are seeking to access lawful health services. The provisions do not otherwise prohibit people from protesting or expressing their views about termination of pregnancy.

5.133 The introduction of safe access zone provisions is consistent with other Australian jurisdictions that have recently reformed their termination of pregnancy laws.<sup>165</sup>

### **Establishment of safe access zones**

5.134 The draft legislation should provide for the establishment of safe access zones around ‘termination services premises’. For the purpose of these provisions, ‘termination services premises’ should be defined to mean premises at which a service of performing terminations is ordinarily provided. However, the draft legislation should make it clear that a pharmacy does not constitute a termination services premises.<sup>166</sup>

5.135 The draft legislation should provide that a place is in the safe access zone if it is in the premises or not more than a certain distance from an entrance to the premises. ‘Premises’ should be defined to mean a building or part of a building. The distance will therefore be measured from an entrance to the premises, or an entrance to the building in which the premises is located.

5.136 The distance should be 150 metres, unless otherwise prescribed by the Minister by regulation. A distance of 150 metres is consistent with the majority of other Australian jurisdictions that have enacted safe access zone provisions. In most cases, this should be sufficient to ensure the privacy and unimpeded access of any person entering or leaving the premises, without imposing an undue burden on the implied freedom of political communication or the right of peaceful assembly.

5.137 However, there may be cases where, due to the particular location or features of the premises, it is necessary to alter the distance of 150 metres (for example, if the termination services premises is part of a multi level, multi complex building). For this reason, the draft legislation should also provide that the Minister may prescribe another distance by regulation. The Minister’s power is not limited to extending the distance, as there may be circumstances where it is appropriate to reduce it (for example, if the termination services premises is located near Parliament House or another public place where protests ordinarily occur).

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<sup>164</sup> See [5.2], n 5 above; Information provided by Queensland Police Service, 5 April 2018.

<sup>165</sup> See the discussion of ‘Safe access zone legislation in other Australian jurisdictions’ in this Chapter.

<sup>166</sup> See further Rec 5-2, n 172 in this Chapter.

5.138 To ensure that the objectives of the safe access zone provisions are upheld, the draft legislation should provide that the Minister may recommend to the Governor in Council the making of the regulation only if satisfied that, having regard to the location of the premises, a distance of 150 metres is insufficient, or greater than is necessary, to ensure the privacy and unimpeded access of persons entering or leaving the premises.

### **Prohibited conduct in safe access zones**

5.139 The draft legislation should provide that it is an offence to engage in 'prohibited conduct' within a safe access zone. For simplicity and certainty, the prohibition should apply at all times.

5.140 'Prohibited conduct' should be defined to mean conduct that relates to terminations, or could reasonably be perceived as relating to terminations, that would be visible or audible to another person in, or entering or leaving, termination services premises, and that would be reasonably likely to deter a person from entering or leaving, or from requesting, undergoing or providing, a termination at the premises. However, the draft legislation should make it clear that, in proving the offence, it is immaterial whether a person saw or heard, or was deterred by, the conduct.

5.141 Ultimately, what constitutes prohibited conduct is a question of fact to be determined depending on the circumstances of each case.<sup>167</sup>

5.142 The draft legislation should make it clear that the offence of engaging in prohibited conduct does not apply to communications between a person employed to provide a service at the termination services premises and a woman who is attending the premises. This is to ensure that communications relating to the treatment of the pregnant person do not give rise to a breach of the section.

5.143 In addition, the draft legislation should provide that it is an offence for a person to make, publish or distribute a restricted recording of another person without the other person's consent and without reasonable excuse. For the purpose of this provision, a 'restricted recording' should be defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises, and that contains information that identifies, or is likely to lead to the identification of, the person. The draft legislation should provide broad and inclusive definitions of 'publish' and 'distribute', to cover the use of various mediums and technologies to publish or distribute, such as live streaming.

5.144 Consistently with the approach taken in other jurisdictions, this offence is intended to address the use of recordings to intimidate or threaten individuals who are seeking to access termination services premises or employees at those premises, and to protect their privacy and dignity.<sup>168</sup> It does not prohibit recordings of a person made, published or distributed with their consent. It also does not apply to footage taken by a security camera for security purposes or a recording made by

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<sup>167</sup> See, eg, *Bluett v Popplewell* [2018] ACTMC 2. In that case, it was held that inconspicuous silent prayer within a safe access zone did not, in the absence of any other symbolic display or gesture, constitute the prohibited behaviour of a 'protest, by any means', because there was no component of expression, communication or message to those around them.

<sup>168</sup> See the discussion of 'Safe access zone legislation in other Australian jurisdictions' in this Chapter.

a police officer acting reasonably in the course of their duties. Such recordings would constitute a 'reasonable excuse.

5.145 The penalty in relation to each new offence should be a fine of 20 penalty units or 1 year's imprisonment.<sup>169</sup> This is approximately double the penalty for a public nuisance offence under the *Summary Offences Act 2005*, and is appropriate because of the targeted nature of the offence and the harm that may be caused. It is also consistent with the penalty prescribed in other jurisdictions that have enacted safe access zone provisions.<sup>170</sup>

5.146 To ensure that police have adequate enforcement powers, these offences should be included in section 30 of the *Police Powers and Responsibilities Act 2000*. Accordingly, a police officer who reasonably suspects that a person has committed, is committing, or is about to commit an offence under the safe access zone provisions, will have the power, without a warrant, to stop, detain and search the person and anything in the person's possession and to seize all or part of a thing that may provide evidence of the commission of an offence.<sup>171</sup> This will enable a police officer, for example, to search a person's mobile phone for evidence that they have made, published or distributed a restricted recording.

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169 The prescribed monetary value of the 'penalty unit' is currently \$130.55: *Penalties and Sentences (Penalty Unit Value) Amendment Regulation 2018* (Qld).

170 See the discussion of 'Safe access zone legislation in other Australian jurisdictions' in this Chapter.

171 *Police Powers and Responsibilities Act 2000* (Qld) ss 29, 30.

## RECOMMENDATIONS

**5-1** The Termination of Pregnancy Bill should include safe access zone provisions and provide that the purpose of these provisions is to protect the safety and well-being, and respect the privacy and dignity of, people accessing the services provided at termination services premises and employees or other persons who need to access those premises in the course of their duties or responsibilities.

[See *Termination of Pregnancy Bill 2018 cl 10*]

**5-2** The Termination of Pregnancy Bill should provide that a place is in the safe access zone for premises at which a service of performing terminations is ordinarily provided ('termination services premises'),<sup>172</sup> if it is in the premises or not more than the prescribed distance from an entrance to the premises.

[See *Termination of Pregnancy Bill 2018 cll 11, 12(1)*]

**5-3** The Termination of Pregnancy Bill should provide that the prescribed distance is 150 metres, unless otherwise prescribed by the Minister by regulation.<sup>173</sup>

[See *Termination of Pregnancy Bill 2018 cl 12(2)–(4)*]

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<sup>172</sup> However, 'termination services premises' should not include a pharmacy: see Termination of Pregnancy Bill 2018 cl 11(b). The draft Bill defines 'pharmacy' to mean 'premises in which a pharmacy business within the meaning of the *Pharmacy Business Ownership Act 2001* is carried on': Termination of Pregnancy Bill 2018 sch 1 (definition of 'pharmacy'). 'Pharmacy business' is defined in that Act to mean 'a business providing pharmacy services', but does not include 'a business operated by the State at a public sector hospital' or 'another business at a hospital that provides pharmacy services only to patients at the hospital': *Pharmacy Business Ownership Act 2001* (Qld) sch (definition of 'pharmacy business').

<sup>173</sup> The Minister may recommend to the Governor in Council the making of the regulation only if satisfied that, having regard to the location of the premises, a prescribed distance of 150 metres is insufficient, or greater than is necessary, to achieve the purposes of the safe access zone provisions, in relation to the premises: Termination of Pregnancy Bill 2018 cl 12(4).

**5-4** The Termination of Pregnancy Bill should provide that it is an offence to engage in prohibited conduct in the safe access zone for termination services premises. ‘Prohibited conduct’ should be defined to mean conduct that: relates to terminations, or could reasonably be perceived as relating to terminations; would be visible or audible to another person in, or entering or leaving, the premises; and would be reasonably likely to deter a person from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, a termination.<sup>174</sup>

[See *Termination of Pregnancy Bill 2018 cl 13*]

**5-5** The Termination of Pregnancy Bill should provide that it is an offence for a person to make, publish or distribute a restricted recording of another person without the other person’s consent and without reasonable excuse. A ‘restricted recording’ should be defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises, and that contains information that identifies, or is likely to lead to the identification of, the person.

[See *Termination of Pregnancy Bill 2018 cl 14*]

**5-6** The Termination of Pregnancy Bill should prescribe a maximum penalty of 20 penalty units or 1 year’s imprisonment for each of the offences in Recommendation 5-4 and 5-5 above.

[See *Termination of Pregnancy Bill 2018 cl 13(3) and 14(2), (3)*]

**5-7** The Termination of Pregnancy Bill should amend section 30 of the *Police Powers and Responsibilities Act 2000*, by including the offences in Recommendation 5-4 and 5-5 above as one of the categories of prescribed circumstances in which a police officer may search a person without a warrant.

[See *Termination of Pregnancy Bill 2018 cl 25*]

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A person’s conduct may be prohibited conduct whether or not another person sees or hears the conduct or is deterred from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, a termination: *Termination of Pregnancy Bill 2018 cl 13(2)*. However, this offence should not apply to a person employed to provide a service at the termination services premises: *Termination of Pregnancy Bill 2018 cl 13(4)*.

# Chapter 6

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### INTRODUCTION

6.1 This chapter addresses the issues of counselling, data collection and consequential amendments to the Criminal Code and other legislation.

### COUNSELLING

6.2 Counselling is an important aspect of clinical care in the delivery of termination services. In this context, ‘counselling’ refers to counselling that might be provided to a woman contemplating a termination, which generally involves providing her with information about her options and supporting her to reach a decision. It also refers to counselling following a termination or a decision not to terminate a pregnancy.<sup>1</sup>

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<sup>1</sup> This is separate from the legal requirement to obtain a patient’s consent to medical treatment, which is discussed at [2.43] ff above. Terms such as ‘informed consent counselling’ or counselling about ‘medical risks’ are sometimes used to describe the process of obtaining a woman’s consent to termination / consent to medical treatment.

As to the different types of counselling, see generally: Parliamentary Committee Report No 24 (2016) ch 15; VLRC Report (2008) [8.60]–[8.68], [8.130]–[8.133].

6.3 The legislation in other Australian jurisdictions does not require a woman to attend counselling before or after a termination. In Western Australia, a medical practitioner is required to offer a woman a referral to counselling about matters related to terminating or completing a pregnancy, and inform her that counselling will be available if desired upon termination or after carrying the pregnancy to term.<sup>2</sup>

6.4 In Queensland, the clinical guideline sets standards for information and counselling in relation to terminations. This includes offering counselling to a woman before and after a termination, and where a woman considers but does not proceed with a termination.<sup>3</sup>

6.5 The clinical guideline sets out good medical practice points, which include providing ‘accurate, impartial and easy to understand information’ about options for continuing the pregnancy and parenting the child or placing the child for adoption, methods of termination and post-termination considerations such as contraception and counselling.<sup>4</sup>

6.6 Good medical practice points also include offering confidential and non-judgmental support and counselling. The clinical guideline recommends counselling be provided by a person — such as a psychologist, social worker or counsellor — who is ‘appropriately qualified and/or trained’, familiar with issues relevant to termination and has no vested interest in the outcome of the woman’s

<sup>2</sup> *Health (Miscellaneous Provisions) Act 1911 (WA)* s 334(5)(b), (c). The counselling must be ‘appropriate and adequate’. The medical practitioner who fulfils these requirements cannot be the medical practitioner who performs, or any medical practitioner who assists in performing, the termination of pregnancy: s 334(6). See also Women and Newborn Health Service, Western Australia, *Termination of Pregnancy: Information and Legal Obligations for Medical Practitioners* (2007) 7, 12; and 32, 38–39.

The Western Australian legislation also requires that a medical practitioner provide a woman with counselling about the medical risk of terminating or completing a pregnancy: s 334(5)(a). In this context, the term counselling is ‘synonymous with providing information’, and does not relate to counselling to assist in reaching a decision: Women and Newborn Health Service, Western Australia, *Termination of Pregnancy: Information and Legal Obligations for Medical Practitioners* (2007) 11–12.

A similar legislative requirement has been repealed in the Australian Capital Territory and Tasmania: *Health Regulation (Maternal Information) Act 1998 (ACT)* s 8(1)(a), (b) (repealed); *Criminal Code (Tas)* s 164(2)(b), (9) (as at 11 February 2014). In Tasmania, during debate on the Reproductive Health (Access to Terminations) Bill 2013, it was stated that ‘counselling is a clinical, service delivery issue rather than one to be directed by law’ and that ‘the decision to attend counselling sits best with the woman’. It was also observed that, for people who do seek counselling, it is important that it be ‘available, accessible, non-judgmental and impartial’: Tasmania, *Parliamentary Debates*, Legislative Council, 12 June 2013, 3 (C Farrell MLC).

<sup>3</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [3], [5], [6], [9]. The clinical guideline states generally that referral to other services is especially relevant where risk factors are present, including youth, sexual assault, domestic violence and particular cultural beliefs or values: [6]. A referral for post-termination counselling is suggested where there are ‘risk factors for long-term post-termination distress’, such as ambivalence prior to termination, lack of a supportive partner, a history of psychiatric illness or membership of a religion or culture that is opposed to termination of pregnancy: [9].

<sup>4</sup> Ibid [5].

pregnancy.<sup>5</sup> In addition, where feasible, counselling is to be offered ‘close to home’ to aid in establishing longer term counselling support.<sup>6</sup>

6.7 Clinical guidelines in South Australia, the Northern Territory and New South Wales similarly recommend that counselling be offered before and after any termination.<sup>7</sup>

6.8 The RANZCOG statement on termination of pregnancy also states that counselling by ‘appropriately qualified personnel’ should be ‘routinely available’ before and after any termination.<sup>8</sup>

6.9 The WHO recognises that women should have access to counselling before and after a termination, but that it should be voluntary, confidential, unbiased (or ‘non-directive’) and provided by a trained person.<sup>9</sup>

## Submissions

6.10 In the Consultation Paper, the Commission sought submissions on whether there should be any requirements in relation to offering counselling for the woman.<sup>10</sup>

6.11 There was a general consensus amongst respondents that counselling is an important aspect of clinical care. Many respondents also emphasised the need for women to be given education and support.

6.12 Overall, respondents were strongly supportive of counselling in relation to termination and considered that it should be available to any person who wishes to access it, before or after a termination.<sup>11</sup> It was observed that counselling is an

<sup>5</sup> Ibid. Counselling might be offered by a registered health practitioner (such as a psychologist or medical practitioner), a person who holds a relevant qualification and is a member of a professional organisation (such as the Psychotherapy and Counselling Federation of Australia or the Australian Association of Social Workers) or another person. It may also be offered by a range of services, including independent counselling services or services that provide terminations.

As to pregnancy counselling services, see generally Parliamentary Committee Report No 24 (2016) [15.2.1]. See, in relation to psychologists, Australian Psychological Society, *Code of Ethics* (2016). See also, in relation to social workers and counsellors, Australian Counselling Association, *Code of Ethics and Practice* (September 2015); Psychotherapy and Counselling Federation of Australia, *Interim Code of Ethics* (2015); Australian Association of Social Workers, *Code of Ethics* (2010). See also Council of Australian Governments Health Council, *National Code of Conduct for Health Care Workers (Queensland)* (October 2015).

<sup>6</sup> Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (updated 2018) [5]. Practitioners should also consider any requirement for a ‘formal mental health referral’, particularly if a woman has a history of mental illness. See also Parliamentary Committee Report No 24 (2016) [15.4.3].

<sup>7</sup> See, eg, Government of South Australia, Department for Health and Aging, *Standards for the management of termination of pregnancy in South Australia* (March 2014) 7; Northern Territory Department of Health, *Clinical Guidelines for Termination of Pregnancy* (June 2017) 21, 24, 42–3; NSW Government, Ministry of Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (July 2014) 3, 7.

<sup>8</sup> RANZCOG, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016) [4.3].

<sup>9</sup> See the discussion of ‘Access to health services, including abortion services’ and the overview table on ‘Other requirements or restrictions’ in Appendix C.

<sup>10</sup> QLRC Consultation Paper No 76 (2017) Q-13.

<sup>11</sup> Eg, Submissions 2, 26, 27, 50, 105, 118, 160, 210, 220, 250, 284, 297, 312, 341, 387, 419, 422, 436, 482, 487, 514, 539, 542, 572, 577, 579, 582, 583, 590, 600, 623, 637, 642, 680, 685, 707, 713, 734, 736, 807, 868, 885, 888.

important source of support for some women,<sup>12</sup> however other women may not want or need it.<sup>13</sup> Generally, respondents stated that counselling services should be accessible, professional, independent, impartial, unbiased, evidence based, inclusive of all options (parenting, adoption and termination), non-judgmental and non-directive.<sup>14</sup>

6.13 However, respondents had differing views about the extent to which counselling should be incorporated into the provision of termination services or be subject to any legislative requirement.

6.14 Some respondents were supportive of a legislative requirement for a woman to attend counselling or to be offered counselling before a termination.<sup>15</sup> The reasons given included:

- the nature, seriousness and gravity of the decision that the woman is making,<sup>16</sup> and because a termination involves ending the life of an unborn child;<sup>17</sup>
- the potential impact of termination on mental, emotional or physical health, and the need to provide resources and support if a woman's health is impacted;<sup>18</sup>

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Several respondents observed that offering or advising about the availability of counselling is a matter of 'good practice', or that whether counselling might be recommended or required should be a clinical decision based on individual circumstances: eg, Submissions 21, 26, 27, 109, 118, 119, 220, 421, 438, 532, 590, 600.

<sup>12</sup> Eg, Submissions 105, 341, 572, 590, 720, 860, 888. The Royal Australian and New Zealand College of Psychiatrists–Queensland Branch observed that accessible, affordable and appropriate mental health services are particularly important for women with particular care needs, including Aboriginal and Torres Strait Islander women, women who undergo termination due to fetal abnormality or at a late gestation, women with a serious mental illness and very young women: Submission 341.

Some respondents observed that counselling might also be important to others, such as the woman's partner: eg, Submissions 26, 81, 540, 690, 857.

<sup>13</sup> Eg, Submissions 118, 172, 220, 312, 419, 500, 542, 546, 572, 577, 590, 642, 736, 810.

<sup>14</sup> Eg, Submissions 2, 20, 26, 32, 35, 50, 53, 76, 111, 112, 135, 140, 165, 210, 220, 312, 341, 368, 378, 387, 406, 419, 433, 436, 448, 464, 482, 487, 510, 512, 539, 542, 546, 571, 572, 590, 600, 608, 649, 671, 674, 679, 734, 736, 740, 769, 773, 819, 826, 830, 834, 836, 872, 885, 888.

A small number of respondents suggested that counselling should prioritise the continuation of the pregnancy: eg, Submissions 434, 444, 448, 558, 575.

<sup>15</sup> Eg, Submissions 4, 49, 51, 65, 69, 100, 111, 137, 140, 144, 169, 170, 187, 194, 200, 224, 244, 264, 272, 277, 282, 283, 287, 288, 323, 328, 340, 359, 371, 385, 395, 396, 428, 433, 434, 444, 450, 455, 471, 491, 498, 502, 508, 512, 513, 515, 517, 518, 522, 528, 535, 543, 548, 551, 554, 557, 565, 575, 589, 599A, 627, 645, 661, 678, 679, 690, 703, 714, 730, 760, 769, 803, 819, 828, 834, 836, 846.

Some respondents also favoured a requirement for counselling following a termination, or supported counselling being made available: eg, Submissions 4, 278, 323, 328, 385, 399, 402, 427, 441, 450, 455, 470E, 502, 507, 515, 557, 589, 596, 658, 661, 666, 703, 766, 819, 834, 842.

Some respondents suggested that there should be a 'cooling off period' between any counselling and the performance of a termination: eg, Submissions 23, 111, 123, 169, 196, 204, 277, 385, 396, 369, 395, 396, 399, 402, 414, 455, 470E, 498, 512, 516, 517, 518, 557, 558, 565, 567, 599A, 608, 640, 645, 652, 655, 666, 703, 708, 740, 747, 763, 769, 773, 819, 836, 843.

<sup>16</sup> Eg, Submissions 371, 495, 508, 540, 550, 834.

<sup>17</sup> Eg, Submissions 75, 88, 272, 283, 289, 298, 308, 309, 314, 321, 343, 376, 388, 389, 396, 398, 427, 430, 434, 444, 447, 471, 493, 496, 498, 507, 516, 528, 530, 540, 548, 549, 574, 575, 633.

<sup>18</sup> Eg, Submissions 4, 51, 81, 84, 187, 204, 214, 218, 244, 255, 258, 264, 272, 282, 323, 359, 371, 385, 394, 396, 398, 413, 426, 427, 447, 470E, 471, 491, 498, 512, 515, 548, 551, 674, 679, 703, 728, 758, 783, 819.

- to provide women with an opportunity to discuss, understand and be given information relevant to the termination, including:
  - all available options for the pregnancy (including termination, adoption and parenting), and available supports;<sup>19</sup>
  - the termination procedure and the advantages and disadvantages, risks, or potential consequences of termination;<sup>20</sup>
  - the unborn child;<sup>21</sup>
- to check for and assist with any external pressure or coercion;<sup>22</sup> and
- concern that the offer or provision of adequate counselling, or more general support, may not always occur in practice.<sup>23</sup>

6.15 Other respondents opposed a legislative requirement to attend counselling or to offer counselling.<sup>24</sup> The reasons given included:

- concern that a legislative requirement could reinforce stigma about terminations, operate as a deterrent or barrier to services or cause delays in access, and waste resources;<sup>25</sup>
- women are capable of making their own decisions and many do not want counselling, with the consequence that having such a requirement might be disrespectful or suggest that women are not fully capable of decision-making;<sup>26</sup>

<sup>19</sup> Eg, Submissions 54, 69, 127, 140, 144, 194, 214, 233, 234, 244, 252, 258, 264, 273, 277, 278, 284, 287, 323, 340, 371, 395, 396, 404, 414, 427, 433, 434, 444, 448, 457, 464, 470E, 498, 507, 512, 518, 528, 535, 543, 550, 552, 557, 558, 565, 575, 587, 589, 608, 634, 659, 679, 690, 703, 723, 758, 760, 766, 797, 800, 803, 819, 828, 832, 836, 841, 842, 855.

<sup>20</sup> Eg, Submissions 53, 54, 58, 81, 127, 181, 194, 233, 244, 264, 272, 323, 350, 371, 385, 399, 409, 427, 434, 444, 455, 457, 464, 470E, 507, 512, 517, 518, 557, 574, 575, 589, 597, 603, 634, 640, 652, 659, 666, 679, 690, 714, 760, 763, 766, 797, 803, 819, 828, 832, 833, 836, 838, 841, 842, 862, 874.

<sup>21</sup> Some respondents submitted that counselling should include showing a woman an ultrasound of the unborn child or having her listen to the fetal heartbeat: eg, Submissions 88, 100, 127, 140, 170, 194, 277, 282, 400, 409, 413, 457, 513, 517, 518, 530, 633, 661, 679, 701, 747, 760, 763, 828, 832.

<sup>22</sup> Eg, Submissions 127, 140, 145, 264, 323, 411, 491, 493, 535, 730, 803, 819, 836, 841, 842.

<sup>23</sup> Eg, Submissions 181, 288, 498, 504, 506, 587, 842.

<sup>24</sup> Eg, Submissions 2, 21, 26, 27, 50, 105, 118, 119, 139, 142, 160, 210, 297, 312, 344, 378, 387, 405, 406, 419, 422, 429, 430, 438, 452, 454, 467, 478, 482, 487, 490, 500, 510, 532, 539, 542, 546, 547, 562, 571, 572, 573, 582, 583, 590, 600, 623, 637, 642, 649, 669, 671, 673, 680, 685, 688, 707, 712, 713, 717, 720, 734, 736, 754, 806, 810, 830, 863, 868, 885, 888. These respondents generally supported counselling and considered that it should always be available, but that it should not be subject to any legislative requirements.

<sup>25</sup> Eg, Submissions 341, 406, 542, 547, 600, 669, 685, 707, 712, 720, 810, 830. A requirement may be a particular barrier for women who are vulnerable or experiencing domestic violence, or for Aboriginal and Torres Strait Islander women: eg, Submissions 546, 707, 720.

<sup>26</sup> Eg, Submissions 108, 118, 438, 500, 542, 546, 572, 734.

- concern about how a requirement might operate in practice and the quality and consistency of counselling services, including that not all counsellors are subject to a professional regulatory scheme;<sup>27</sup>
- a legislative requirement to offer counselling may be unnecessary because the process of obtaining informed consent seeks to provide women with information about the procedure and alternatives, determine that the termination is voluntary and allow for any uncertainty, ambivalence or distress to be identified and addressed, and because offering access to counselling is a standard part of good clinical practice and is adequately reflected in Queensland clinical guidelines.<sup>28</sup>

## Conclusion

6.16 The draft legislation should not impose any requirement that a woman be offered counselling or required to attend counselling before a termination (or after a woman has had a termination).

6.17 It is important that professional, unbiased, confidential and non-judgmental counselling is available and accessible to women who are contemplating a termination, and women who have undergone, or contemplated but decided against, a termination.

6.18 Counselling is better addressed as a matter of clinical practice, rather than by legislation. Consistently with treating termination as a health matter, the decision to attend counselling should be one that is made by a woman in consultation with relevant health practitioners.

6.19 Counselling is adequately and appropriately addressed by current clinical practice and guidelines relevant to the provision of termination services. The inclusion of counselling in guidelines acknowledges the importance of counselling while also giving a practitioner the flexibility to take into account each woman's individual circumstances. Professional regulation requires that medical and other health practitioners comply with clinical standards.

6.20 Any legislative requirement in relation to counselling could be an additional barrier to accessing services for some women. It could also give rise to uncertainty regarding enforceability and lawfulness for health practitioners.

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<sup>27</sup> Eg, Submissions 50, 135, 487, 539, 542, 562, 582, 623, 868. Several respondents noted a lack of consistent regulation of counselling, although it was observed that efforts to improve regulation are being made by relevant peak bodies: Submissions 50, 312, 487, 514, 539, 562, 582, 590, 600; also, eg, Submissions 573, 642, 673, 647, 688, 720, 734, 806, 810, 868. Some respondents also expressed concern that women might be intentionally or unintentionally directed to or provided with counselling services that are not objective: eg, Submissions 50, 135, 487, 542, 582, 868.

<sup>28</sup> Eg, Submissions 50, 119, 387, 429, 487, 490, 497, 500, 529, 532, 546, 562, 571, 581, 582, 583, 590, 669, 673, 688, 707, 720, 736, 810, 868, 879.

More generally, some respondents observed that counselling is offered and provided in practice, that counselling is a matter for good medical practice and medical guidelines rather than legislation, and that current Queensland guidelines about counselling are sufficient: eg, Submissions 21, 27, 118, 119, 220, 429, 467, 685, 717, 888. It was suggested that 'compulsory requirements are not best practice nor in the best interests of Queensland women and pregnant persons': Submission 546.

6.21 Finally, some respondents supported a requirement to attend counselling before a termination on the basis that it is a means of providing women with information about the procedure and the associated risks, or ensuring that a woman is not being pressured or coerced into a termination. The Commission observes that these matters are generally addressed as part of the process of obtaining consent to medical treatment.<sup>29</sup>

## DATA COLLECTION AND REPORTING

6.22 As mentioned in Chapter 2, there is no standardised national data collection or reporting specific to terminations,<sup>30</sup> and available data for Queensland are incomplete.

6.23 Queensland Health maintains a number data of collections relating to health matters and the use of health services in Queensland, including the Queensland Hospital Admitted Patient Data Collection and the Perinatal Data Collection.<sup>31</sup> Although not specific to terminations, these collections include some data about the incidence of terminations in Queensland.<sup>32</sup>

6.24 The Queensland Hospital Admitted Patient Data Collection records data submitted by public hospitals and licensed private health facilities about relevant clinical diagnoses and procedures that occur for admitted patients.<sup>33</sup> Accordingly, it records all patient admissions in those facilities that are identified as having involved a termination.<sup>34</sup>

6.25 The Perinatal Data Collection collects data on all births in Queensland, including stillbirths of at least 20 weeks gestation or 400 grams in weight and neonatal deaths ('perinatal deaths').<sup>35</sup> Along with other data collected about perinatal deaths, such as the mother's age, the fetal birth weight and whether the pregnancy

<sup>29</sup> See the discussion of 'Consent to medical treatment' in Chapter 2.

<sup>30</sup> See the reference to Medicare data in the discussion of 'The incidence of terminations' in Queensland in Chapter 2.

<sup>31</sup> See generally Queensland Health, *Statistical Services Branch* (16 October 2017) <<https://www.health.qld.gov.au/hsu>>.

<sup>32</sup> See the data on the incidence of terminations in Queensland in Chapter 2 above.

<sup>33</sup> See Queensland Health, *Queensland Hospital Admitted Patient Data Collection (QHAPDC)* (2 March 2016) <<https://www.health.qld.gov.au/hsu/collections/ghapdc>>. All public hospitals and licensed private health facilities are required to submit data to the Department of Health, Statistical Services Branch, about patients 'separated' (meaning discharged, died, transferred or statistically separated) from those hospitals. Hospitals have 35 days after the end of a reference period to submit their data to the Department: Information provided by Queensland Health, 13 December 2017 and 20 and 23 February 2018.

<sup>34</sup> Information provided by Queensland Health, 13 December 2017 and 20 and 23 February 2018.

<sup>35</sup> The *Public Health Act 2005* (Qld) ch 6 pt 1 requires the Chief Executive of the Department of Health to collect perinatal data and requires hospitals and other designated persons to notify the Chief Executive in the approved form. Notifications are to be made within 35 days after the day of birth: *Public Health Regulation 2005* (Qld) s 13. See generally, and for the approved forms, Queensland Health, *Perinatal Data Collection* (22 June 2016) <<https://www.health.qld.gov.au/hsu/collections/pdc>>. A 'perinatal death' is a stillbirth (of at least 20 weeks gestation or 400 g birth weight) or a neonatal death (of a live born infant within the first 28 days of life): Queensland Department of Health, *Perinatal Statistics: Queensland 2016, Preliminary* (January 2018) 12–14. Queensland data is incorporated into the National Perinatal Data Collection: see generally Australian Institute of Health and Welfare, *National Perinatal Data Collection* (1 March 2018) <<https://www.aihw.gov.au/about-our-data/our-data-collections/national-perinatal-data-collection>>.

was a multiple pregnancy, the data records those perinatal deaths that are identified as a termination.<sup>36</sup>

6.26 Queensland Health does not, however, have data on terminations that occur in an outpatient setting where the patient is not admitted to a public hospital or licensed private health facility. Accordingly, the available Queensland data do not include medical terminations carried out by general practitioners in an outpatient setting.<sup>37</sup>

6.27 Queensland Health publishes annual reports on perinatal statistics.<sup>38</sup> Data relating to terminations from the Queensland Hospital Admitted Patient Data Collection is not, however, routinely published.<sup>39</sup>

### Other jurisdictions

6.28 The termination legislation in South Australia, Western Australia and the Northern Territory requires the notification of detailed information about terminations to the relevant health department. The notifiable information varies in each jurisdiction, but generally includes information about where and when the termination occurred, the reason for termination, the gestation of the pregnancy, the method of termination and general patient characteristics (such as the patient's age and place of residence).

6.29 In South Australia, a medical practitioner must provide a certificate and notice in the prescribed form to the Chief Executive<sup>40</sup> for every termination performed by the practitioner.<sup>41</sup> In addition, the chief executive officer of a hospital at which a pregnancy is terminated must notify the Chief Executive of the number of terminations at the hospital during the calendar month.<sup>42</sup> Failure to comply with these notification requirements is an offence, punishable by a fine of up to \$200.<sup>43</sup> Data on

<sup>36</sup> See Queensland Department of Health, *Perinatal Statistics: Queensland 2016, Preliminary* (January 2018) Table 10.13 and related Tables.

<sup>37</sup> Information provided by Queensland Health, 13 December 2017 and 20 and 23 February 2018.

<sup>38</sup> See generally Queensland Health, *Perinatal reports and information* (23 November 2016) <<https://www.health.qld.gov.au/hsu/peri>>.

<sup>39</sup> Information provided by Queensland Health, 23 February 2018. An application can be made to Queensland Health to access data for research purposes, and may be granted if it is in the public interest: *Public Health Act 2005* (Qld) ch 6 pt 4. See generally Queensland Health, *How to access data from the Statistical Services Branch for your research project* (24 April 2018) <<https://www.health.qld.gov.au/hsu/how-to-access-data-from-ssb>>. See also *Public Health Act 2005* (Qld) ch 6 and *Information Privacy Act 2009* (Qld) which impose obligations about the confidentiality of information.

<sup>40</sup> The Chief Executive means the chief executive of the administrative unit of the Public Service that is, under the relevant Minister, responsible for the administration of the *Health Care Act 2008* (SA): *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 3 (definition of 'chief executive').

<sup>41</sup> *Criminal Law Consolidation Act 1935* (SA) s 82A(4)(b); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 4, sch 1. The certificate and notice must be delivered or posted within 28 days of the termination.

<sup>42</sup> *Criminal Law Consolidation Act 1935* (SA) s 82A(4)(b); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 5, sch 2. The notice must be provided within 20 days of the end of the calendar month.

<sup>43</sup> *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 8. It is also an offence, with a maximum penalty of \$200, to knowingly provide information that is false or misleading.

the incidence of terminations is reported annually, and published online, by South Australia Health along with other pregnancy outcome statistics.<sup>44</sup>

6.30 In Western Australia, a medical practitioner who performs a termination must notify the Chief Health Officer in the prescribed form about the termination.<sup>45</sup> The Department of Health, Western Australia publishes annual reports on induced termination data.<sup>46</sup>

6.31 In the Northern Territory, a medical practitioner who performs or directs the performance of a termination must report prescribed information about the termination to the Chief Health Officer.<sup>47</sup> Failure to comply with the requirements is an offence, punishable by a fine of up to \$3080.<sup>48</sup> These requirements were introduced in 2017, and collected data has not been published.

6.32 In its 2008 report, the Victorian Law Reform Commission considered the inclusion of similar legislative notification requirements. However, it found that this was not necessary in Victoria because private providers are required to give detailed statistics to the Department of Health and Human Services as part of their registration requirements, and public providers must provide similar statistical information as part of their funding agreements.<sup>49</sup> Data on the incidence of terminations in Victoria is not routinely published.<sup>50</sup>

6.33 The Victorian Law Reform Commission observed that the States and Territories should ideally work together to improve and standardise national data collection.<sup>51</sup>

44 See Pregnancy Outcome (Statistics) Unit, SA Health, *Pregnancy outcome statistics* (21 December 2017) <<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>>.

45 *Health (Miscellaneous Provisions) Act 1911* (WA) s 335(5)(d). The notification is to be provided within 14 days of the termination, and must not contain any particulars that may identify the patient: s 335(5)(e). A medical practitioner must also notify the Chief Health Officer, within 48 hours, of attending on a termination (other than a termination performed by the practitioner): s 335(5)(a). Notification requirements are also imposed on midwives and homebirth practitioners: s 335(1)–(4).

46 See Government of Western Australia Department of Health, *Reports on induced abortions in Western Australia* <<http://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia>>.

47 *Termination of Pregnancy Law Reform Act 2017* (NT) s 17; *Termination of Pregnancy Law Reform Regulations* (NT) regs 8, 10. The information must be provided in the approved form within the prescribed time, namely: for a termination by surgical procedure or by a combination of both a surgical procedure and use of a termination drug, within 28 days after the termination is performed; for a termination by the use of a termination drug or by a means other than a surgical procedure or the use of a termination drug, within 28 days after the practitioner's last consultation with the woman in relation to the termination: *Termination of Pregnancy Law Reform Regulations* (NT) reg 9.

48 *Termination of Pregnancy Law Reform Regulations* (NT) reg 10. The offence is an offence of strict liability. It is a defence if the medical practitioner has a reasonable excuse. The maximum penalty is 20 penalty units, presently \$3080: see *Penalty Units Regulations* (NT) reg 2.

49 VLRC Report (2008) [8.191]–[8.198], Rec 12. See generally Victoria Health and Human Services, Victorian Admitted Episodes Dataset (VAED) Manual (27th ed, June 2017) 3–4 <<https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>>. As to private providers, see *Health Services Act 1988* (Vic) s 158(1)(o); *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013* (Vic) pt 13.

50 VLRC Report (2008) [8.199].

51 VLRC Report (2008) [8.201]–[8.202].

## Submissions

6.34 In the Consultation Paper, the Commission sought submissions on whether there should be mandatory reporting of termination data in Queensland.<sup>52</sup>

6.35 Most respondents who addressed this question, including a number of peak health profession bodies, expressed general support for data collection and reporting.<sup>53</sup> Many of these respondents considered that improved data collection would help inform service delivery and policy development.<sup>54</sup> RANZCOG submitted that:<sup>55</sup>

In order to better understand the individual and public health impacts of termination of pregnancy, the College supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.

6.36 The Australian Women's Health Network similarly submitted that:<sup>56</sup>

Every effort should be made to develop a reliable data base (drawing from public and private state and national data, including Medicare) for decisions about workforce planning and development, service delivery planning, addressing barriers to service access, and monitoring the success or otherwise of public health interventions in reducing rates of unplanned pregnancy, at both state and national levels.

6.37 Some respondents, who were opposed to the decriminalisation of termination, supported data collection for greater transparency.<sup>57</sup> The Lutheran Church of Australia submitted that:<sup>58</sup>

Keeping accurate statistics also reminds both the public and health providers that the taking of unborn human life is a significant matter. It would go some way towards showing respect for life if the Queensland government could produce evidence to show that each of the over 10 000 abortions performed annually in recent years was performed only after ascertaining that the grounds for termination were clearly met.

6.38 Others expressed concerns that data collection and reporting should protect individual privacy and avoid unintended consequences.<sup>59</sup> AMA Queensland submitted that:<sup>60</sup>

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<sup>52</sup> QLRC Consultation Paper No 76 (2017) Q-20.

<sup>53</sup> Eg, Submissions 26, 50, 89, 101, 105, 108, 118, 119, 140, 210, 220, 276, 341, 387, 406, 422, 429, 482, 487, 490, 539, 562, 572, 582, 583, 590, 600, 621, 623, 629, 674, 707, 712, 720, 754, 819, 836, 882, 885.

<sup>54</sup> Eg, Submissions 26, 50, 108, 119, 210, 220, 249, 276, 341, 387, 406, 422, 429, 482, 487, 490, 539, 546, 562, 572, 583, 590, 600, 621, 623, 629, 669, 707, 712, 720.

<sup>55</sup> Submission 482.

<sup>56</sup> Submission 590.

<sup>57</sup> Eg, Submissions 42, 65, 86, 145, 327, 411, 434, 493, 575, 589, 603, 661, 690, 819.

<sup>58</sup> Submission 589.

<sup>59</sup> Eg, Submissions 27, 116, 262, 297, 438, 478, 583, 621, 707, 712, 885.

<sup>60</sup> Submission 885.

More data is always valuable and helps promote public health. However, even if this data is anonymised it must be limited to collecting basic incidence and demographic data for legitimate public health purposes. If this data goes beyond this limited scope, for example by including information on whether or not the patient undertook counselling or what their reason for seeking a termination was, it could have the unintended effect of stigmatising women who obtain terminations.

6.39 Another respondent, a lawyer, similarly submitted that:<sup>61</sup>

with any mandatory reporting system, extreme care must be taken to ensure that the reporting requirement does not become stigmatising for women undergoing abortion, and that the data set to be reported does not have the unintended consequence of breaching their privacy.

6.40 The Institute for Urban Indigenous Health Ltd expressed concern about the potential risk of identification of women in 'relatively smaller communit[ies] of Aboriginal and Torres Strait Islander women, and particularly those from discrete communities'.<sup>62</sup>

6.41 The Sunnybank Centre for Women expressed the view that:<sup>63</sup>

Mandatory reporting requirements should not be so onerous as to deter or discourage the provision of medical termination of pregnancy by General Practitioners in private practice.

6.42 Some respondents, including Marie Stopes Australia, expressed general support for mandatory reporting, but considered that this would be better achieved at a national level.<sup>64</sup>

6.43 A few respondents opposed the introduction of mandatory reporting obligations, suggesting that this should be treated in the same way as other medical or surgical procedures, or that a mandatory requirement would impose an unnecessary administrative burden.<sup>65</sup> The Queensland Council for Civil Liberties submitted, for example, that 'this is no different from the reporting of other medical procedures, and so there should be no special requirement for mandatory reporting'.<sup>66</sup>

6.44 Similarly, a specialist obstetrician and gynaecologist considered that, whilst there should be a specific data collection for termination, this should not be required by legislation.<sup>67</sup>

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61 Submission 438.

62 Submission 707.

63 Submission 27.

64 Submissions 526, 674. Marie Stopes Australia suggested that new Medicare item numbers could be created that specifically identify surgical and medical termination of pregnancy.

65 Eg, Submissions 109, 456, 467, 500, 669.

66 Submission 669.

67 Submission 532.

## Conclusion

6.45 The collection and reporting of data about termination is important, and would help inform the delivery of and access to termination services, and the impact of legislative reforms.

6.46 However, the categories of data to be collected and the extent to which data should be publicly released are matters for health legislation and administration, taking into account a range of considerations including service delivery requirements, confidentiality and privacy obligations, and national data collection agreements.

6.47 Accordingly, the Commission does not recommend that the draft legislation include provisions about collection or reporting of data about terminations.

## CONSEQUENTIAL AMENDMENTS TO THE CRIMINAL CODE

### Section 282 of the Criminal Code

6.48 Section 282 of the Criminal Code provides a defence for medical treatment and surgical operations, including terminations.

6.49 The Commission's recommended provisions for lawful terminations in Chapter 3 of this Report have the potential to operate inconsistently with section 282 of the Criminal Code.

### Submissions

6.50 Section 282 was not the subject of a specific question in the Consultation Paper.<sup>68</sup>

### Conclusion

6.51 The Commission's terms of reference do not require it to review section 282 of the Criminal Code. However, they require it to make recommendations to 'provide clarity in the law'.<sup>69</sup>

6.52 As noted in Chapter 2, section 282 limits the circumstances in which a termination is lawful under the current law to those where the termination is performed to 'preserve the mother's life', an expression associated in the context of laws relating to terminations with the Menhennitt ruling.<sup>70</sup> Under that ruling, this expression has been held to mean a termination that is necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the

<sup>68</sup> One respondent suggested that the phrase 'preserve the mother's life' in section 282(1)(b) should be 'limited to a "serious threat of death" if the pregnancy is not terminated': Submission 679.

<sup>69</sup> See terms of reference, paras 2 and C in Appendix A.

<sup>70</sup> Criminal Code (Qld) s 282(1)(b); *R v Davidson* [1969] VR 667. See the discussion of s 282 and judicial interpretation under the 'Current law in Queensland' in Chapter 2.

pregnancy would entail and in the circumstances not out of proportion to the danger to be averted.<sup>71</sup>

6.53 The Commission's recommended provisions for lawful termination would alter the current law to provide that a termination is lawful if it is performed by a medical practitioner and, for terminations after 22 weeks, in accordance with the stated requirements for a lawful termination.<sup>72</sup>

6.54 The recommended provisions also authorise a medical practitioner to perform a termination, after 22 weeks, in particular emergency circumstances.<sup>73</sup>

6.55 However, the Commission recommends that it should continue to be unlawful (under a new offence provision) for an 'unqualified person' to perform or assist in performing a termination.<sup>74</sup> An 'unqualified person' means:

- in relation to performing a termination — a person who is not a medical practitioner;<sup>75</sup> and
- in relation to assisting in the performance of a termination — a person who is not a medical practitioner or a nurse, midwife or authorised pharmacist providing the assistance in the practice of their respective professions.

6.56 The Commission recommends that the scope of section 282 should be amended in several respects.

6.57 Arguably, section 282(1)(a) and the definition of 'patient' in section 282(4) in their current form have the effect that a medical practitioner who performs a termination is not excused from criminal liability.

6.58 In their current form, the definitions of 'medical treatment' and 'surgical operation' in subsection (4) exclude, for subsection (1)(a), a surgical operation or medical treatment 'intended to adversely affect an unborn child'. 'Patient' is defined in subsection (4) to mean 'the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided'.

6.59 Arguably, subsection(1)(a) and the definition of 'patient' in subsection (4) have the combined effect that, in relation to a termination, an operation performed on or treatment provided to an unborn child (the 'patient') would not be for the 'benefit' of the unborn child. Similarly, in the case of multiple pregnancies, an operation on or treatment to an unborn child to save the life of another unborn child would arguably not be for the benefit of the 'patient' — either the mother or the unborn child 'on whom the surgical operation is performed or of whom the medical treatment is provided'.

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71 *R v Davidson* [1969] VR 667, 672.

72 See Recs 3-1 to 3-4.

73 See Rec 3-4 and the discussion of 'an exception for emergencies' in Chapter 3 above. As noted in Chapter 3, it is unnecessary for similar provision to be made for a termination performed before 22 weeks since no requirements are recommended for such a termination that would need to be exempted in the case of an emergency.

74 See Recs 3-8 ff.

75 See the discussion of 'Medical practitioners' in Chapter 3 above.

6.60 Section 282(1)(a) should be omitted and replaced by a new section which provides that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child if performing the surgical operation or providing the medical treatment is reasonable, having regard to all the circumstances of the case.

6.61 The recommended new defence should be available to a medical practitioner performing a termination or a health practitioner assisting (within their scope of practice) in the performance of a termination under the recommended new provisions for lawful terminations, but not to an unqualified person.

6.62 Accordingly, the Commission recommends that the definitions of 'medical treatment' and 'surgical operation' in section 282(4) be amended by the omission of the references to subsection (1)(a) and by limiting the exclusion in respect of medical treatment or a surgical operation 'intended to adversely affect an unborn child' to medical treatment or a surgical operation by an 'unqualified person'.

6.63 In addition, section 282(1)(b) should be omitted and replaced by a new section to provide, consistently with Recommendation 3-4 above, that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child in an emergency if it is necessary to perform the operation or provide the treatment to save the mother's life or the life of another unborn child.

6.64 The words 'to save the mother's life' are recommended instead of the current test 'to preserve the mother's life'. The current test might be broadly interpreted in accordance with the *Menhennitt* ruling. However, the Commission considers that the scope of the section 282 defence for an 'unqualified person' should not exceed what a medical practitioner would be permitted to do in an emergency under the recommended new provisions for lawful terminations.

6.65 The words 'or the life of another unborn child' should be added to the provision to take into account the rare possibility that it may be necessary in an emergency to perform an operation on or provide treatment to a woman with multiple pregnancies to save the life of an unborn child.

6.66 Under the recommended amendments, the definition of 'patient' in section 282(4) is no longer necessary for the operation of the section and should be omitted.

6.67 Depending on the circumstances, the effect of the recommended amendments would be to provide a defence for a medical practitioner (and a health practitioner assisting within their scope of practice) in respect of:

- an offence under section 313(1) of the Criminal Code where the medical practitioner performs a termination other than in accordance with the provisions for a lawful termination; or
- offences relating to harm or death to the mother.

6.68 To engage the defence in either circumstance a medical practitioner (or a health practitioner assisting within their scope of practice) would be required to show that:

- they acted in good faith;
- they acted with reasonable care and skill; and
- performing the operation or providing the treatment was reasonable, having regard to all the circumstances of the case.

### Section 313 of the Criminal Code

6.69 The Commission's recommended provisions for lawful terminations in Chapter 3 of this report have the potential to be inconsistent with section 313 of the Criminal Code.

### Submissions

6.70 Although not the subject of a specific question in the Consultation Paper, the operation of section 313 of the Criminal Code was raised by some respondents.

6.71 The Human Rights Law Centre Ltd raised a concern that section 313(1) of the Criminal Code may criminalise 'late-term' consensual terminations lawfully performed by qualified practitioners, and argued it should be repealed:<sup>76</sup>

[Section 313(1)] could apply to abortions where the fetus is capable of being born alive (often referred to as a 'late-term abortion'). Section 313(1) is worded in such a way as to create uncertainty about the circumstances in which a late-term abortion performed with a woman's consent by a qualified practitioner could be the subject of a criminal prosecution.

...

Any criminal provisions that seek to prevent the destruction of a fetus by an unqualified person or to ensure appropriate punishment where a criminal act against a woman destroys or harms her fetus, must be appropriately adapted to this purpose and not capable of extending to late-term consensual abortions performed by qualified practitioners. This necessitates the repeal of section 313(1). (note omitted)

6.72 However, the Human Rights Law Centre Ltd supported the retention of section 313(2) to cover 'unlawful acts against women that harm them by destroying or injuring the fetus they are carrying':<sup>77</sup>

The section attaches the harm to the fetus to an unlawful assault on a woman, and has been interpreted as addressing 'the occasioning of harm via an assault on the pregnant female to the life forming within her', whilst not imputing 'any requirement regarding the likely fate of that life without her.'

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<sup>76</sup> Submission 888.

<sup>77</sup> Ibid, quoting *R v Waigana* (2012) A Crim R 20, [15].

6.73 The Human Rights Law Centre Ltd suggested that, in the alternative, Queensland should adopt the approach taken in Victoria<sup>78</sup> and New South Wales.<sup>79</sup>

6.74 Some respondents highlighted the apparent inconsistency between section 313(2) and section 292, in arguing that a fetus should be protected from termination.<sup>80</sup> One respondent commented that:<sup>81</sup>

[There is an] apparent contradiction between the protection accorded to the ‘child’ in section 313(2) and the statement that he or she is ‘not a human being capable of being killed’ in section 292.

## Conclusion

6.75 The Commission’s terms of reference do not require it to review section 313 of the Criminal Code. However, they require it to make recommendations to ‘provide clarity in the law’.<sup>82</sup>

### Section 313(1)

6.76 As noted in Chapter 2, the scope of section 313(1) is uncertain.<sup>83</sup> On one reading, the phrase in section 313(1), ‘about to be delivered of a child’, suggests it has an extremely limited scope and potentially may apply only to cases in which delivery is imminent. On the other hand, the section could be given a much broader meaning and apply to a ‘viable’ fetus, that is, one that is capable of being born alive.

6.77 Whatever interpretation is correct, section 313(1) has the potential to effectively criminalise an otherwise lawful termination performed at later gestation, under the Commission’s recommended new provisions for lawful terminations.

6.78 One way to deal with the perceived inconsistency, as suggested by the Human Rights Law Centre Ltd,<sup>84</sup> is to repeal section 313(1).<sup>85</sup> Victoria and Tasmania have adopted this approach.

<sup>78</sup> See *Abortion Law Reform Act 2008* (Vic) s 9 (Act as passed), which amended the *Crimes Act 1958* (Vic) by repealing former s 10 and amending the definition of ‘serious injury’ in s 15 to include ‘the destruction, other than in the course of a medical procedure, of the fetus of a pregnant woman, whether or not the woman suffers any other harm’. This definition of serious harm applies to a range of offences, including situations in which serious harm is caused recklessly and negligently, as well as intentionally.

<sup>79</sup> See *Crimes Amendment (Grievous Bodily Harm) Act 2005* (NSW) which amended the definition of ‘grievous bodily harm’ in s 4 of the *Crimes Act 1900* (NSW) to include the destruction (other than in the course of a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers any harm.

<sup>80</sup> Eg, Submissions 140, 244, 515. Other respondents commented that s 313 recognises that the life of an unborn child has value and should be protected, for example, from later termination: eg, Submissions 105, 168, 560.

<sup>81</sup> Submission 244.

<sup>82</sup> See terms of reference, paras 2 and C in Appendix A.

<sup>83</sup> See the discussion of s 313 under the ‘Current law in Queensland’ in Chapter 2.

<sup>84</sup> Submission 888.

<sup>85</sup> See also MJ Rankin, ‘The Offence of Child Destruction—Issues for Medical Abortion’ (2013) 35(1) *Sydney Law Review* 1, 3 who argues that ‘the mere existence of the offence of child destruction creates serious legal uncertainty as to what constitutes a lawful medical abortion; in essence, the maintenance of the offence may serve to make the lawful unlawful’.

6.79 Victoria abolished its equivalent offence to section 313(1) in 2008.<sup>86</sup> This was a recommendation of the Victorian Law Reform Commission.<sup>87</sup>

6.80 Prior to its repeal, section 10(1) of the *Crimes Act 1958* (Vic) had provided:<sup>88</sup>

Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother shall be guilty of the indictable offence of child destruction, and shall be liable on conviction thereof to level 4 imprisonment (15 years maximum).

6.81 The Victorian Law Reform Commission stated:<sup>89</sup>

The [child destruction] offence is an anachronism, developed to cover a potential former, rather than current, problem: the calculated and intentional killing of a child in the process of childbirth to avoid punishment for infanticide or murder. Punishment could, theoretically, be avoided due to a gap between abortion and homicide laws.

The offence creates a lack of clarity in Victorian law, which has three different aspects. First, an unlawful abortion that occurs at a stage when a fetus is capable of being born alive falls within the ambit of both section 65 (abortion) and section 10 (child destruction) of the *Crimes Act*. The reach of those offences may not be the same because the Menhennitt ruling about the meaning of the word 'unlawful' in section 65 may not apply to the child destruction offence. Secondly, the offence has been interpreted, and used, in Victoria as applying in circumstances far removed from abortion: that is, when harm has been caused to a viable fetus following an assault on a pregnant woman. Thirdly, the offence requires the fetus to be 'capable of being born alive', which is a concept that has a contested meaning. It draws in the complexities of the common law 'born alive' rule and confuses the lines between child destruction, abortion, and homicide offences. (notes omitted)

6.82 Tasmania repealed its equivalent offence of 'causing death of child before birth' in 2013.<sup>90</sup> Prior to its repeal, section 165 of the *Criminal Code* (Tas) had prohibited causing 'the death of a child which has not become a human being in such a manner that he would have been guilty of murder if such child had been born alive' (unless the death is caused by 'means employed in good faith for the preservation of its mother's life').<sup>91</sup>

<sup>86</sup> See *Abortion Law Reform Act 2008* (Vic) s 9 (Act as passed), which repealed s 10 of the *Crimes Act 1958* (Vic). See n80 above.

<sup>87</sup> VLRC Report (2008) Rec 1, 109.

<sup>88</sup> *Crimes Act 1958* (Vic) s 10(1), reprint no. 200 at 1 July 2008.

<sup>89</sup> Ibid [7.6]–[7.7].

<sup>90</sup> See *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 14(g) (Act as passed) (commenced 12 February 2014).

<sup>91</sup> *Criminal Code* (Tas) s 165, at 11 February 2014.

6.83 England and Wales first addressed the potential inconsistency between their offence equivalent to section 313(1)<sup>92</sup> and their termination laws by preserving that offence.<sup>93</sup> In 1990, the *Abortion Act 1967* (UK) was amended to provide that:<sup>94</sup>

No offence under the *Infant Life (Preservation) Act* shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.

6.84 As a result, the offence equivalent to section 313(1) does not apply to a medical practitioner who performs a lawful termination in compliance with the *Abortion Act 1967* (UK).

6.85 The Commission favours the approach adopted by England and Wales. For clarity and certainty, the Commission considers it is necessary to amend section 313 to exclude the operation of section 313(1) in circumstances where a termination is otherwise lawful under the Commission's recommended new termination legislation.

### **Section 313(2)**

6.86 Section 313(2) requires an 'unlawful assault' against a pregnant female to occur before the offence can be established. The Commission concludes that this necessarily excludes a lawful termination carried out with the consent of the pregnant woman from the scope of section 313(2).

6.87 This issue was discussed in *Preston v Parker*.<sup>95</sup> In that case, one of the submissions made by the appellant in his appeal against his conviction was that one person cannot give consent to a criminal act against a second person, such that section 313(2) 'has the effect that a woman cannot give lawful consent to an abortionist to kill her baby'.<sup>96</sup>

6.88 The court said:<sup>97</sup>

the offence created by s 313(2) has as an essential element the unlawful assault of a pregnant female. As such, lack of consent of the female [to the force constituting the assault] is an element of this offence.

6.89 The Commission is of the view that, as section 313(2) applies only when there is an unlawful assault of the woman, no question of inconsistency arises between section 313(2) and the Commission's other recommendations.

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<sup>92</sup> See *Infant Life (Preservation) Act 1929*, 19 & 20 Geo 5, c 34, s 1.

<sup>93</sup> See *Abortion Act 1967* (UK) (Act as passed).

<sup>94</sup> See *Abortion Act 1967* (UK) s 5(1), as inserted by the *Human Fertilisation and Embryology Act 1990* (UK) s 37(4) (commenced on 1 April 1991). Section 5(1) of the *Abortion Act 1967* (UK) as originally enacted stated: 'Nothing in this Act shall affect the provisions of the *Infant Life (Preservation) Act 1929* (protecting the life of the viable fetus)'.

<sup>95</sup> [2010] QDC 264. In that case, the appellant was convicted of trespass under the *Summary Offences Act 2005* (Qld) when he remained on the steps of a termination clinic (obstructing the entrance to the premises) after being given two directions by the police to 'move on'.

<sup>96</sup> [2010] QDC 264, [49], [231]. The appeal was brought under the *Justices Act 1886* (Qld) s 222.

<sup>97</sup> *Ibid* [232].

## CONSEQUENTIAL AMENDMENTS TO OTHER ACTS

6.90 A number of Queensland laws include provisions that may require consequential amendment as a result of the Commission's recommended new legislative framework.<sup>98</sup>

### Guardianship and Administration Act 2000

6.91 The *Guardianship and Administration Act 2000* includes provisions dealing with terminations. Under that Act, a termination is a 'special health matter' for which consent may be given, for an adult with impaired capacity, by the tribunal.<sup>99</sup> Section 71 of the Act provides:<sup>100</sup>

#### 71 Termination of pregnancy

- (1) The tribunal may consent, for an adult with impaired capacity for the special health matter concerned, to termination of the adult's pregnancy only if the tribunal is satisfied the termination is necessary to preserve the adult from serious danger to her life or physical or mental health.
- (2) Termination of an adult's pregnancy, to which the tribunal has consented for the adult, is not unlawful. (underlining added)

6.92 The matters in section 71(1) of which the tribunal must be satisfied before giving consent reflect the current circumstances in which a termination would be lawful under sections 224, 225 or 226 of the Criminal Code.<sup>101</sup>

6.93 The provision requires consequential amendment to reflect the Commission's recommended new provisions about lawful terminations.<sup>102</sup> Accordingly, the Commission recommends that the draft legislation amend the provision as follows:

<sup>98</sup> Namely, the recommendations to repeal ss 224, 225 and 226 of the Criminal Code (Qld); to insert a new offence for termination performed by an unqualified person; and to introduce new provisions about when a medical practitioner may perform a termination: see Recs 1-1, 3-1 to 3-4, 3-8 ff above.

<sup>99</sup> *Guardianship and Administration Act 2000* (Qld) ss 65, 68, sch 2 ss 6, 7(c).

<sup>100</sup> As with other special health care matters, the tribunal would also need to apply the 'general principles' and the 'health care principle' under the *Guardianship and Administration Act 2000* (Qld) s 11, sch 1. The health care principle relevantly provides (in sch 1 pt 2 item 12(1)) that power for a special health matter should be exercised:

- (a) in the way least restrictive of the adult's rights; and
- (b) only if the exercise of power—
  - (i) is necessary and appropriate to maintain or promote the adult's health or wellbeing; or
  - (ii) is, in all the circumstances, in the adult's best interests.

The Act requires health providers to provide the information to the tribunal that it requests to ensure it has the information necessary to make an informed decision: ss 76, 130. The Act further provides that, generally, the exercise of power for a special health matter (or health matter) is ineffective to give consent to health care for an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care: s 67.

<sup>101</sup> See the discussion of 'Judicial interpretation: when a termination is "lawful"' in Chapter 2.

<sup>102</sup> Namely, Recs 3-1 to 3-4 above as to when a medical practitioner may perform a termination. Other provisions of general application under the *Guardianship and Administration Act 2000* that are relevant to the exercise of power by the tribunal would continue to apply: see n 100 above.

Act or instrument	Omit	Insert
<i>Guardianship and Administration Act 2000</i> s 71(1)	The words 'the termination is necessary to preserve the adult from serious danger to her life or physical or mental health'.	The words 'the termination may be performed by a medical practitioner under the <i>Termination of Pregnancy Act 2018</i> '.

6.94 This does not require the tribunal to 'stand in the shoes of' a medical practitioner, but to be satisfied that a termination may be performed by a medical practitioner under the lawful termination provisions (for example, that a woman is more than 22 weeks pregnant and a medical practitioner has considered the specified matters, formed the requisite view and consulted with another medical practitioner who has considered those matters and reached the same view).

### Provisions referring to sections 224, 225 or 226 of the Criminal Code

6.95 A small number of Queensland laws include provisions that refer specifically to offences in sections 224, 225 or 226 of the Criminal Code, including:

- *Criminal Practice Rules 1999*;<sup>103</sup>
- *Evidence Act 1977*;<sup>104</sup>
- *Penalties and Sentences Act 1992*;<sup>105</sup> and
- *Transport Operations (Road Use Management) Act 1995*.<sup>106</sup>

6.96 Sections 224, 225 and 226 are proposed to be repealed.<sup>107</sup> Accordingly, those provisions will require consequential amendment to omit the references to sections 224, 225 or 226.

6.97 Consideration will also be required as to whether the omitted references to the repealed sections should be replaced with a reference to the recommended new offence for termination by an unqualified person.<sup>108</sup> This may require consideration

<sup>103</sup> *Criminal Practice Rules 1999* (Qld) sch 3 pt 4, Forms 125, 126, 127, made under the *Supreme Court of Queensland Act 1991* (Qld) s 85. It specifies the form in which the offences against ss 224, 225 and 226 of the Criminal Code are to be stated in an indictment or complaint: s 15.

<sup>104</sup> *Evidence Act 1977* (Qld) ss 14B (definition of 'sexual assault offence' para (a)(ii)), 21A(1) (definition of 'sexual offence' para (b)), 21AC (definition of 'offence of a sexual nature'). Those definitions—which apply for the purposes of the provisions in that Act dealing with, respectively, the 'sexual assault counselling privilege', and the evidence of 'special witnesses' and 'affected children'—include offences against a provision of the Criminal Code, chapter 22, 'other than section 224, 225 or 226'.

<sup>105</sup> *Penalties and Sentences Act 1992* (Qld) s 151F(2) (definition of 'sexual assault offence' para (a)). It defines 'sexual assault offence', for the purpose of the provisions in that Act dealing with 'drug and alcohol treatment orders', to mean 'an offence against the following—(a) the Criminal Code, chapter 22, other than an offence against section 224, 225 or 226; (b) the Criminal Code, chapter 32'.

<sup>106</sup> *Transport Operations (Road Use Management) Act 1995* (Qld) s 122 (definition of 'disqualifying offence', para (b)), sch 2. The schedule includes s 226 of the Criminal Code as a 'disqualifying offence' for the purpose of the provisions in that Act about the authorisation of crossing supervisors for schemes to help children safely cross roads.

<sup>107</sup> See Rec 1-1 above.

<sup>108</sup> See Rec 3-8 ff above.

as to the manner in which amendments are made<sup>109</sup> and of policy matters specific to the Act in question.<sup>110</sup>

### Provisions referring to chapters 22 or 29 of the Criminal Code

6.98 There are also some Acts that include provisions referring to offences in chapters 22 or 29 of the Criminal Code, including:

- *Evidence Act 1977*;<sup>111</sup>
- *Prostitution Act 1939*;<sup>112</sup> and
- *Criminal Law (Rehabilitation of Offenders) Act 1986*.<sup>113</sup>

6.99 Where those provisions refer to offences under 'chapter 22', they encompass the offences under sections 224, 225 and 226 of the Criminal Code. The repeal of those sections will require consideration of whether the provisions of those other Acts should be amended to include the recommended new offence (which is proposed to be inserted into chapter 29 of the Criminal Code).<sup>114</sup>

6.100 Conversely, where those provisions refer to offences under 'chapter 29', they will, unless amended, capture the recommended new offence. Consideration will need to be given as to whether those provisions should be amended to exclude the recommended new offence.

6.101 This will require consideration of policy matters specific to each of those Acts, for example, whether the recommended new offence should be a 'disqualifying offence' for certain types of licences.

<sup>109</sup> For example, under the *Supreme Court of Queensland Act 1991* (Qld), rules are made by the Governor in Council with the consent of the rules committee which is empowered to approve forms for use under that Act: see *Supreme Court of Queensland Act 1991* (Qld) ss 85(1)(a), (2), 87, 89, sch 1 pt 3 item 27. Amendment of the *Criminal Practice Rules 1999* sch 3 to replace the forms for ss 224, 225 and 226 of the Criminal Code with a new form for the recommended new offence will also require consideration of the particular content.

<sup>110</sup> For example, amendment of the *Transport Operations (Road Use Management) Act 1995* (Qld) s 122 (definition of 'disqualifying offence', para (b)), sch 2 will require consideration of whether the recommended new offence should be a 'disqualifying offence' for crossing supervisors; and amendment of the definitions in the *Evidence Act 1977* (Qld) identified at n 104 above will require consideration of whether the recommended new offence should be captured by or excluded by those definitions for the purpose of the relevant provisions.

<sup>111</sup> *Evidence Act 1977* (Qld) ss 21AC (definition of 'offence involving violence'). It defines 'offence involving violence', for the purpose of the provisions of that Act relating to evidence of 'affected children', to include an offence against a 'provision of chapter 29' of the Criminal Code. See also *Evidence Act 1977* (Qld) ss 93B(5) (definition of 'prescribed criminal proceeding'), 132B(1), which have the effect of applying the respective provisions to criminal proceedings against a person for an offence defined in the Criminal Code, chapters 28 to 32 or chapters 28 to 30, respectively.

<sup>112</sup> *Prostitution Act 1939* (Qld) sch 1. The schedule includes 'any offence in chapter 22' of the Criminal Code (Qld), 'if the offence relates to a child or a person with an impairment of the mind', as a 'disqualifying offence' for the provisions of that Act about brothel licences. See also *Introduction Agents Act 2001* (Qld) sch 1 pt 1; and *Security Providers Act 1993* (Qld) sch 1 pt 1, which include offences against 'chapter 22' and 'chapter 29' of the Criminal Code (Qld) as 'disqualifying offences' for the provisions of those Acts dealing with the licensing, respectively, of introduction agents and security providers.

<sup>113</sup> *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld) s 9A. Column 2, items 5, 7A(1) and 8(1) include the 'offences defined in the Criminal Code, chapter 22' as offences for which a person applying for a particular position, office or status is required to disclose their criminal history.

<sup>114</sup> See Rec 3-8 ff above.

## RECOMMENDATIONS

### Consequential amendments to section 282 of the Criminal Code

**6-1** Section 282(1)(a) of the Criminal Code should be omitted and replaced with a new subsection (1) to provide that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child if performing the surgical operation or providing the medical treatment is reasonable, having regard to all the circumstances of the case.

[See *Termination of Pregnancy Bill 2018 cl 19(1)*]

**6-2** Section 282(1)(b) of the Criminal Code should be omitted and replaced with a new subsection (1A) to provide that a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or an unborn child in an emergency if it is necessary to perform the operation or provide the treatment to save the mother's life or the life of another unborn child.

[See *Termination of Pregnancy Bill 2018 cl 19(1)*]

**6-3** The definitions of 'medical treatment', 'surgical operation' and 'patient' in section 282(4) of the Criminal Code should be omitted and the following new definitions inserted to provide that:

- (a) 'medical treatment', for subsection (1), does not include medical treatment carried out by an unqualified person that is intended to adversely affect an unborn child;
- (b) 'surgical operation', for subsection (1), does not include a surgical operation performed by an unqualified person that is intended to adversely affect an unborn child; and
- (c) 'unqualified person' has the same meaning as in the provision in Recommendation 3-9 above.

[See *Termination of Pregnancy Bill 2018 cl 19(2)–(3)*]

### Consequential amendments to section 313 of the Criminal Code

**6-4** Section 313 of the Criminal Code should be amended to provide that 'a person does not commit an offence against section 313(1) by performing a termination, or assisting in the performance of a termination, under the *Termination of Pregnancy Act 2018*'.

[See *Termination of Pregnancy Bill 2018 cl 20*]

**Consequential amendments to other Acts**

- 6-5** Section 71(1) of the *Guardianship and Administration Act 2000* should be amended to omit the words ‘the termination is necessary to preserve the adult from serious danger to her life or physical or mental health’ and to insert the words ‘the termination may be performed by a medical practitioner under the *Termination of Pregnancy Act 2018*’.

[See *Termination of Pregnancy Bill 2018* cll 22–23]

- 6-6** Consequential amendments to the provisions of other Queensland laws should be made where necessary and desirable in light of the repeal of sections 224, 225 and 226 of the Criminal Code in Recommendation 1-1 above and the introduction of the new offence in Recommendation 3-8 above.



# Appendix A

## Terms of reference

### Queensland's laws relating to the termination of pregnancy

#### Background

In Queensland, an unlawful abortion is a crime. The relevant sections are found in Queensland's Criminal Code and are as follows:

#### **Section 224 (Attempts to procure abortion)**

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

#### **Section 225 (The like by women with child)**

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

#### **Section 226 (Supplying drugs or instruments to procure abortion)**

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

#### **Section 282 (Surgical operations and medical treatment)**

- (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—
  - (a) a person or an unborn child for the patient's benefit; or
  - (b) a person or an unborn child to preserve the mother's life;if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.
- (2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.
- (3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.
- (4) In this section—

**health professional** see the *Hospital and Health Boards Act 2011*, schedule 2.

**medical treatment**, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

**patient** means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

**surgical operation**, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child.

In 2016, two Bills that sought to reform the law relating to termination of pregnancy were introduced into the Queensland Legislative Assembly by the Member for Cairns, Mr Robert Pyne MP, namely:

- the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (the first Bill); and
- the Health (Abortion Law Reform) Amendment Bill 2016 (the second Bill).

The first Bill was introduced on 10 May 2016 and referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Parliamentary Committee (the Parliamentary Committee) for detailed consideration.

On 26 May 2016, the Legislative Assembly expanded the Parliamentary Committee's referral to require it to also conduct a wide-ranging enquiry into the law and clinical practice of terminations in Queensland (the general enquiry).

The Parliamentary Committee held public hearings and received over 1,400 submissions in relation to the first Bill.

On 26 August 2016, the Parliamentary Committee tabled its report on the first Bill and its general enquiry (Report on the first Bill). The Parliamentary Committee was of the view that the first Bill failed to address a number of important policy issues and to achieve a number of its own stated objectives. It did not recommend that the Bill be passed.

On 17 August 2016, the second Bill was introduced to the Queensland Legislative Assembly and was also referred to the Parliamentary Committee for detailed consideration. Over 1,200 submissions were received on the second Bill.

On 17 February 2017, the Parliamentary Committee tabled its report on the second Bill (the Report on the second Bill). The Committee was unable to reach agreement on whether or not the second Bill should be passed.

On 28 February 2017:

- both Bills were withdrawn from the Legislative Assembly by the Member for Cairns; and
- the Queensland Government announced that Queensland's laws in relation to the termination of pregnancy would be referred to the Queensland Law Reform Commission for its advice, with a view to a Bill being introduced in the next term of Government so as to modernise Queensland's laws relating to the termination of pregnancy.

## Terms of Reference

I, YVETTE MAREE D'ATH, Attorney-General and Minister for Justice and Minister for Training and Skills, refer to the Queensland Law Reform Commission, for review and investigation, the issue of modernising Queensland's laws relating to the termination of pregnancy pursuant to section 10 of the *Law Reform Commission Act 1968*.

## Scope

The Queensland Law Reform Commission is asked to recommend how Queensland should amend its laws relating to the termination of pregnancy to:

1. Remove terminations of pregnancy that are performed by a duly registered medical practitioner(s) from the Criminal Code sections 224 (Attempts to procure abortion), 225 (The like by women with child), and 226 (Supplying drugs or instruments to procure abortion).
2. Provide clarity in the law in relation to terminations of pregnancy in Queensland.

The Queensland Law Reform Commission is asked to prepare draft legislation based on its recommendations.

In providing advice and preparing draft legislation, the Queensland Law Reform Commission should have regard to the following:

- A. Existing practices and services in Queensland concerning termination of pregnancy including those provided by medical practitioners, counsellors and support services.
- B. Existing legal principles relating to termination practices in Queensland.
- C. The Queensland Government's commitment to modernise and clarify the law in relation to terminations of pregnancy.
- D. The consultation with stakeholders that occurred during the Parliamentary Committee's consideration of the first and second Bills.
- E. The views of experienced clinical practitioners.
- F. The views of the Queensland community.
- G. Legislative and regulatory arrangements in other Australian and international jurisdictions.

## Consultation

The Queensland Law Reform Commission shall consult with any group or individual, in or outside of Queensland, to the extent that it considers necessary.

## Timeframe

The Queensland Law Reform Commission is to provide a report on the outcomes of the review to the Attorney-General and Minister for Justice and Minister for Training and Skills by **30 June 2018**.

Dated the 13th day of June 2017

**YVETTE D'ATH MP**

Attorney-General and Minister for Justice  
Minister for Training and Skills



# Appendix B

## List of respondents

1	Hayley Turner
2	Anna McCormack
3, 3A	Michael Bennett Gardner
4	David Leifer
5	Raven Wolf
6	Shannon
7	Jesse Wheeler
8	Robert Martin
9	Mitchell Levy
10	Emily Taylor
11	David Norris
12	William Van Ristell
13	Benjamin Kemp
14	Brittany
15	Miranda Kelly
16	Garth Leslight
17	Anne Bada
18	Sally Wilkinson
19	Patricia Hovey
20	Lara O'Brien
21	Emma Vincent-Weekes
22	Confidential
23	Dr Timothy Coyle
24	Confidential
25	Confidential
26	Australian Association of Social Workers (Qld)
27	Sunnybank Centre for Women
28	Clyde James Roberts
29	Tenille
30	Grace Nakhil
31	Name not provided
32	Mandy Grgich
33	Christopher Dee

34	Name not provided
35	Richard Mendez
36	Charmaine Dyer
37	Melanie Lennard
38	Victoria Carnell
39	Lou Jackson
40	Beth
41	Brett Hore
42	Brett Jeffries
43	Dale Knight
44	Jessica Robinson
45	Ellie Self
46	Name not provided
47	Ellen Grierson
48	Ronda Roy
49	Catherine Hore
50	Children by Choice
51	Name not provided
52	Emily Ferguson
53	Julie McKenzie
54	Kerri-Lee Johnson
55	Paul R Nolan
56	Ian Bishop
57	Heather Johnson
58	Name not provided
59, 59A	Simone Eclair
60	Amy Blomberg
61	Deborah Ramsay
62	Shane Smith
63	Sophia
64	Debbie Tedge
65	Brian Modra
66	Bernice Stirling
67	Name not provided

68	Confidential
69	Glenys Watter
70	Christine Riches
71	Name not provided
72	Veronica Atkins
73	Name not provided
74	Name not provided
75	James Grieshaber
76	Arthur Bailey
77	Corey Salmon
78	Stuart Thorpe
79	Lorraine Uttley
80	Karl Rickards
81	Wayne Dionysius
82	David and Alison Murray
83	Dimitra Zuniga
84	Jacqui Halpin
85	Gillian Reid
86	Pascal
87	Sharon Robinson
88	Owen Hitchings
89	National Council of Single Mothers and their Children Inc.
90	Lyn Henderson
91	Helen Allen
92	Lesley
93	Juliette Smith
94	Grace Bell
95	Wendy Xu
96	Alan Bolin
97	Cynthia Wege
98	Denis Todd
99	Deborah Tweedale
100	Rowan Shann
101	Dr E W M Carrette
102	Chantal Watson
103	Danielle Kuskopf
104	Tony
105	Unborn Children's advocacy Network

106	Katherine
107	Maynessa Lloyd
108	Dr Merike Johnson
109	Daniel Gosewisch
110	Confidential
111	Dr Michael J Pearcy
112	C J Apelt
113	James and Clare Spratt
114	Confidential
115	Nev Wells
116	Christine Nicholls
117	Christy Withers
118	The Australian Psychological Society Limited
119	Health Consumers Queensland Ltd.
120	Denise Peterson
121	Elizabeth
122	Dr Alex Deagon
123	Jan Webb
124	Shirley Strickland
125	Neil Menzies
126	Gerard Auld
127	Timothy Carden
128	Name not provided
129	Jason and Alana Wilcox
130	Joel Delaney
131	Wendy Coad
132	Agnes Gockel
133	Endeavour Forum Inc.
134	Adrian Smith
135	Jessica Hill
136	Tony Young
137	Rebecca Pitt
138	Ruth Dukes
139	Lisa Durnian
140	Dr Ciara Ross
141	Carmel Menkens
142	William Smith
143	James Gerard Walsh

144	Lois and Siegfried Recklies
145	Helen Connell
146	Natasha Milner
147	Greg Byrne
148	Robb Mackay
149	Uta Lippmann
150	Carol O'Connell
151	Donna Clarkson
152	Pamela Anemaat
153	Valerie McLean
154, 154A	Peter Davidson
155	Rodney and Cheryl Ham
156	John Appleton
157	Cameron Geraghty
158	Sarah Lindsay
159	Neil Hayter
160	Name not provided
161	Maria McLaughlin
162	Patrick Stratford
163	Ray Strickland
164	National Foundation for Australian Women Ltd
165	Thomas J Dempsey
166	Neil Pokarier
167	Tanya Duncan
168	Graham Preston
169	Samantha Bryan
170	40 Days for Life Brisbane Inc.
171	Ian Rivlin
172	Christine Remington
173	Karen Willcocks
174	Name not provided
175	Liliana Medhurst
176	Megan Nielson
177	Graeme and Elizabeth Furlong
178	Tom Slockee
179	J Lewis
180	Ron Chambers
181	Ian Kilminster

182	Justin Pagotto
183	Connie Wong
184	Michelle Jaques
185	Pauline Heskes
186	Sandra Beaumont
187	Malcolm and Rosemary Pryor
188	Theresa Foley
189	Barbara
190	Kathy
191	David Heycock
192	Russell Grigg
193	Paul Reid
194	Jasmine Pillay
195, 195A	Dr Michelle Middlemost
196	Nicole Osmak
197	Judith Bolin
198	Dr T B Lynch
199	Patricia M McNamee
200	Kerry Warren
201	Lyn Scurry
202	E Tate
203	Diana M Chapman
204	Robert Osmak
205	Philip Callahan
206	Confidential
207	Bianca Watt
208	D and A Outred
209	Mateesha
210	Sexual Health Quarters
211	Heather Haley
212	Maddie
213	C A Rolt
214	Ainsley Chalmers
215	Robert F Thorpe
216	Phillip Servaes
217	John Mathiesen
218	Phil Marshall
219	Kristie Napier

220	Professor Caroline de Costa
221	Kim Lee
222	Paul Farrugia
223	Confidential
224	Andrea Kahler
225	Gordon Lewis
226	Sylvia Huxham
227	Linda Rewbridge
228	Mandy Lee
229	Essie Grubb
230	Dr Kate Smart
231	Kerry H Dempsey
232	Greg Fraser
233	Julie Lawson
234	B Hungerford-Morgan
235	David and Alex Todd
236	Karin Shuttleworth
237	Jaime Hungerford-Morgan
238	Arthur Marriott
239	Elaine McConaghy
240	Ellen Lund
241	Wynand van Niekerk
242	Grant Dixon
243	Anthony Pointing
244	John Spence
245	Debbie Leaf
246	Brian Kickbusch
247	Carolyn Carter
248	Bernadette Davies
249	Dawn Wallace
250	Laura Windred
251	Patricia Hawkins
252	Murray Lumsden
253	Des and Margaret Mortensen
254	Name not provided
255	Jamie Telleman
256	Solomon Jale
257	Jemma Telleman
258	Helen Selke

259	Marlene Corbin
260	Gloria Bracken
261	Diana
262	Silvia Candido-Borges
263	Kait L
264	Graham Lawn
265	Lisa Rigby
266	Maria Cardillo
267	Lee-Ann Holmes
268	Shirley Gilmore
269	Joan A Armstrong
270	Barbara Bluett
271	Ray Wong
272	M Richmond
273	Laurel and William Holm
274	Geoffrey Gray
275	Adrian Steel
276	Castan Centre for Human Rights Law
277	Gail Osmak
278	James Nolet
279	Colin Lamb
280	Helen Oberthur
281	Royal Flying Doctor Service Queensland Section
282	Janelle Patch
283	L Carlson
284	Helen Marie Dingle
285	John Szilard
286	Right to Life Australia Inc.
287	Joan Winton
288	Carolyn Simmons
289	Peter and Morvyth Howard
290	Lesley Parker
291	Margaret Clarke
292	Juanita Brown-Duthie
293	John Gavan Breen AO
294	Neroli Mooney
295	Christine Hargraves
296	Queensland Advocacy Incorporated

297	Gold Coast Centre Against Sexual Violence Inc.
298	Diane and Rick Whittle
299	Sherrilyn Church
300	Annette Hill
301	Norma Hill
302	Isabel Bryce
303	Lynette Harrison
304	Stephen and Carol Porter
305	Sandra Lewis
306	Danik and Tam Lucas
307	Confidential
308	Olwyn Shay
309	Karen Mitchell
310	Ralph Escriva
311	Anne Escriva
312	Centre Against Sexual Violence Inc.
313	Dave Cory
314	Helen Cozynsen
315, 315A	Lenore Stevenson
316	Diana and Stacey Johnson
317	Barry and Anne Mulquin
318	Brian Peacock
319	Peter and Heather Mitchelhill
320	Maureen and Aubrey Wallace
321	Christoph and Barbara Danell
322	Maia Kshemya
323	Susan Marie Pedler
324	Renai Ahlatis
325	Josephine Clarey
326	Maureen Perry
327	Marion Dingwall
328	Andrew Gleeson
329	Joy Andrew
330	Lyn Fox
331	Geraldine Callaghan
332	Alan and Marie Alford
333	Elizabeth Scott
334	David Gleeson

335	June Sargent
336	Thomas Sargent
337	Tressa Edwards
338	Sherelle Carman
339	Jennifer Moore
340	Robin Victor Pym
341	The Royal Australian and New Zealand College of Psychiatrists – Queensland Branch
342	Shirley Hogg
343	Louise Smith
344	Alison Courtice
345	Neil Champion
346	Frances Lavis
347	June Bell
348	Dr Don Hardgrave
349	Dr Mehreen Faruqi MLC (NSW)
350	Jo Ellsum
351	Dr Jeremy Patrick
352	Carmen Douglas
353	Noel G Huxham
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355	Peter and Maria Bellas
356	Lexie K O'Brien
357	Michael and Roswitha Armit
358	Confidential
359	Dale Buchanan
360	Lynne Braithwaite
361	Jan Finlay
362	Confidential
363	Leon Edmonds
364	Craig Kirk
365	Troy Surkitt
366	Laura Matthews
367	Ross Musumeci
368	Warren Gordon Elliott
369	P F Raisin
370	Rhyll Hansen
371	Katherine Spadaro
372	Margaret Ochsner

373	Linda Stevenson
374	Ingrid Steinhardt
375	Ann Whitmore
376	Nora King
377	Joe Simard
378	Reproductive Choice Australia
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380, 380A	Steve Purtill
381	Alan Mitter
382	Raelene Purtill
383	Margaret Smith
384	Elizabeth Fais
385	Barbara de Regt
386	Ben and Ariel Drew
387	Associate Professor Kathleen Baird
388	Glen Wright
389	Geoffrey and Sandra Oakes
390	David Munn
391	John Giles Wood
392	Lynda Wood
393	Johanna Jackman
394	Lynette Thomas
395	Anthony Quinn
396	William and Sandra Tento
397	Ruth Edith Ferguson
398	Louise Simento
399	Margaret Airoidi
400	John F McInerney
401	Katherine Manuel
402	Vicki McCosker
403	Robyn Davies
404	Beverley Edwards
405	Mark
406	Women's Abortion Rights Campaign Brisbane
407	David A W Miller
408	Joanne Enderby
409	Stephen Marshall
410	Arthur W Hartwig

411	Elizabeth Anne Sebastian
412	Juliet Ballinger
413	Frances Pepper
414	Lea Matibag
415	Lida de Lange
416	Bernard Hugh O'Hara
417	Robyn Munns
418	Matthew
419	Young Queenslanders for the Right to Choose
420	Melanie Newbery
421	Lucinda Shaw
422	North Queensland Combined Women's Services Inc. (The Women's Centre)
423	Confidential
424	Andrew Jurello
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426	Mark Vegar
427, 427A	Vivien Duncan
428	Susan Maree Innes
429	Professor Heather Douglas
430	Rex Frazer
431, 431A	Mike Leonard
432	Lesley Hughes
433	Catholic Women's League State of Queensland Inc.
434	Conrad Newbery
435	Melissa Taylor
436	Queensland Nurses and Midwives' Union
437	Ross Cooper
438	Julie Hamblin
439	Lachlan
440	Olwyn Ball
441	Mary Sheppard
442	Ann Cherry
443	Peter Jacobson
444	Duncan Moody

445	Associate Professor Kate Galloway and Jemima McGrath
446	Mary and Cameron Beck
447	June M Nicotra
448	Roman Catholic Bishops of Queensland
449	Jen O'Kane
450	Sarah Hannah Milosevic
451	Mary Rose Mumme
452	Michelle Mogilski
453	Confidential
454	Judy Andrews
455	Maree Stewart
456	Dr Colin T Gulbrandson
457	Cecily Mac Alpine
458	Nancy Conwell
459	Lillian Hosking
460	Ursula and William Renton-Power
461	Justus Selke
462	Angela Clifford
463, 463A	Theresa Toomey
464	William (Bill) Clifford
465	S Waddell
466	Julie Simonds
467	South Australian Abortion Action Coalition
468	Jennifer Goodhew
469	Women's Health Services Alliance (Qld)
470, 470A-E	Carolyn Mowat
471	Ruth Crowe
472	Kim Coffey
473	Rev Brian Robertson
474	Doyle Bramblet
475	Rhys Parry
476	Confidential
477	Geraldine George
478	Sue Bond
479	Nicole Young

480	Dorothy Long
481	Anne T Coyle
482	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
483	Dr Rachel Carling-Jenkins MLC (Vic)
484	Cliff and Kaye Hollings
485	Peter and Margaret Fitzsimmons
486	Civil Liberties Australia Inc., assisted by the TC Beirne School of Law UQ Pro Bono Centre
487	National Alliance of Abortion and Pregnancy Options Counsellors
488	J Pearl Miller
489	Name not provided
490	People With Disability Australia
491	FamilyVoice Australia
492	Tom Koorts
493	Valerie Ruth Pym
494	Adjunct Associate Professor Anna Walsh
495	World Federation of Doctors who Respect Human Life – Queensland Branch
496	Anne McIntyre
497	Angela Zyla
498	Jennifer Conomos
499	Marie Genevieve Audibert
500	Sustainable Population Australia Inc. (Queensland Branch)
501	Confidential
502	Patricia Cawte
503	Dorothy Anne Herbert
504	Pregnancy Help Australia Ltd
505	Natasha Andersen
506	Genesis Pregnancy Support Inc.
507	Jillian Keating
508	Barbara Fitzpatrick
509	Eve Bennett
510	Queensland Greens
511	Michael Berkman MP
512	Jennifer Loscher

513	Adrian Watter
514	Eleanor Forrest
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516	Name not provided
517	Safe Communities Australia
518	Lynda M Utting
519	Isabel Jean (Jeanie) Young
520	Henry Ko
521	Helen and Paul McHugh
522	Debra Quinn
523	L Rankine
524	Michael Byrne
525	Confidential
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527	Damien Madden
528	Gregory M Shadbolt
529	Katie Williams
530	Mary-Anne Poidevin
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532	Professor David A Ellwood
533	Beverley Lowcock
534	Len and Sylvia Williams
535	Liam Elmer
536	Frances McKenna
537	Patrick Curran
538	Sarah Keetley
539	Sexual Health Society of Queensland
540	Iain Simonds
541	Marlene Andersen
542	Fair Agenda
543	Russell and Wendy Conwell
544	Heather Conwell
545	Brydan Doecke
546	Katherine Kerr
547	Emma Prater
548	Margaret Goodhew
549	John Gillespie
550	Alfred Jeffs

551	Kerri-Ann Caswell
552	Tessa Buckley
553	Lucius Majoor
554	Christine Morrell
555	The Knights of the Southern Cross (Qld)
556	Mary Grace
557	Margaret Farley
558	Cecilia Ford
559	Confidential
560	Andrew Alevras
561	Assistant Professor Abigail R A Aiken and Rebecca Gomperts
562	Ending Violence Against Women Queensland Inc. Peak Body
563	Judy Chandler
564	Ben Wong
565	Cheryl Gothmann
566	Albert Francesca
567	Sarah Doecke
568	St Joseph's Catholic Church, Biloela (submission with 137 signatures)
569	Lyn and Gary Ham
570	Kay Christensen
571	Mary Barram
572	Professor Lindy Willmott, Professor Ben White and Penny Neller
573	Queensland Teachers' Union
574	Jeff R Eacersall
575	Rebecca Holloway
576	Melanie Zambelli
577	Beth Wilson AM
578	Sonya Slater
579	The Royal Australasian College of Physicians
580	Jana Mackie
581	Grant Buchanan
582	Pro Choice Queensland
583	Australian Lawyers for Human Rights
584	Royal Australasian College of Medical Administrators

585	Danieka Montague
586	Lucia Bunce
587	Presbyterian Church of Queensland
588	David Grace
589	Lutheran Church of Australia
590	Australian Women's Health Network
591	Rod Force
592	Women's Health Victoria
593	Jim McDonald MP
594	Janette Edson
595	Raphael Abrahao and Renata Alanis
596	Name not provided
597	Rosalie Keirle
598	Madeleine Nargar
599, 599A	Bruce Wilding
600	Public Health Association of Australia
601	Democratic Labour Party Queensland Branch
602	Family Council of Victoria
603	Michael Gregg
604	Hazel Lees
605	Mary Crabb
606	Karen Gilmore
607	Sean Farrell
608	Amanda Stoker
609	Beth Ashkar
610	Confidential
611	Sydney Francis Thomson
612	Jeremiah Selke
613	Mary Price
614	Ian Turner
615	M Cottrell
616	Oriano Giammichele
617	T.C. Clair
618	John Athony Mullane
619	Brother Christopher A Pritchard
620	Sam and Vilma Spina

621	Australian College of Nursing
622	Alexis Lamb
623	Society of Australian Sexologists Ltd (Qld)
624	Queensland Council of Unions
625	Anne Kercher
626	Geoff Melloy
627	Yarran Johnston
628	Angela
629	TASC National Limited
630	Australian Abortion Network
631	Noela Grierson
632	Dr Sebastian Moss
633	Leigh and Nicky Speedy
634	Joy Wurst
635	Mick Cuskelly
636	Jeremy Hunter
637	Dr Carole Ford OAM
638	Jeff Sommers
639	Murray J Greene
640	Judith Law
641	Amanda Van Der Poel
642	Atheist Foundation of Australia
643	L Allen Warren
644	Feminists for Life Australia
645	Jon and Susan Kirk
646	Peter and Paula Draper
647	Debbie Gravenall
648	Shane Wallis
649	Maree and Ian Millar
650	Christopher and Taylor Da Silva
651	Robyn Riley
652	Lorraine Jensen
653	Kathryn Doolan-Roche
654	Christine Starr
655	Anne Browne
656	Gaylene Wildey
657	Edith Lapthorne
658	Heather Roll

659	Laurence Manning
660	Anna Fabian
661	Dr Robert Pollnitz
662	Queensland Medical Students' Council
663	Jeanette Linde
664	Kerry Bond
665	William and Tracy Ronnfeldt
666	Bev Lenton
667	Confidential
668	Adjunct Associate Professor Mark Fowler
669	Queensland Council for Civil Liberties
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671	True Relationships and Reproductive Health
672	Karen Antrobus
673	WWILD – Sexual Violence Prevention Association Inc.
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675, 675A	Anonymous
676	Name not provided
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678	Erin Hutchinson
679	Queensland Cherish Life Inc. Rockhampton Branch
680	Bronwyn Bye and Monica Bennett-Ryan
681	Dr Joanne MacLean
682	Jeanette Cheung
683	Micah Projects
684	Tiffany Eising
685	Dr Catriona Melville
686	Ken Pitcher
687	David White
688	Queensland Sexual Assault Network
689	Confidential
690	Uniting Church in Australia, Queensland Synod
691	Robert Walker

692	Leo Fitzgerald
693	Asha and Joel Butler
694	David and Clarissa Stone
695	Lenny McInnes
696	The Canberra Declaration
697	Name not provided
698	Shaun Kavanagh
699	Carolyn Bourne
700	Professor Michael Quinlan
701	Bruce Gavin Starr
702	Institute for Judaism and Civilization Inc
703	Australian Christian Lobby
704	Belinda Newman
705	Douglas Espie
706	Dr Paul Faigl
707	Institute for Urban Indigenous Health Ltd
708	Paul Borger
709	Confidential
710	Alison Janet Sherrington
711	Raymond Newman
712	Joanne Stagg-Taylor, Dr Karen Crawley, Zoe Rathus, and Associate Professor Sue Harris-Rimmer
713	Zig Zag Young Women's Resource Centre Inc
714	Darren Speers
715	Dr Philip Martin
716	Jennifer Slade
717	Family Planning Alliance Australia
718	Name not provided
719	Lois Coetzee
720	Women's Legal Service Queensland
721	Dr Greg Walsh
722	Anne Window
723	Andrew J Elliott
724	C Kelleher
725	Olga Helen Kirk
726	Rita Joseph

727	Dr Mel Heazlewood
728	Sam and Carmel Musumeci
729	John Beasley
730	Judith Searle
731	Alexander Cornell Stewart
732	Dr Gwendoline (Wendy) Burton
733	Name not provided
734	Family Planning NSW
735	Janet Rosario
736	Sisters Inside Inc.
737	Veronica Donnelly
738	Confidential
739	Christine Tay
740	Merle Ross
741	Stephen Brennan
742	Anneke Pickvance
743	Rachel Fisher
744	Silvia Molenaar
745	Debbie Keeble
746	Yvonne Nash
747	Marilyn Rowsome
748	Anna Fisher
749	Elizabeth Bott
750	James Wilson
751	Confidential
752	Joanne Holland
753	Veronica and Michael Jones
754	Queensland Domestic Violence Service Network
755	Wolfgang Jenke
756	Joan Campbell
757	Peter Vincent
758	Jim and Debbie Rogers
759	Bernard Gaynor (online submission endorsed by 1417 initials)
760	Tony Behan
761	Elizabeth Kusay
762	Yvonne Boyle
763	Name not provided

764	Linda Behan
765	Jean
766	Senator Fraser Anning (Qld)
767	Esther Shorten
768	Christopher L Robertson
769	Women's Forum Australia
770	Confidential
771	Julie Rose
772	Helen Curtis
773	Cherish Life Qld – Gold Coast Branch
774	Jane Taylor
775	Sandra Kramer
776	Dads4Kids
777	Delima Faigl
778	Confidential
779	S Morrissey
780	Lorraine Thomas
781	Kerry McGorlick
782, 782A	Ruby Riguet
783, 783A	Chris Lee
784	Stephen Bailey
785	For Life, Australia
786	Chris Stanley
787	Confidential
788	Simon Bott
789	Lucy Graham
790	Doug Purton
791	Marilyn (Lyn) Oliver
792	Adele Kellar
793	Geoff Steffen
794	Isaac Scot
795	Noela
796	Joelene Scot
797	Sarah Balmer
798	Name not provided
799	Andrew Lamb
800	Daryl Harper

801	Neville and Narelle Blunt
802	Maurice Fischer
803	Kathy Williams
804	Kenneth John Teisen
805	Lorraine Hockey
806	Pamela Doherty
807	Lyndall Davies
808	Indra Hill
809	Carmel Kavanagh
810	Women's Electoral Lobby (NSW)
811	Paul Taylor
812	Syd Gould
813	Jim and Libby Evans
814	Marian Raleigh
815	Confidential
816	Confidential
817	Sue Murany
818	Confidential
819	Cherish Life Queensland Inc.
820	Anonymous
821, 821A	Rebecca Fischer
822	Daniel Hinds
823	Frances Micallef
824	Josh Eising
825	Michelle Cole
826	Guild of Saint Luke (Catholic Doctors Qld)
827	Leonie McEniery
828	Janne Peterson
829	Matthew Fredericksen
830	Madelaine Twomey
831	Confidential
832	Cherish Life Gladstone Branch
833	Name not provided
834	Milly Neundorf
835	Damian Jones
836	Priceless House
837	Dr Andrew McGee, Dr Melanie Jansen and Dr Sally Sheldon

838	Malessa Brisbane
839	Therese Rideout
840	Andrew Smith
841	The Australian Family Association (Queensland Branch)
842	Abortion Rethink
843	Karen Berg
844	Mary Le Feuvre
845	Lacey Millican
846	Paul Traynor Barry
847	Kerry Wood
848	Leo Garbellotto
849	Peter R Sprague
850	Eileen Fesuk
851	John Boyd
852	Shirley Hill
853	Confidential
854	Josephine Cory
855	Trevor Dean
856	John and Shirley Prato
857	Michael Conway
858	Amanda Giles
859	W B Larkin
860	Women's Bioethics Alliance
861	Name not provided
862	Paul Groves
863	Labor for Choice Queensland
864	Tim Lovett
865	Joan Gilmartin
866	Dr Nicky Jones
867	Ken and Ann Myatt
868	Humanist Society of Queensland
869	Jeff Kollen
870	Annette Rattray
871	Dr Katrina Haller
872	Submission signed by 278 individuals
873	Barbara Mandile
874	Noelle Melrose
875	Eleanor M Betteridge

876	Royal Australian College of General Practitioners Queensland
877	The Hon Greg Donnelly MLC (NSW)
878	Bar Association of Queensland (BAQ)
879	Queensland Law Society (QLS)
880	Ken Mackenzie
881	Y Shemlowski

882	Metro North Hospital and Health Service
883	White Ribbon Australia
884	Mary Lambert
885	Australian Medical Association (AMA) Queensland
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887	Name not provided
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# Appendix C

## International human rights and abortion

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### INTRODUCTION

[1] Several international instruments are relevant to reform of termination of pregnancy laws, including:

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

[2] Each of those instruments has been ratified by the Commonwealth Government. Such instruments have no direct legal effect on domestic law<sup>1</sup> until given effect in legislation.<sup>2</sup> Recourse might also be had to relevant international law in the interpretation of ambiguous or uncertain legislation, or in the development of the common law.<sup>3</sup>

## RIGHTS OF WOMEN

### Right to non-discrimination and equality, including in family relations and health care

[3] The CEDAW imposes an obligation on state parties, including Australia, to take all appropriate measures, including legislation, to eliminate discrimination against women<sup>4</sup> and to ensure the full development and advancement of women for the purpose of their enjoyment of human rights and fundamental freedoms on an equal basis with men.<sup>5</sup>

[4] Relevantly, the CEDAW requires a state party to take all appropriate measures to eliminate discrimination against women in the field of health care<sup>6</sup> (article 12(1)) and in all matters relating to family relations (article 16(1)). In particular, article 16(1)(e) stipulates that a state party is to 'ensure, on a basis of equality of men and women':<sup>7</sup>

The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

<sup>1</sup> See, eg, *Bradley v Commonwealth* (1973) 128 CLR 557, 582 (Barwick CJ and Gibbs J); *Simsek v MacPhee* (1982) 148 CLR 636, 641–42 (Stephen J); *Koowarta v Bjelke-Petersen* (1982) 153 CLR 168, 211–12 (Stephen J); *Kioa v West* (1985) 159 CLR 550, 570–71 (Gibbs CJ); *Dietrich v The Queen* (1992) 177 CLR 292, 305 (Mason CJ and McHugh J); *Attorney-General (Can) v Attorney-General (Ont)* [1937] 1 DLR 673, 678–9 (Lord Atkin).

<sup>2</sup> The Commonwealth Parliament has power to enact legislation to implement for Australian law the terms of international agreements to which Australia is a party under the external affairs powers in s 51(xxix) of the *Constitution: Commonwealth v Tasmania* (1983) 158 CLR 1; and *Richardson v Forestry Commission (Tas)* (1988) 164 CLR 261.

<sup>3</sup> See, eg, *Garland v British Rail Engineering Ltd* [1983] 2 AC 751, 771 (Lord Diplock); *Jago v District Court (NSW)* (1988) 12 NSWLR 558 (CA), 569 (Kirby P), 581–82 (Samuels JA); *Dietrich v The Queen* (1992) 177 CLR 292, 306 (Mason CJ and McHugh J), 321 (Brennan J), 337 (Deane J), 360 (Toohey J), 373 (Gaudron J); *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287–8 (Mason CJ and Deane J); *Mabo v Queensland [No 2]* (1992) 175 CLR 1, 41–2 (Brennan J).

<sup>4</sup> *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 2(f), (g), including by modifying or abolishing existing laws that discriminate against women and removing national penal provisions which constitute discrimination against women.

<sup>5</sup> *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 3.

<sup>6</sup> Including in relation to 'family planning'. See also art 12(2) which provides for 'appropriate services in connection with pregnancy, confinement and the post-natal period'; art 10(h) which requires state parties to ensure, on a basis of equality of men and women, 'access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning'; and art 14(2)(b) which requires state parties to ensure to women in rural areas, on a basis of equality of men and women, 'access to adequate health care facilities, including information, counselling and services in family planning'.

<sup>7</sup> Similar provision is included in the *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 23(1)(b).

[5] The United Nations Committee on the Elimination of Discrimination against Women (the 'CEDAW Committee') has explained, in relation to article 16(1), that:<sup>8</sup>

The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women's lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.

... Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government.

[6] The CEDAW Committee has also explained, in relation to article 12(1), that:<sup>9</sup>

It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women ... [and that] barriers to women's access to appropriate health care include laws that criminalise medical procedures only needed by women [and that] punish women who undergo those procedures.

[7] In this context, the CEDAW Committee has recommended that:<sup>10</sup>

When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.

[8] In its consideration of Australia's most recent state party report, 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:<sup>12</sup>

<sup>8</sup> Committee on the Elimination of Discrimination against Women, *General recommendation No 21: Equality in marriage and family relations*, 13th sess (1994) [21]–[22].

<sup>9</sup> Committee on the Elimination of Discrimination against Women, *General recommendation No 24: Article 12 of the Convention (women and health)*, 20th sess (1999) [11]–[14]. See also *Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review*, 57th sess (10–28 February 2014) 1–2.

<sup>10</sup> CEDAW Committee General Recommendation No 24, above n 9, [31](c). See also *Statement of the CEDAW Committee*, above n 9, 2; and Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined seventh and eighth periodic reports of Peru*, 58th sess, UN Doc CEDAW/C/PER/CO/7-8 (24 July 2014) in which the Committee recommended, among other things, that 'punitive measures for women who undergo abortion' be removed: [36](c).

<sup>11</sup> Committee on the Elimination of Discrimination against Women, *List of issues and questions with regard to the consideration of periodic reports: Australia*, 46th sess, UN Doc CEDAW/C/AUL/Q/7 (14 September 2009) [30]. See Australia's response in Committee on the Elimination of Discrimination against Women, *Responses to the list of issues and questions with regard to the consideration of the combined sixth and seventh periodic reports: Australia*, 46th sess, UN Doc CEDAW/C/AUL/Q/7/Add.1 (29 January 2010) [191]:

State and territory governments are responsible for legislation relating to the performance of abortions. The Australian Government respects the rights of state and territory governments to manage legislation relevant to their jurisdictions and has not announced any plans to intervene in abortion legislation.

<sup>12</sup> Committee on the Elimination of Discrimination against Women, *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*, 46th sess, UN Doc CEDAW/C/AUL/CO/7 (30 July 2010) [16]. The CEDAW Committee went on to state (at [17]) 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.

### Right to health, including sexual and reproductive health and autonomy

[9] In addition to article 12(1) of the CEDAW, the ICESCR recognises ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.<sup>13</sup>

[10] This is understood to include the right to sexual and reproductive health and associated freedoms.<sup>14</sup> In particular, reproductive health is said to concern ‘the capability to reproduce and the freedom to make informed, free and responsible decisions’.<sup>15</sup>

[11] The United Nations Committee on Economic, Social and Cultural Rights (the ‘ESCR Committee’) has explained that:<sup>16</sup>

The right to sexual and reproductive health entails a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the [ICESCR].

[12] The ESCR Committee has further observed that:<sup>17</sup>

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

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The Committee acknowledges the important role played by the Standing Committee of Attorneys-General in harmonising anti-discrimination strategies, but reiterates its previous recommendation that the State party promote and guarantee the implementation of the Convention throughout the country, including through its power to legislate for the implementation of treaty obligations in all states and territories.

<sup>13</sup> *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966, art 12(1). Similar provision is made in the *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 25.

<sup>14</sup> See generally Committee on Economic, Social and Cultural Rights, *General Comment No 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/GC/22 (2 May 2016) [1]; and Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000)—The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/2000/4 (11 August 2000) [8], [11], [14], [21]. See also, eg, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011) 2, [6]–[10]; and Statement of the CEDAW Committee, above n 9, 1.

<sup>15</sup> ESCR Committee General Comment No 22, above n 14, [6]. See also United Nations Population Fund, *Programme of Action of the International Conference on Population and Development 1994* (20th Anniversary ed, 2014) [7.2].

<sup>16</sup> ESCR Committee General Comment No 22, above n 14, [5].

<sup>17</sup> *Ibid* [25].

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.

[13] The ESCR Committee has recognised that restrictive abortion laws undermine autonomy and the right to equality and non-discrimination, and that state parties should repeal or reform such laws.<sup>18</sup> It has explained that such laws — particularly those that criminalise women undergoing abortions — interfere ‘with an individual’s freedom to control his or her own body and ability to make free, informed and responsible decisions in this regard’.<sup>19</sup>

[14] Similarly, in relation to article 12 of the CEDAW, the CEDAW Committee has recognised that health services should ‘be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice’.<sup>20</sup> It has expressed concern about, and called for measures to prevent, coercion in sexual and reproductive health (including the removal of laws that criminalise abortion).<sup>21</sup>

[15] Taking account of the relevant international instruments, the United Nations Special Rapporteur on the right to health has observed that:<sup>22</sup>

Criminal laws penalising and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realisation of women’s right to health and must be eliminated. These laws infringe women’s dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes ... Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.

[16] The ESCR Committee has explained that, in fulfilling their core obligations to ensure the right to sexual and reproductive health under the ICESCR, state parties

<sup>18</sup> Ibid [34], and see [40]–[41]. One of the core obligations of state parties under the ICESCR is to repeal laws and policies that criminalise or undermine access to sexual and reproductive health services: [49](a).

<sup>19</sup> Ibid [56]–[57].

<sup>20</sup> CEDAW Committee General recommendation No 24, above n 9, [31](e).

<sup>21</sup> See Committee on the Elimination of Discrimination against Women, *General recommendation No 19: Violence against women*, UN Doc A/47/38 (1993) [24](m); Committee on the Elimination of Discrimination against Women, *General recommendation No 35 on gender-based violence against women, updating general recommendation No 19*, UN Doc CEDAW/C/GC/35 (14 July 2017) [31](a); CEDAW Committee General Recommendation No 21, above n 8, [22].

<sup>22</sup> *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011) [21]. See also *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 71st sess, Agenda Item 69(b), UN Doc A/71/304 (5 August 2016) [46]. Special Rapporteurs are independent experts appointed by the United Nations Human Rights Council to examine and report on specific issues: see United Nations Human Rights Office of the High Commissioner, *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2017) <<http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx>>.

should be guided by the guidelines of United Nations agencies such as the World Health Organization ('WHO') and the United Nations Population Fund ('UNFPA').<sup>23</sup>

[17] The WHO adopts a broad understanding of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.<sup>24</sup> This is also applied in the context of sexual and reproductive health.<sup>25</sup>

[18] The WHO has released a number of guidelines on reproductive health issues, including safe abortion.<sup>26</sup> The Safe Abortion Guidance is intended to provide evidence-based best practices for policy-makers, programme managers and service providers. It aims to improve women's health outcomes, recognising that maternal deaths due to unsafe abortions are largely preventable.<sup>27</sup> As well as addressing clinical care and health system issues, it contains recommendations about legal and regulatory matters, including the grounds on which abortion should be lawful.<sup>28</sup> The tables beginning at [109] below summarise these recommendations.

[19] The WHO has also published an interagency statement on the prevention of 'gender-biased sex selection'.<sup>29</sup> It recognises that, in some countries, pervasive social and cultural factors may contribute to a systematic preference for male children and lead to sex selective practices, such as 'sex-selective abortion'.<sup>30</sup> It observes that state parties have an obligation to respect, protect and fulfil the human rights of women and girls, and eliminate discrimination. At the same time, sex selective practices must be addressed without denying women access to needed services,

<sup>23</sup> ESCR Committee General Comment No 22, above n 14, [49]. See also, eg, *Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014—Report of the Secretary-General*, UN Doc A/69/62 (12 February 2014) [504](c) which urges countries to take the actions indicated by the WHO to remove legal barriers to abortion services.

<sup>24</sup> *Constitution of the World Health Organization*, preamble. The objective of the WHO is the attainment by all people of the highest possible level of health. Australia is a signatory to the Constitution: art 1. In addition, it has been observed that the right to health in art 12 of the ICESCR 'embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health': ESCR Committee General Comment No 14, above n 14, [4].

<sup>25</sup> See UNFPA Programme of Action, above n 15, [7.2]:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

See also, eg, WHO, *Sexual and reproductive health: Defining sexual health* (2017) <[http://www.who.int/reproductivehealth/topics/sexual\\_health/sh\\_definitions/en/](http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/)>; WHO, *Reproductive health* (2017) <[http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)>.

<sup>26</sup> WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) (the 'Safe Abortion Guidance'). See also WHO, 'Health worker roles in providing safe abortion care and post-abortion contraception' (Guideline, 2015).

<sup>27</sup> WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 1:

[globally,] an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional five million women. Almost every one of these deaths and disabilities could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion. (note omitted)

<sup>28</sup> WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) ch 4.

<sup>29</sup> WHO, 'Preventing gender-biased sex selection: An interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO' (2011).

<sup>30</sup> *Ibid* v, 4, 13, 14–15.

including safe abortion, as this would further violate their rights.<sup>31</sup> It recommends measures to address the underlying causes of gender discrimination and for the ethical use of relevant technologies by health professionals, rather than measures to restrict access to services.<sup>32</sup>

[20] The Office of the United Nations High Commissioner for Human Rights ('OHCHR') has also released an information series on sexual and reproductive health and rights, including on abortion. It provides guidance on key issues, including the decriminalisation of abortion.<sup>33</sup> This is also reflected in the tables beginning at [109] below.

[21] Reproductive health also forms a key component of the Programme of Action of the International Conference on Population and Development ('ICPD') and its subsequent activities<sup>34</sup> and the work of the UNFPA.<sup>35</sup> The Programme of Action emphasises the holistic nature of reproductive health, the importance of informed choice and the need to prevent unwanted pregnancies. It states that abortion should not be promoted as a method of family planning, but that, where abortion is legal, it should be safe and women should have access to post-abortion care, counselling and family planning support.<sup>36</sup>

[22] In its statement as part of the 2014 follow-up to the Programme of Action, the CEDAW Committee explained that:<sup>37</sup>

State parties have obligations to enable women to prevent unwanted pregnancies, including through family planning and education on sexual and reproductive health. The Committee has also called upon State parties to address the power imbalances between men and women, which often impede women's autonomy, particularly in the exercise of choices on safe and responsible sex practices.

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31 Ibid v, 3–4, 10.

32 Ibid vi, 6–7, 10. It is observed that legal restrictions on the use of technologies for sex selection and on sex-selective abortion have little effect without broader measures to address underlying social and gender inequalities; and that restricted access to services may lead to a greater demand for clandestine procedures, putting women at risk: v, 5–7.

33 Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (2015) <<http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>>.

34 The ICPD was convened in 1994 under the auspices of the United Nations. More than 175 governments (as well as several inter-governmental and non-governmental organisations) attended the ICPD, which adopted the UNFPA Programme of Action, above n 15. See generally United Nations Population Fund, *International Conference on Population and Development (ICPD)* <<http://www.unfpa.org/events/international-conference-population-and-development-icpd>>.

Implementation of the Programme of Action was reviewed, resulting in a further Framework of Actions in the Beyond 2014 Report, above n 23. As part of the review, an expert meeting on women's health was convened in Mexico City in 2013: see *ICPD Beyond 2014 Expert Group Meeting on Women's Health: Rights, Empowerment and Social Determinants—Meeting Report*, UN Doc UNFPA/WP.GTM.2 (9 December 2013).

35 See generally United Nations Population Fund, *Sexual & reproductive health* (16 November 2016) <<http://www.unfpa.org/sexual-reproductive-health>>. The UNFPA is the lead agency for the Programme of Action.

36 United Nations Population Fund, *Programme of Action of the International Conference on Population and Development 1994* (20th Anniversary ed, 2014) [8.25].

37 Statement of the CEDAW Committee, above n 9, 2.

Unsafe abortion is a leading cause of maternal mortality [death] and morbidity [injury]. As such, State parties should legalise abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe fetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. State parties should also remove punitive measures for women who undergo abortion.

[23] Health, including universal access to sexual and reproductive health care services and the prevention of maternal and newborn mortality, is also one of seventeen Sustainable Development Goals adopted by the United Nations General Assembly in 2015.<sup>38</sup> Australia reviewed its implementation of those Goals in 2018, but did not specifically comment on abortion or other sexual and reproductive health care.<sup>39</sup>

### Access to health services, including abortion services

[24] Full enjoyment of the right to sexual and reproductive health requires ‘access to a whole range of health facilities, goods, services and information’, without discrimination,<sup>40</sup> including education and information, family planning and contraception, and safe abortion.<sup>41</sup>

[25] The ESCR Committee has explained that there are four inter-related and essential elements of comprehensive sexual and reproductive health care:<sup>42</sup>

- Availability — This encompasses the availability of health facilities, goods and services, the availability of trained and skilled personnel and providers, and the availability of essential medicines. Relevantly, this requires that medicines

<sup>38</sup> *Transforming our world: the 2030 Agenda for Sustainable Development*, GA Res 70/1, UN GAOR, 70th sess, Agenda Items 15 and 116, UN Doc A/RES/70/1 (21 October 2015). Sustainable Development Goal 3 is to ‘[e]nsure healthy lives and promote well-being for all at all ages’ and encompasses nine targets including for reducing maternal and neonatal mortality and ensuring access to sexual and reproductive health services.

<sup>39</sup> Australian Government, *Report on the Implementation of the Sustainable Development Goals* (2018) 33–6 <<http://dfat.gov.au/aid/topics/development-issues/2030-agenda/Pages/sustainable-development-goals.aspx>>. Australia expressed support for ‘the WHO’s right to health objectives’ and the right of Australians ‘to achieve the highest attainable standard of physical and mental health’, observing that although Australia’s population is, overall, relatively healthy, ‘more needs to be done to address poor health outcomes for some groups,’ including Aboriginal and Torres Strait Islander Australians: 33.

See generally United Nations Department of Economic and Social Affairs, *High-Level Political Forum on Sustainable Development: Voluntary National Reviews* <<https://sustainabledevelopment.un.org/vnrs/>>. Member states are encouraged to conduct regular and inclusive reviews of progress; reviews are voluntary: *The 2030 Agenda for Sustainable Development*, above n 38, [72]–[74], [79].

<sup>40</sup> ESCR Committee General Comment No 22, above n 14, [5], [34], and see [45] in which it is explained that, in meeting their obligation to fulfil the right of everyone to sexual and reproductive health, state parties should:

aim to ensure universal access without discrimination for all individuals, including those from disadvantaged and marginalised groups, to a full range of quality sexual and reproductive health care, including ... safe abortion care ...

<sup>41</sup> See generally *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011).

<sup>42</sup> ESCR Committee General Comment No 22, above n 14, [11]–[21], and see [49](c) and [62]. See generally *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, above n 22, [79] as to the core requirements of availability, accessibility, acceptability and quality for the right to health.

for abortion and post-abortion care be available and that refusal to provide services based on conscience 'must not be a barrier to accessing services'.

- Accessibility — This encompasses physical and geographical accessibility of health facilities, goods and services (including to persons living in rural and remote areas), affordability of services and accessibility of information.
- Acceptability — That is, health facilities, goods, services and information must be respectful of diverse cultures and needs.
- Quality — That is, facilities, goods, services and information should be 'evidence-based and scientifically and medically appropriate and up-to-date'. Relevantly, the quality of care is impaired by the failure to incorporate technological advances and innovations, such as medication for abortion.

[26] This involves the removal of both legal and practical barriers to access.

[27] Core obligations under the ICESCR include the obligations to remove laws and policies that criminalise or undermine access to sexual and reproductive health services, to guarantee universal and equitable access to such services and to take measures to prevent unsafe abortions and provide post-abortion care and counselling.<sup>43</sup> The ESCR Committee has explained, for example, that:<sup>44</sup>

Preventing unintended pregnancies and unsafe abortions requires States to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalise restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.

[28] More specifically, the ESCR Committee has identified that state parties should:<sup>45</sup>

- remove third party authorisation requirements, 'such as parental, spousal and judicial authorisation requirements', for access to abortion services and information;
- remove biased counselling and mandatory waiting periods for access to abortion services;
- prohibit and prevent third parties from imposing practical or procedural barriers to services, such as physical obstruction of facilities and dissemination of misinformation;<sup>46</sup> and

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<sup>43</sup> ESCR Committee General Comment No 22, above n 14, [49](a), (c), (e).

<sup>44</sup> Ibid [28]. See also, eg, CEDAW Committee General Recommendation No 19, above n 21, [24](m) in which state parties are urged to take measures to 'ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control'.

<sup>45</sup> ESCR Committee General Comment No 22, above n 14, [41]–[43].

<sup>46</sup> The ESCR Committee has further observed (at *ibid* [59]) that:

- regulate the practice of conscientious objection so that it does not inhibit access<sup>47</sup> or the performance of services in urgent or emergency situations.

[29] The CEDAW Committee has expressed similar concerns. For example:<sup>48</sup>

The obligation to respect rights requires State parties to refrain from obstructing action taken by women in pursuit of their health goals. ... For example, State parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorisation of husbands, partners, parents or health authorities, because they are unmarried or because they are women. (note omitted)

[30] The CEDAW Committee has also referred to the particular obstacles faced by rural women in accessing sexual and reproductive health care, including safe abortion:<sup>49</sup>

Globally, the presence of skilled birth attendants and medical personnel is lower in rural than urban areas and leads to poor prenatal, perinatal and postnatal care. There is a greater unmet need for family planning services and contraception owing to poverty, the lack of information and the limited availability and accessibility of services. Rural women are more likely to resort to unsafe abortion than their urban counterparts, a situation that puts their lives at risk and compromises their health. Even in countries in which abortion is legal, restrictive conditions, including unreasonable waiting periods, often impede access for rural women. When abortion is illegal, the health impact is even greater.

[31] The CEDAW Committee has recommended that state parties should ensure that high quality health care services are physically accessible to and affordable for rural women (including access to safe abortion and post-abortion care) and that laws that criminalise or require waiting periods or third party authorisation for abortion should be repealed.<sup>50</sup>

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Violations of the obligation to protect occur when a State fails to take effective steps to prevent third parties from undermining the enjoyment of the right to sexual and reproductive health. This includes the failure to prohibit and take measures to prevent all forms of violence and coercion committed by private individuals and entities, including ... abuse and harassment ...; violence targeting ... women seeking abortion or post-abortion care ...

47 '[I]ncluding by requiring referrals to an accessible provider capable of and willing to provide the services being sought': *ibid* [43]. See also Committee on Economic, Social and Cultural Rights, *Concluding observations on Poland*, UN Doc E/C.12/POL/CO/6 (26 October 2016) [46]–[47]; Committee on the Elimination of Discrimination against Women, *Concluding observations on Poland*, UN Doc CEDAW/C/POL/CO/7-8 (14 November 2014) [36]–[37](a)–(b); and CEDAW Committee General Recommendation No 24, above n 9, [11] in which it is stated that, if services are refused on the basis of conscientious objection 'measures should be introduced to ensure that women are referred to alternative health providers'.

48 CEDAW Committee General Recommendation No 24, above n 9, [14]. See also [11] in relation to conscientious objection:

It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

49 Committee on the Elimination of Discrimination against Women, *General recommendation No 34 (2016) on the rights of rural women*, UN Doc CEDAW/C/GC/34 (7 March 2016) [38], and see [37]. See also *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 14(2)(b) described at n 6 above.

50 CEDAW Committee General Recommendation No 34, above n 49, [39](a), (c).

[32] The United Nations Special Rapporteur on the right to health has similarly raised concerns about laws that restrict access to safe abortion, including restrictive grounds on which abortion is lawful, conscientious objection laws, mandatory waiting periods and counselling requirements, and requirements for third party authorisation.<sup>51</sup> He has also observed that measures should be taken to protect abortion service providers from harassment and violence.<sup>52</sup>

[33] The Special Rapporteur has highlighted a number of concerns about the consequences of restrictive abortion laws, including the 'chilling effect' on information and data collection, 'stigmatisation' of those who use or provide abortion services, the greater likelihood of unsafe abortions and associated health risks, and negative impacts on mental health.<sup>53</sup> He has expressed the view that legal restrictions on abortion should be evidence-based on the grounds of public health and proportionate to ensure respect for human rights:<sup>54</sup>

When criminal laws and legal restrictions used to regulate public health are neither evidence-based nor proportionate, States should refrain from using them to regulate sexual and reproductive health, as they not only violate the right to health of affected individuals, but also contradict their own public health justification.

[34] In addition to general recommendations for laws criminalising abortion to be removed, the ESCR and CEDAW Committees have each called on individual state parties to review their legislation and decriminalise abortion where the pregnancy endangers the life or health of the woman,<sup>55</sup> results from rape or incest<sup>56</sup> or involves serious fetal impairment.<sup>57</sup> (In the case of fetal impairment, the United Nations Committee on the Rights of Persons with Disabilities has cautioned, however, against distinctions based solely on disability.<sup>58</sup>)

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51 *Interim Report of the Special Rapporteur of the Human Rights Council*, above n 41, [23]–[24].

52 *Ibid* [28].

53 See *ibid* [24]–[28], [31]–[36].

54 *Ibid* [18].

55 See Committee on Economic, Social and Cultural Rights, *Concluding observations on Costa Rica*, UN Doc E/C.12/CRI/CO/4 (4 January 2008) [46]; Committee on Economic, Social and Cultural Rights, *Concluding observations on Nepal*, UN Doc E/C.12/1/Add.66 (24 September 2001) [55]; Committee on the Elimination of Discrimination against Women, *Concluding observations on Angola*, UN Doc CEDAW/C/AGO/CO/6 (27 March 2013) [32](g). See also Committee on the Elimination of Discrimination against Women, *Views: Communication No 22/2009*, 50th sess, UN Doc CEDAW/C/50/D/22/2009 (25 November 2011) ('*TPF v Peru*') [9.2](a).

56 See Committee on Economic, Social and Cultural Rights, *Concluding observations on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories*, UN Doc E/C.12/GBR/CO/5 (12 June 2009) [25]; Committee on Economic, Social and Cultural Rights, *Concluding observations on Chile*, UN Doc E/C.12/1/Add.105 (1 December 2004) [53]; ESCR Committee Concluding Observations on Costa Rica, above n 55, [46]; ESCR Committee Concluding Observations on Nepal, above n 55, [55]; Committee on the Elimination of Discrimination against Women, *Concluding observations on the Dominican Republic*, UN Doc CEDAW/C/DOM/CO/6-7 (30 July 2013) [37](c); CEDAW Committee Concluding Observations on Angola, above n 55, [32](g). See also *TPF v Peru*, UN Doc CEDAW/C/50/D/22/2009, [9.2](c).

57 See ESCR Committee Concluding Observations on the United Kingdom, above n 56, [25]; CEDAW Committee Concluding Observations on the Dominican Republic, above n 56, [37](c).

58 See [86]–[88] below.

## Related rights, including the right to privacy and family and the right to life

[35] The reproductive health rights of women also intersect with rights in other international instruments, in particular, the ICCPR.

[36] The CEDAW Committee has identified, for example, that violations of women's reproductive rights may amount to torture or cruel, inhuman or degrading treatment:<sup>59</sup>

Violations of women's sexual and reproductive health and rights, such as forced sterilisations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.

[37] This is confirmed in the jurisprudence of the United Nations Human Rights Committee ('HRC'), which has found that denying access to abortion in circumstances where the pregnancy involves a fatal fetal impairment<sup>60</sup> or is the result of rape<sup>61</sup> is a violation of the prohibition against cruel, inhuman or degrading treatment.

[38] It has also been recognised that the right to private and family life under article 17 of the ICCPR encompasses women's reproductive decisions.<sup>62</sup> The HRC has explained in its General Comment that:<sup>63</sup>

[An] area where States may fail to respect women's privacy [under article 17] relates to their reproductive functions, for example, where there is a requirement for the husband's authorisation to make a decision in regard to sterilisation; ... or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.

<sup>59</sup> CEDAW Committee General Recommendation No 35, above n 21, [18].

See also Committee Against Torture, *General Comment No 2: Implementation of article 2 by State parties*, UN Doc CAT/C/GC/2 (24 January 2008) [22], in relation to the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, GA Res 39/46, 10 December 1984. Freedom from torture and cruel, inhuman or degrading treatment is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 5; *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 7; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 37(a); and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 15.

<sup>60</sup> See Human Rights Committee, *Views: Communication No 2425/2014*, 119th sess, UN Doc CCPR/C/119/D/2425/2014 (12 June 2017) ('*Whelan v Ireland*') [7.7], [8]; Human Rights Committee, *Views: Communication No 2324/2013*, 116th sess, UN Doc CCPR/C/116/D/2324/2013 (17 November 2016) ('*Mellet v Ireland*') [7.6], [8]; and Human Rights Committee, *Views: Communication No 1153/2003*, 85th sess, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) ('*Huamán v Perú*') [6.3].

<sup>61</sup> See Human Rights Committee, *Views: Communication No 1608/2007*, 101st sess, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011) ('*VDA v Argentina*') [9.2], [10]. See also Human Rights Committee, *General Comment No 28: Article 3 (The equality of rights between men and women)*, UN Doc CCPR/C/21/Rev.1/Add.10 (29 March 2000) [11].

<sup>62</sup> The right to private and family life is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 12; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 16; and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 22.

<sup>63</sup> HRC General Comment No 28, above n 61, [20].

[39] In its jurisprudence, the HRC has found that denying access to abortion in certain circumstances, by unreasonably interfering in the woman's decision, constitutes a violation of article 17.<sup>64</sup>

[40] In addition, it has been recognised that the right to life in article 6 of the ICCPR is relevant in this context.<sup>65</sup> In particular, the HRC has identified that the right to life requires consideration of measures 'to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions'.<sup>66</sup>

[41] The HRC has called on individual state parties to review their legislation to provide exceptions to their prohibitions against abortion, particularly to protect the life or health of the woman and in cases of rape or incest.<sup>67</sup>

[42] Most recently, it has called on Ireland to amend its restrictive laws to ensure compliance with the ICCPR:<sup>68</sup>

the State party should amend its law on voluntary termination of pregnancy, including if necessary its Constitution, to ensure compliance with the Covenant, including ensuring effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing being subjected to criminal sanctions ... (note omitted)

[43] That direction was made in the context of a case involving a fatal fetal impairment. The HRC explained:<sup>69</sup>

The Committee considers it well-established that the author was in a highly vulnerable position after learning that her much-wanted pregnancy was not viable. As documented in the psychological reports submitted to the Committee, her physical and mental situation was exacerbated by the following circumstances arising from the prevailing legislative framework in Ireland and by the author's treatment by some of her health care providers in Ireland: being unable to continue receiving medical care and health insurance coverage for her treatment from the Irish health care system; feeling abandoned by the Irish health care system and having to gather information on her medical options alone; being forced to choose between continuing her non-viable pregnancy or traveling to

<sup>64</sup> See *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [7.9], [8]; *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [7.8], [8]; *Huamán v Peru*, UN Doc CCPR/C/85/D/1153/2003, [6.4]; and *VDA v Argentina*, UN Doc CCPR/C/101/D/1608/2007, [9.3], [10].

<sup>65</sup> *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 6(1). The right to life is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 3; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 6(1); and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 10. See [54]–[58] below.

<sup>66</sup> HRC General Comment No 28, above n 61, [10].

<sup>67</sup> See Human Rights Committee, *Concluding observations on the Philippines*, UN Doc CCPR/C/PHL/CO/4 (13 November 2012) [13]; Human Rights Committee, *Concluding observations on the Dominican Republic*, UN Doc CCPR/C/DOM/CO/5 (19 April 2012) [15]; Human Rights Committee, *Concluding observations on Guatemala*, UN Doc CCPR/C/GTM/CO/3 (19 April 2012) [20]. See also Human Rights Committee, *Concluding observations on Panama*, UN Doc CCPR/C/PAN/CO/3 (17 April 2008) [9].

<sup>68</sup> *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [9]. See also *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [9]. As to the *Constitution of Ireland*, see [76] below.

<sup>69</sup> *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [7.5]. See also *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [7.4], which involved similar facts.

another country while carrying a dying fetus, at personal expense and separated from the support of her family; suffering the shame and stigma associated with the criminalisation of abortion of a fatally-ill fetus; having to leave the baby's remains in a foreign country; and failing to receive necessary and appropriate bereavement counselling in Ireland. Much of the suffering the author endured could have been mitigated if she had been allowed to terminate her pregnancy in the familiar environment of her own country and under the care of health professionals whom she knew and trusted; and if she had received necessary health benefits that were available in Ireland, which she would have enjoyed had she continued her non-viable pregnancy to deliver a stillborn child in Ireland.

### Right to health of girls and adolescent females

[44] The CEDAW and ESCR Committees recognise that the right to sexual and reproductive health and autonomy extends to children and adolescents, in accordance with their evolving capacities.<sup>70</sup>

[45] Moreover, the right to 'the enjoyment of the highest attainable standard of health' is expressly recognised for children in article 24(1) of the CRC.<sup>71</sup> This has been interpreted to include the right to sexual and reproductive health.

[46] The United Nations Committee on the Rights of the Child (the 'CRC Committee') has explained that:<sup>72</sup>

Children's right to health contains a set of freedoms and entitlements. The freedoms, which are of increasing importance in accordance with growing capacity and maturity, include the right to control one's health and body, including sexual and reproductive freedom to make responsible choices. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.

[47] The CRC Committee has observed the importance of recognising the life course and evolving capacities of the child:<sup>73</sup>

Childhood is a period of continuous growth from birth to infancy, through the preschool age to adolescence. Each phase is significant as important developmental changes occur in terms of physical, psychological, emotional and social development, expectations and norms. The stages of the child's development are cumulative and each stage has an impact on subsequent phases, influencing the children's health, potential, risks and opportunities. Understanding the life course is essential in order to appreciate how health problems in childhood affect public health in general [and] ... children's evolving

<sup>70</sup> See, eg, CEDAW Committee General Recommendation No 24, above n 9, [8]; ESCR Committee General Comment No 22, above n 14, [49](f); and Statement of the CEDAW Committee, above n 9, 1. The CEDAW Committee has noted that 'girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy': CEDAW Committee General Recommendation No 24, above n 9, [12](b).

<sup>71</sup> *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 24(1). 'Child' is defined to mean 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier': art 1. See also art 24(2)(f) which provides for 'preventive health care ... and family planning education and services'.

<sup>72</sup> Committee on the Rights of the Child, *General Comment No 15: on the right of the child to the enjoyment of the highest attainable standard of health (art 24)*, UN Doc CRC/C/GC/15 (17 April 2013) III [A].

<sup>73</sup> *Ibid* II [F].

capacities have a bearing on their independent decision-making on their health issues.

[48] The CRC Committee has highlighted the importance of ensuring access by adolescents to comprehensive sexual and reproductive health services, including sexuality education, family planning and safe abortion.<sup>74</sup> It has observed that state parties should ‘work to ensure that girls can make autonomous and informed decisions on their reproductive health’ and that:<sup>75</sup>

[sexual and reproductive health services] should be designed to enable all couples and individuals to make sexual and reproductive decisions freely and responsibly, including the number, spacing and timing of their children, and to give them the information and means to do so.

[49] In this context, the CRC Committee has observed, for example, that adolescents should not be ‘deprived of any sexual and reproductive health information or services due to providers’ conscientious objections’.<sup>76</sup>

[50] The Programme of Action of the ICPD also specifically highlighted the need to address ‘adolescent sexual and reproductive health issues, including unwanted pregnancy [and] unsafe abortion’:<sup>77</sup>

Recognising the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need ... In doing so ... these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.

[51] This was reiterated in the 2014 follow-up to the Programme of Action, which also emphasised the importance of preventing unsafe abortion among young women. In particular, it provides that:<sup>78</sup>

<sup>74</sup> The Special Rapporteur on the right to health has also observed that ‘[d]uring adolescence, the right to be heard and to be taken seriously transitions into the right to make autonomous decisions about one’s health care and treatment’: *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 32nd sess, Agenda Item 3, UN Doc A/HRC/32/32 (4 April 2016) [57].

<sup>75</sup> CRC Committee General Comment No 15, above n 72, III [B].

<sup>76</sup> Ibid.

<sup>77</sup> UNFPA Programme of Action, above n 15, [7.44], [7.45] (note omitted).

<sup>78</sup> Beyond 2014 Report, above n 23, [371] and see [320]–[325], [361]–[376]. It is explained (at [375]) that:

Young adolescents face a higher risk of complications from unsafe abortions, and women under the age of 25 account for almost half of all abortion deaths. Evidence points to the fact that adolescents are more likely to delay seeking an abortion and, even in countries where abortion may be legal, they resort to unsafe abortion providers owing to fear, lack of knowledge and limited financial resources. (notes omitted)

See also ICPD Beyond 2014 Expert Group Meeting, above n 34, Rec 1(c). It is observed in that report that the ‘majority of those who die or are injured’ from unsafe abortions ‘are low-income women and adolescent girls who have neither money nor the knowledge needed to find a safe provider’: 25.

States should remove legal barriers preventing women and girls from access to safe abortion, including revising restrictions within existing abortion laws, in order to safeguard the lives of women and girls and, where abortion is legal, ensure that all women have ready access to safe, good-quality abortion services.

[52] The CRC Committee has also called on individual state parties to decriminalise abortion in particular circumstances, including where the pregnancy endangers the life or health of the girl<sup>79</sup> or results from rape or incest.<sup>80</sup>

[53] In his report on the right to health of adolescents, the Special Rapporteur on the right to health has similarly observed the importance of such measures:<sup>81</sup>

States are strongly encouraged to decriminalise abortion, in accordance with international human rights norms, and adopt measures to ensure access to legal and safe abortion services. Criminal laws with respect to abortion result in a high number of deaths, poor mental and physical health outcomes, infringement of dignity and amount to violations of the obligations of States to guarantee the right to health of adolescent girls. Furthermore, information about and access to abortion services must be available, accessible and of good quality, without discrimination, at a minimum in the following circumstances: when the life or health of the mother is at risk, when the mother is the victim of rape or incest and if there is severe and fatal fetal impairment. Post-abortion care must be available and accessible to all adolescent girls irrespective of the legal status of abortion. (note omitted)

## RECOGNITION OF THE FETUS

### Right to life and the fetus or unborn child

[54] The UDHR declares that ‘all human beings are born free and equal in dignity and rights’ (article 1) and that ‘[e]veryone has the right to life, liberty and security of person’ (article 3).

[55] The right to life of every human being is also recognised in the ICCPR (article 6). Specifically, article 6(1) of the ICCPR provides that:

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

[56] The HRC has described this as the ‘supreme right’, basic to all human rights, ‘from which no derogation is permitted’ and which should not be narrowly

<sup>79</sup> Committee on the Rights of the Child, *Concluding observations on Chile*, UN Doc CRC/C/CHL/CO/3 (23 April 2007) [56]; Committee on the Rights of the Child, *Concluding observations on Chad*, UN Doc CRC/C/15/Add.107 (24 August 1999) [30].

<sup>80</sup> CRC Committee Concluding observations on Chile, above n 79, [56].

<sup>81</sup> *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, above n 74, [92].

interpreted.<sup>82</sup> It is not, however, absolute; it prohibits the ‘arbitrary deprivation’ of life.<sup>83</sup>

[57] The right to life in article 6 of the ICCPR is reaffirmed in article 10 of the *Convention on the Rights of Persons with Disabilities* (the ‘CRPD’).<sup>84</sup>

[58] In addition, the right to life of children is specifically recognised in article 6 of the CRC, which provides that:

1. State Parties recognise that every child has the inherent right to life.
2. State Parties shall ensure to the maximum extent possible the survival and development of the child.<sup>85</sup> (note added)

[59] Under article 1 of the CRC, ‘child’ is defined to mean ‘every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier’.

[60] It has been argued that the right to life under those instruments is capable of applying to the fetus or unborn child.<sup>86</sup> For example, it has been suggested that the natural and ordinary meaning of provisions such as articles 1 and 6 of the CRC includes the ‘unborn child’:<sup>87</sup>

<sup>82</sup> Human Rights Committee, *General Comment No 6: Article 6 (Right to life)*, 16th sess (27 July 1982) [1]; Human Rights Committee, *General Comment No 14: Article 6 (Right to life)*, 23rd sess (1984) [1]. See also Human Rights Committee, *General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life—Revised draft prepared by the Rapporteur*, 120th sess (July 2017) [2]–[3].

<sup>83</sup> See, eg, HRC General Comment No 36, above n 82, [16].

<sup>84</sup> See [83] below.

<sup>85</sup> ‘Survival and development’ rights under art 6(2) of the CRC ‘include rights to adequate food, shelter, clean water, formal education, primary health care, leisure and recreation, cultural activities and information about [the child’s] rights’: Unicef, *Rights under the Convention on the Rights of the Child* (7 August 2014) <[https://www.unicef.org/crc/index\\_30177.html](https://www.unicef.org/crc/index_30177.html)>. ‘Development’ is to be interpreted ‘as a holistic concept, embracing the child’s physical, mental, spiritual, moral, psychological and social development’: Committee on the Rights of the Child, *General Comment No 5 (2003): General measures of implementation of the Convention on the Rights of the Child*, 34th sess, UN Doc CRC/GC/2003/5 (27 November 2003) 4.

<sup>86</sup> See, eg, PA Tozzi, ‘International Law and the Right to Abortion’ (International Organizations Law Group Legal Studies Series No 1, Catholic Family and Human Rights Institute, 2010) 6, 7; PJ Flood, ‘Does International Law Protect the Unborn Child?’ in JW Koterski (ed), *Life and Learning XVI: Proceedings of the Sixteenth University Faculty of Life Conference at Villanova University 2006* (2007) 3, 7–8, 9; T Finegan, ‘International Human Rights Law and the “Unborn”’: Texts and *Travaux Préparatoires* (2016) 25 *Tulane Journal of International & Comparative Law* 89, 116, 120–21; R Joseph, *Human rights and the unborn child* (Martinus Nijhoff, 2009).

In support of this view, reference has been made to various provisions including: *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 6(5), which provides that ‘[s]entence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women’; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 24(2)(d), which requires, among other things, measures to ‘ensure appropriate pre-natal and post-natal health care for mothers’; and *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, preamble para [9], which refers to ‘safeguards and care ... before as well as after birth’ (see [63]–[66] below).

<sup>87</sup> Finegan, above n 86, 116–17. See also Flood, above n 86, 6, 7, 10; and Tozzi, above n 86, 7:

A plain reading of the language in the CRC also favors protection of unborn life. CRC article 1 defines a child as ‘every human being below the age of eighteen years.’ It thus defines a ceiling, but not a floor, as to who is a child—in other words, it pointedly does *not* say that the status of the ‘child’ attaches at the time of birth. (emphasis in original)

a strong case can be made that the ‘natural and ordinary meaning’ of both Articles 1 and 6 [of the CRC] includes the unborn human being. Article 1 refers to ‘every human being below the age of eighteen years’—the unborn child satisfies both these criteria. Article 6 refers to ‘every child’ having ‘the inherent right to life’. ‘Inherent’, as a natural law term, means existing in something on the basis of that thing’s essential nature, which in this context can only mean the child’s human nature.

[61] However, none of those instruments explicitly extends the right to life to the fetus or unborn child. It is generally regarded that the right to life under those instruments applies from birth; whilst the fetus or unborn child may be entitled to some protections, it is left to individual countries to provide for any such protections in their domestic laws, provided they are not inconsistent with their other human rights obligations.<sup>88</sup> This is consistent with the position adopted under regional human rights treaties, including the *European Convention on Human Rights*.<sup>89</sup>

[62] In support of this view, reference has been made to the history of the drafting and negotiation of the instruments, which shows ‘a consistent pattern of avoiding any explicit recognition’ of rights before birth.<sup>90</sup> During the drafting of the UDHR, the ICCPR and the CRC, various proposals to extend the relevant articles to

<sup>88</sup> See, eg, RJ Cook and BM Dickens, ‘Human Rights Dynamics of Abortion Law Reform’ (2003) 25(1) *Human Rights Quarterly* 1, 24; P Alston, ‘The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child’ (1990) 12 *Human Rights Quarterly* 156, 161, 177–8. See further [67] and [72] below.

<sup>89</sup> The *Convention for the Protection of Human Rights and Fundamental Freedoms*, 213 UNTS 221 / ETS No 5, as amended by Protocols No 11 and 14 (the ‘*European Convention on Human Rights*’), art 2(1) provides:

Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Relevantly, the interpretation of art 2(1) is summarised in the following oft-quoted passage of the judgment of the European Court of Human Rights in *Vo v France* (2004) 8 Eur Court HR 67, 106–7 [80]:

in the circumstances examined to date by the Convention institutions—that is, in the various laws on abortion—the unborn child is not regarded as a ‘person’ directly protected by Article 2 of the Convention and ... if the unborn do have a ‘right’ to ‘life’, it is implicitly limited by the mother’s rights and interests. The Convention institutions have not, however, ruled out the possibility that in certain circumstances safeguards may be extended to the unborn child.

Cf the *American Convention on Human Rights*, OAS Treaty Series No 36 (1960), art 4(1), which provides:

Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.

It has been noted that the *American Convention on Human Rights* (also known as the ‘Pact of San José’) is the only human rights treaty to have a provision that protects life before birth: see, eg, Amnesty International, ‘The UN Human Rights Committee’s Proposed General Comment on the Right to Life: Amnesty International’s Preliminary Observations’, Submission to the Human Rights Committee (2015) 20. Article 4(1), by including the words ‘in general’ and ‘arbitrarily’, has been interpreted by the Inter-American Commission on Human Rights as not conferring an absolute right to life on the fetus or unborn child such as would prevent terminations of pregnancy in appropriate cases, for example, to save the life of the mother: Inter-American Commission on Human Rights, *Baby Boy* (case 2141), Resolution 23/81, 6 March 1981, [19](h), [25], [30].

<sup>90</sup> Alston, above n 88, 161. See also, eg, MK Eriksson, ‘The Legal Position of the Unborn Child in International Law’ (1993) 36 *German Yearbook of International Law* 86, 104.

recognise a right to life 'from the moment of conception' were made, but did not succeed.<sup>91</sup>

[63] There was also debate about incorporating in the CRC the reference to 'safeguards and care ... before as well as after birth' that appears in the preamble to the Declaration of the Rights of the Child.<sup>92</sup> The final outcome was for the preamble to the CRC to quote directly from the Declaration. Accordingly, the ninth paragraph of the preamble to the CRC states that:

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth' ...

[64] However, a statement was included in the preparatory materials on behalf of the working group that, 'in adopting this paragraph', it is 'not intend[ed] to prejudice the interpretation of article 1 or any other provision of the Convention by State Parties'.<sup>93</sup>

[65] The CRC does not itself provide guidance about the precise scope of the ninth paragraph of the preamble. It has been suggested that the protection to which it refers might include provision of maternal health care to promote a child's capacity to survive and thrive after birth.<sup>94</sup>

[66] It has been said that the preambular paragraph is not itself enforceable and does not extend the meaning of articles 1 or 6 of the CRC:<sup>95</sup>

it would be inconsistent with general principles of treaty interpretation to suggest that a provision in the preamble which is not reflected in the operative part of the text, can be relied upon, on its own, to extend very considerably the natural and ordinary meaning of the actual terms used in Articles 1 and 6 [of the CRC]. While the preambular paragraph can be considered to form one part of the basis for interpretation of the treaty, there is no obvious reason why the preamble would be resorted to in order to interpret what would otherwise appear to be a natural and ordinary meaning of the term 'child'. In international law, at least, there is no

<sup>91</sup> See, eg, Commission on Human Rights, *Report of the Working Group on a draft convention on the rights of the child*, 45th sess, UN Doc E/CN.4/1989/48 (2 March 1989) [76]–[77]; LA Rehof, 'Article 3' in A Eide et al (eds), *The Universal Declaration of Human Rights: A Commentary* (Scandinavian University Press, 1992) 73, 75–6; R Copelon et al, 'Human Rights Begin at Birth: International Law and the Claim of Fetal Rights' (2005) 13(26) *Reproductive Health Matters* 120, 122; Alston, above n 88, 159, 162–63; and Eriksson, above n 90, 104 in relation to art 3 of the UDHR, art 6 of the ICCPR and art 1 of the CRC.

<sup>92</sup> See *Declaration on the Rights of the Child*, GA Res 1386 (XIV), 20 November 1959, preamble para [3].

<sup>93</sup> Commission on Human Rights, *Report of the Working Group on a draft convention on the rights of the child*, 45th sess, UN Doc E/CN.4/1989/48 (2 March 1989) [43]–[44]. It is noted that the paragraph is, therefore, of 'limited purpose': Copelon et al, above n 91, 122.

<sup>94</sup> Cook and Dickens, above n 88, 24; Copelon et al, above n 91, 122. Cf Joseph, above n 86, 121–3 which criticises this interpretation for failing to accord adequate recognition to protection of the child before birth.

<sup>95</sup> Alston, above n 88, 169–70. Cf Finegan, above n 86, 117 in which it is argued that:

The preamble to a treaty ... enunciates the broad general principles relevant to the treaty. The ninth preambular paragraph thus enunciates the principle that what proceeds it concerns all children, born and unborn. No article of the [CRC] comes close to contradicting this principle.

As to the interpretation of treaties, see the *Vienna Convention on the Law of Treaties*, 115 UNTS 331, arts 31, 32.

precedent for interpreting either that term, or others such as ‘human being’ or ‘human person’ as including a fetus. Where the intention has been to extend the reach in that way, the practice has been to specify that fact<sup>96</sup>—an approach which was rejected in the drafting of the [CRC]. (notes omitted; note added)

[67] The approach taken to the CRC was to leave the question of rights before birth unaddressed, giving individual countries the flexibility to adopt their own position.<sup>97</sup> It has been explained that:<sup>98</sup>

The text of the [CRC], as currently drafted, clearly leaves open the possibility for individual ratifying states to adopt ‘appropriate’ legal and other measures to protect the unborn child. ... Equally, however, it is clear that neither the text of the Convention itself, nor any of the relevant circumstances surrounding its adoption, lend support, either of a legal or other nature, to the suggestion that the Convention requires legislation to recognise and protect the right to life of the fetus.

[68] The CRC Committee has not released a General Comment on article 6 of the CRC. However, in its General Comment on the right to health of children, it has highlighted the importance of maternal health to the health of newborn infants:<sup>99</sup>

Among the key determinants of children’s health, nutrition and development are the realisation of the mother’s right to health and the role of parents and other caregivers. A significant number of infant deaths occur during the neonatal period, related to the poor health of the mother prior to, and during, the pregnancy and the immediate post-partum period, and to suboptimal breastfeeding practices. The health and health-related behaviours of parents and other significant adults have a major impact on children’s health.

[69] The CRC Committee has also released a General Comment on the implementation of the convention rights in early childhood. It notes that early

<sup>96</sup> See *American Convention on Human Rights*, OAS Treaty Series No 36 (1960), art 4(1), discussed at n 89 above.

<sup>97</sup> Alston, above n 88. See also, eg, Eriksson, above n 90, 105: ‘there was consensus that the matter be left unaddressed’; AF Janoff, ‘Rights of the Pregnant Child vs. Rights of the Unborn Under the Convention on the Rights of the Child’ (2004) 22 *Boston University International Law Journal* 163, 167: ‘[t]he plain meaning of the [CRC’s] terms does not clarify whether the Convention provisions apply to a “child” before birth’. See also Australia, *Parliamentary Debates*, Senate, 26 October 1989, 2313 (G Evans, Foreign Minister):

Although a reference to the rights of the child ‘before as well as after birth’, taken from the 1959 United Nations Declaration on the Rights of the Child does appear in the preamble of the draft convention, at the same time a statement in the *travaux préparatoires*—the preparatory materials—makes it clear that the contentious issue of the child’s rights before birth is a question to be determined by individual state parties.

Some countries entered declarations, when ratifying the CRC, of their views on this question. Declarations were entered by: the United Kingdom, to the effect that it considers the CRC to be applicable ‘only following a live birth’; China, France and Tunisia, to the effect that the CRC should be not be interpreted to present an obstacle to their national laws on termination of pregnancy; and Argentina, Guatemala and the Holy See, to the effect that in their view the right to life applies before birth. See United Nations Treaty Collection, Status of Treaties, ch IV, [11] Convention on the Rights of the Child.

<sup>98</sup> Alston, above n 88, 177–78. Cf Finegan, above n 86, 120–21, in which it is acknowledged that Alston’s article remains the most influential on the topic, but is suggested that ‘sensitivities over domestic abortion laws were the reason’ for omitting an explicit recognition of the right to life before birth and that the CRC, which was not ‘an entirely neutral compromise’, leaves room for the recognition of such rights outside the context of abortion.

<sup>99</sup> CRC Committee General Comment No 15, above n 72, II [D]. See also *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966, art 12(2)(a) which identifies ‘the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child’ as an aspect of the right to health.

childhood includes ‘all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school’.<sup>100</sup> With respect to the rights to life, survival and development in article 6 of the CRC, it observes that:<sup>101</sup>

State parties are urged to take all possible measures to improve perinatal care for mothers and babies, reduce infant and child mortality, and create conditions that promote the well-being of all young children during this critical phase of their lives.

[70] In its General Comment on article 6 of the ICCPR, the HRC has similarly identified the reduction of infant mortality as an aspect of the fulfilment of the right to life, particularly through the elimination of ‘malnutrition and epidemics’.<sup>102</sup>

[71] Accordingly, protections are indirectly provided to the child before birth through the promotion of maternal health care.

[72] The HRC is presently drafting a new General Comment on article 6 of the ICCPR.<sup>103</sup> In the first reading draft released in 2015, the question of the right to life before birth was addressed in the following terms, clarifying that it cannot be assumed that article 6 imposes an obligation to recognise the right to life of unborn children:<sup>104</sup>

the Covenant does not explicitly refer to the rights of unborn children, including to their right to life. In the absence of subsequent agreements regarding the inclusion of the rights of the unborn within article 6 and in the absence of uniform State practice which establishes such subsequent agreements, the Committee cannot assume that article 6 imposes on State parties an obligation to recognise the right to life of unborn children. Still, State parties may choose to adopt measures designed to protect the life, potential for human life or dignity of unborn children, including through recognition of their capacity to exercise the right to life, provided that such recognition does not result in violation of other rights under the Covenant, including the right to life of pregnant mothers and the prohibition against exposing them to cruel, inhuman and degrading treatment or punishment. (notes omitted)

<sup>100</sup> Committee on the Rights of the Child, *General Comment No 7 (2005): Implementing child rights in early childhood*, 40th sess, UN Doc CRC/C/GC/7/Rev.1 (20 September 2006) [1], [4].

<sup>101</sup> *Ibid* [10]. The CRC Committee refers, in particular, to addressing ‘malnutrition and preventable diseases, ... adverse living conditions, [and] neglect, insensitive or abusive treatment’. It also observes that the right to survival and development must be implemented in a ‘holistic manner’, including through the enforcement of other convention rights such as the ‘rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play’.

<sup>102</sup> HRC General Comment No 6, above n 82, [5].

<sup>103</sup> See Office of the United Nations High Commissioner for Human Rights, *Draft General Comment on Article 6 of the International Covenant on Civil and Political Rights—Right to life* (2017) <<http://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx>>.

<sup>104</sup> Human Rights Committee, *Draft general comment No 36: Article 6 Right to life*, 115th sess, UN Doc CCPR/C/GC/R.36/Rev.2 (2 September 2015) [7]. The HRC commenced its first reading of the draft during its 115th session, following a half day of general discussion focusing on the views of national human rights institutions, non-government organisations, academics and submissions from other interested parties. The HRC completed its first reading at its 120th session, and invited further submissions on a revised draft. The excerpt quoted at [72] above does not appear in the revised draft.

[73] The draft General Comment also recognises that the right to life of a pregnant woman requires access to safe, lawful abortions:<sup>105</sup>

Although State parties may adopt measures designed to regulate terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or her other rights under the Covenant, including the prohibition against cruel, inhuman and degrading treatment or punishment. Thus, any legal restrictions on the ability of women to seek abortion must not, inter alia, jeopardise their lives or subject them to physical or mental pain or suffering which violates article 7. State parties must provide safe access to abortion to protect the life and health of pregnant women, and in situations in which carrying a pregnancy to term would cause the woman substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or when the fetus suffers from fatal impairment. State parties may not regulate pregnancy or abortion in a manner that runs contrary to their duty to ensure that women do not have to undertake unsafe abortions. [For example, they should not take measures such as criminalising pregnancies by unmarried women or applying criminal sanctions against women undergoing abortion or against physicians assisting them in doing so, when taking such measures is expected to significantly increase resort to unsafe abortions]. Nor should State parties introduce humiliating or unreasonably burdensome requirements on women seeking to undergo abortion. The duty to protect the lives of women against the health risks associated with unsafe abortions requires State parties to ensure access for women and men, and, in particular, adolescents, to information and education about reproductive options, and to a wide range of contraceptive methods. State parties must also ensure the availability of adequate prenatal and post-abortion health care for pregnant women. (notes omitted)

[74] This is consistent with the jurisprudence and comments made by the HRC and other treaty bodies concerning the reproductive health rights of women and girls.

[75] It is recognised that, whilst protections may be accorded to the fetus or unborn child, an absolute right to life before birth would conflict with the rights of pregnant women and girls.<sup>106</sup> In the balance between such rights, the general trend has been for ‘the rights of the mother [to] supersede the right to life of an unborn child’.<sup>107</sup>

[76] Some countries have specifically recognised the right to life of the fetus in domestic law. For example, the Irish Constitution provides that:<sup>108</sup>

The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

<sup>105</sup> Human Rights Committee, *General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life—Revised draft prepared by the Rapporteur*, 120th sess (July 2017) [9]. See also the comments to the same effect in the earlier draft: Human Rights Committee, *Draft general comment No 36: Article 6 Right to life*, 115th sess (2 September 2015) UN Doc CCPR/C/GC/R.36/Rev.2, [7].

<sup>106</sup> See, eg, Copelon et al, above n 91, 125–6; Alston, above n 88, 174, 178; and Amnesty International, above n 89, 21.

<sup>107</sup> Janoff, above n 97, 188. See also the statement in *Vo v France* (2004) 8 Eur Court HR 67, [80], quoted at n 89 above, that ‘if the unborn do have a “right” to “life”, it is implicitly limited by the mother’s rights and interests’.

<sup>108</sup> *Constitution of Ireland* s 40.3(3).

[77] As discussed at [42]–[43] above, Ireland has been called upon by the HRC to amend its laws, including its Constitution if necessary, to ensure compliance with the ICCPR regarding women’s access to safe terminations of pregnancy.<sup>109</sup>

[78] The Australian Government has taken the view that the right to life under the ICCPR ‘was not intended to protect life from the point of conception but only from the point of birth’.<sup>110</sup>

### Non-discrimination on the basis of disability

[79] The CRPD is intended to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’.<sup>111</sup>

[80] Article 4(1) of the CRPD requires state parties to ‘undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability’, including by the adoption of appropriate legislative measures and the modification or abolition of existing laws that constitute discrimination.

[81] Further, article 5(2) prohibits ‘all discrimination on the basis of disability’.

[82] The CRPD reaffirms several fundamental rights, including the rights to family (article 23)<sup>112</sup> and health, including sexual and reproductive health

<sup>109</sup> The Government of Ireland has foreshadowed introducing less restrictive termination laws following a constitutional referendum on 25 May 2018 at which a majority voted to repeal art 40.3(3) of the *Constitution of Ireland* (known as the Eighth Amendment) which protects the right to life of the unborn, with due regard to the equal right to life of the mother: see generally Referendum Ireland, *Referendum on the Thirty-sixth Amendment of the Constitution Bill 2018* <<http://www.referendum.ie/current-referendum/>>; Department of Health (Ireland), *General Scheme of a Bill to Regulate Termination of Pregnancy* (28 March 2018) <<https://health.gov.ie/blog/publications/general-scheme-of-a-bill-to-regulate-termination-of-pregnancy/>>; Referendum Commission (Ireland), *Referendum on the Regulation of Termination of Pregnancy* <<https://refcom2018.refcom.ie/>>.

<sup>110</sup> Joint Standing Committee on Treaties, Parliament of Australia, *Report No 95: Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008* (2008) 17, quoting Evidence to Joint Standing Committee on Treaties, Parliament of Australia, Canberra, 16 June 2008, 6 (Peter Arnaudo, Attorney-General’s Department). See also National Interest Analysis [2008] ATNIA 18, attachment on consultation [16].

<sup>111</sup> *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 1. Art 1 further provides that:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

<sup>112</sup> *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 23(1)(b) requires state parties to ‘take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships’, including to ensure:

The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided.

Article 23(1)(c) also requires measures to ensure that ‘[p]ersons with disabilities, including children, retain their fertility on an equal basis with others’.

(article 25).<sup>113</sup> It also recognises the right of children with disabilities to the full enjoyment of rights and freedoms on an equal basis with other children (article 7).<sup>114</sup>

[83] As noted above, article 10 of the CRPD also reaffirms, for persons with disabilities, the right to life:

State Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

[84] Consistently with other treaties, article 10 is silent on the question of the right to life before birth, 'leaving each state to determine when life begins according to its own ... legal principles'.<sup>115</sup>

[85] Although the CRPD does not expressly recognise rights before birth, the United Nations Committee on the Rights of Persons with Disabilities (the 'CRPD Committee') has raised concerns about abortion laws in some countries that permit termination of pregnancy on the basis of fetal impairment.

[86] The CRPD Committee has not released a General Comment canvassing this issue, but has called on some countries to amend their laws to abolish distinctions based solely on disability.

[87] For example, in its concluding observations on Spain, the CRPD Committee made the following comment and recommendation:<sup>116</sup>

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<sup>113</sup> *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 25(a) recognises that persons with disabilities have 'the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability' and requires, among other things, provision to persons with disabilities of:

the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

<sup>114</sup> See also *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, preamble para (r).

<sup>115</sup> CJ Petersen, 'Reproductive Justice, Public Policy, and Abortion on the Basis of Fetal Impairment: Lessons from International Human Rights Law and the Potential Impact of the Convention on the Rights of Persons with Disabilities' (2015) 28(1) *Journal of Law and Health* 121, 158. See also 153:

the drafters of the CRPD agreed to describe the 'right to life' in very simple terms. The provision on the 'right to life' ... does not refer to 'the unborn' and it does not state that life begins at conception. ... the drafters decided against including any express reference to abortion within the treaty. (notes omitted)

See also Joint Standing Committee on Treaties, Parliament of Australia, *Report No 95: Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008* (2008) 17; and National Interest Analysis [2008] ATNIA 18, attachment on consultation [16]:

A number of submissions suggested that Article 10—the right to life—obliges State Parties to prohibit abortion; particularly abortion on the basis of disability confirmed through in utero testing. Life from the point of conception was not intended to be protected by the right to life, as enunciated in Article 6 of the [ICCPR]. Given that the [CRPD] does not create any new rights, the Australian Government considers that Article 10 of the Convention carries this meaning also.

<sup>116</sup> Committee on the Rights of Persons with Disabilities, *Concluding observations on Spain*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011) [17]–[18].

The Committee takes note of Act 2/2010 of 3 March 2010 on sexual and reproductive health, which decriminalises voluntary termination of pregnancy, allows pregnancy to be terminated up to 14 weeks and includes two specific cases in which the time limits for abortion are extended if the fetus has a disability: until 22 weeks of gestation, provided there is 'a risk of serious anomalies in the fetus', and beyond week 22 when, inter alia, 'an extremely serious and incurable illness is detected in the fetus'. ...

The Committee recommends that the State party abolish the distinction made in Act 2/2010 in the period allowed under law within which a pregnancy can be terminated based solely on disability.

[88] The CRPD Committee made similar comments and recommendations in its concluding observations on Hungary and Austria.<sup>117</sup>

[89] Those comments and recommendations were made in the context of the general provisions about non-discrimination under articles 4 and 5 of the CRPD, and not with reference to the right to life in article 10.

[90] The effect of the Committee's comments has been questioned. One academic commentator has observed, for example, that:<sup>118</sup>

It appears that the Committee is implicitly taking the position that a fetus enjoys rights under the CRPD, despite the lack of any explicit statement to this effect in the treaty. If this is the case, the Committee's approach marks a departure from the predominant approach in international law, which has traditionally not provided for fetal rights in human rights treaties but rather allowed each individual state to determine whether a fetus enjoys legal rights within that state's domestic legal system. ... In this author's view, the only other possible interpretation of the Committee's recommendation [to] abolish all distinctions based upon disability in [the] abortion law[s] is that the Committee may believe that permitting abortion on the ground of fetal impairment devalues, and therefore discriminates against, people who are already living with disabilities. (notes omitted)

[91] That author has argued that the CRPD Committee's comments, by focusing on the removal of formal discrimination in the legislative framework, are 'too simplistic and do not adequately acknowledge the tensions between reproductive freedom and the rights of persons with disabilities':<sup>119</sup>

Ironically, Spain and Hungary could both comply with the Committee's comments by amending their laws to provide all women with unfettered access to abortion. Such amendments would address what the Committee views as the formal discrimination in the legislative framework, but would do nothing to reduce the incidence of disability-selective abortions. On the other hand, if a country moves in the opposite direction, and reduces access to abortion, it could have the effect of violating numerous human rights treaties, including the CRPD, which give persons with disabilities the right to determine the number and spacing of their

<sup>117</sup> Committee on the Rights of Persons with Disabilities, *Concluding observations on Hungary*, UN Doc CRPD/C/HUN/CO/1 (22 October 2012) [17]–[18]; Committee on the Rights of Persons with Disabilities, *Concluding observations on Austria*, UN Doc CRPD/C/AUT/CO/1 (30 September 2013) [14]–[15].

<sup>118</sup> Petersen, above n 115, 159, commenting in particular on the CRPD Committee's concluding observations on Hungary.

<sup>119</sup> *Ibid* 161–2.

children and the right to reproductive health services. Such legislation could also motivate more women to seek illegal and unsafe abortions ... (note omitted)

[92] In that author's view, 'more systemic ways of encouraging prospective parents to voluntarily continue a pregnancy that may lead to the birth of a child with disability' should be considered.<sup>120</sup>

[93] This also raises more complex questions about 'disability-selective' abortion:<sup>121</sup>

the decision to abort [following a diagnosis of fetal impairment] does not necessarily reflect a societal policy of trying to prevent the birth of persons with disabilities. Rather, it might reflect compassion for the pregnant woman, respect for her right to physical autonomy, or recognition that she is in the best position to determine whether she should continue the pregnancy.

However, many disability rights scholars and activists would argue that society does not simply allow pregnant women to make their own decisions. Instead, the medical profession and other powerful institutions actively encourage disability-selective abortion by recommending genetic screening and prenatal testing and then counselling prospective parents in a manner that discourages them from continuing a pregnancy if the tests reveal fetal impairment. (note omitted)

## FREEDOMS OF CONSCIENCE AND EXPRESSION

### Freedom of thought, conscience and religion

[94] Both the UDHR (article 18) and the ICCPR (article 18) recognise the right to 'freedom of thought, conscience and religion', including the freedom to manifest a religion or belief either individually 'or in community with others and in public or private'.<sup>122</sup>

[95] Article 18(3) of the ICCPR provides that the freedom to manifest one's religion or beliefs may be restricted, but only by limitations prescribed by law and that are 'necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others'.<sup>123</sup>

[96] The HRC has explained that:<sup>124</sup>

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120 Ibid.

121 Ibid 137.

122 See Human Rights Committee, *General Comment No 22: Article 18*, 48th sess, UN Doc CCPR/C/21/Rev.1/Add.4 (27 September 1993) [1]:

The right to freedom of thought, conscience and religion (which includes the freedom to hold beliefs) in article 18(1) is far-reaching and profound; it encompasses freedom of thoughts on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others.

The freedom of thought, conscience and religion is also recognised in the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 14(1).

123 See also, in the same terms, the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 14(3).

124 HRC General Comment No 22, above n 122, [8].

paragraph 3 of article 18 is to be strictly interpreted: restrictions are not allowed on grounds not specified there, even if they would be allowed as restrictions to other rights protected in the Covenant, such as national security. Limitations may be applied only for those purposes for which they were prescribed and must be directly related and proportionate to the specific need on which they are predicated. Restrictions may not be imposed for discriminatory purposes or applied in a discriminatory manner.

[97] The ICCPR does not expressly refer to a right of conscientious objection. However, the HRC has observed that such a right (in the context of military service) can be derived from article 18.<sup>125</sup>

[98] In the context of the sexual and reproductive health rights of women and girls (and in relation to abortion specifically), treaty bodies have identified that the practice of conscientious objection by health professionals should be regulated to ensure that it does not inhibit access to services, including in emergencies and by referral to alternative health providers.<sup>126</sup> The HRC has also observed that article 18 of the ICCPR 'may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion'.<sup>127</sup>

[99] The WHO Safe Abortion Guidance recommends that health professionals who claim conscientious objection should be required to refer the person to another provider so that access to lawful abortion services is not impeded.<sup>128</sup>

Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure, while not referring the woman to an abortion provider. In the absence of a readily available abortion-care provider, this practice can delay care for women in need of safe abortion, which increases risks to their health and life. While the right to freedom of thought, conscience, and religion is protected by international human rights law, international human rights law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others. Therefore laws and regulations should not entitle providers and institutions to impede women's access to lawful health services.

Health-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health. Health services should

125 Ibid [11].

126 See the comments and observations of the ESCR Committee referred to at [25], [28] and n 47 above, the comments of the CEDAW Committee referred to at nn 47 and 48 above and the comments of the CRC Committee referred to at [49] above. See also, eg, Statement of the CEDAW Committee, above n 9, 2; Committee on the Elimination of Discrimination against Women, *Concluding observations on Italy*, UN Doc CEDAW/C/ITA/CO/7 (24 July 2017) [41](d), [42](d); Committee on the Elimination of Discrimination against Women, *Concluding observations on Croatia*, UN Doc CEDAW/C/HRV/CO/4-5 (28 July 2015) [30](a), [31](a); *Report of the Office of the United Nations High Commissioner for Human Rights: Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights*, UN Doc A/HRC/18/27 (8 July 2011) [30]. The Special Rapporteur on the right to health has also raised concerns about conscientious objection: see [32] above.

127 HRC General Comment No 28, above n 61, [21].

128 WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) [4.2.2.5], and see [3.3.6]. See also the table at [111] below.

be organised in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation. (notes omitted)

## Freedom of opinion and expression

[100] Both the UDHR (article 19) and the ICCPR (article 19) recognise the right to freedom of opinion and expression.<sup>129</sup> This includes the freedom to hold opinions without interference<sup>130</sup> and the freedom to seek, receive and impart information and ideas regardless of frontiers and through any media.<sup>131</sup>

[101] The HRC has described these freedoms as constituting ‘the foundation stone for every free and democratic society’ and as forming ‘a basis for the full enjoyment of a wide range of other human rights’.<sup>132</sup> They are closely linked with the rights to freedom of association and assembly and freedom of thought, conscience and religion,<sup>133</sup> and are enjoyed individually and collectively.<sup>134</sup>

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<sup>129</sup> See also the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 13; and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 21.

<sup>130</sup> See, in particular, *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 19(1) which provides that ‘[e]veryone shall have the right to hold opinions without interference’. Freedom of opinion is said to be largely a private matter, in contrast with the freedom of expression in art 19(2) which is said to be largely a public matter: *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression*, 51st sess, Agenda Item 10, UN Doc E/CN.4/1995/32 (14 December 1994) [24], [26].

<sup>131</sup> See, in particular, *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 19(2) which provides:

Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

Article 19(2) includes, for example, political discourse, commentary on one’s own and on public affairs, discussion of human rights and religious discourse. It also encompasses the right of access to public information: Human Rights Committee, *General Comment No 34: Article 19 (Freedoms of opinion and expression)*, 102nd sess, UN Doc CCPR/C/GC/34 (12 September 2011), [11], [18].

<sup>132</sup> HRC General Comment No 34, above n 131, [2], [4].

<sup>133</sup> *Ibid* [4]; *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression*, 14th sess, Agenda Item 3, UN Doc A/HRC/14/23 (20 April 2010) [27].

The freedoms of association and peaceful assembly are recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 20; *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, arts 21, 22; and *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 15.

<sup>134</sup> *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 133, [29]:

[Freedom of opinion and expression] endows social groups with the ability to seek and receive different types of information from a variety of sources and to voice their collective views. This freedom extends to mass demonstrations of various kinds, including the public expression of spiritual or religious beliefs or of cultural values.

[102] Freedom of opinion is not subject to restriction.<sup>135</sup> However, article 19(3) of the ICCPR recognises that freedom of expression ‘carries with it special duties and responsibilities’ and may be restricted in certain circumstances:<sup>136</sup>

The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

- (a) For respect of the rights or reputations of others;
- (b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

[103] It has been observed that the reference in article 19(3) to ‘special duties and responsibilities’ recognises that ‘the exercise of freedom of expression might entail a violation of the rights of others’ so that there is a responsibility ‘not to abuse’ the freedom.<sup>137</sup>

[104] In addition, article 5 of the ICCPR provides that:

Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognised herein or at their limitation to a greater extent than is provided for in the present Covenant.

[105] The HRC has explained that restrictions on the freedom of expression may be imposed only in accordance with article 19(3) and in conformity with ‘the strict tests of necessity and proportionality’.<sup>138</sup> In addition, restrictions must not jeopardise the right of freedom of expression itself, or other rights and principles under the ICCPR.<sup>139</sup>

[106] The United Nations Special Rapporteur on the right to freedom of opinion and expression has identified the following principles on restrictions of the freedom of expression:<sup>140</sup>

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<sup>135</sup> See HRC General Comment No 34, above n 131, [9]. See also *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (1994), above n 130, [24].

<sup>136</sup> See also art 20 of the ICCPR which prohibits propaganda for war and requires that advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence shall be prohibited by law.

<sup>137</sup> *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (1994), above n 130, [36].

<sup>138</sup> HRC General Comment No 34, above n 131, [22].

<sup>139</sup> *Ibid* [21], [26].

<sup>140</sup> *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 133, [77], [79](a)–(g), (i), (k)–(l). See also the additional principles at [79](h) and (j) in relation, for example, to propaganda for war, child pornography, racial hatred, genocide and declared states of emergency.

- As a general principle, permissible restrictions must constitute an exception and be kept to the minimum necessary to pursue the legitimate aim of safeguarding other human rights.<sup>141</sup>
- In particular—
  - Restrictions must not undermine the essence of the freedom;
  - The relationship between the freedom and the restriction (or the rule and the exception) must not be reversed;
  - Restrictions must be provided for in laws;<sup>142</sup>
  - Laws imposing restrictions must be accessible and unambiguous so that they can be understood by and applied to everyone;
  - Laws imposing restrictions must provide remedies for, or mechanisms for challenging, unlawful or abusive applications of the restriction (including judicial review);
  - Laws imposing restrictions must not be arbitrary or unreasonable;
  - Restrictions must be necessary;<sup>143</sup>
  - The continued relevance of restrictions should periodically be examined;
  - Restrictions must be consistent with other recognised human rights, and with fundamental principles of universality, interdependence, equality and non-discrimination; and
  - Where there is doubt about the scope or interpretation of a law imposing a restriction, the prevailing consideration must be the protection of fundamental human rights.

[107] The Special Rapporteur has identified that the requirement of ‘necessity’ means that restrictions must:<sup>144</sup>

- (i) Be based on one of the grounds for limitations recognised by the Covenant;
- (ii) Address a pressing public or social need which must be met in order to prevent the violation of a legal right that is protected to an even greater extent;
- (iii) Pursue a legitimate aim;

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<sup>141</sup> See further [108] below.

<sup>142</sup> See further HRC General Comment No 34, above n 131, [24]–[25].

<sup>143</sup> See further [107] below.

<sup>144</sup> *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 133, [79](g).

- (iv) Be proportionate to that aim and be no more restrictive than is required for the achievement of the desired purpose. The burden of demonstrating the legitimacy and the necessity of the limitation or restriction shall lie with the State.

[108] As to proportionality, the HRC has explained that ‘restrictions must not be overbroad’:<sup>145</sup>

‘restrictive measures must conform to the principle of proportionality; they must be appropriate to achieve their protective function; they must be the least intrusive instrument amongst those which might achieve their protective function; they must be proportionate to the interest to be protected ... The principle of proportionality has to be respected not only in the law that frames the restrictions but also by the administrative and judicial authorities in applying the law’. The principle of proportionality must also take account of the form of expression at issue as well as the means of its dissemination (note omitted).

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<sup>145</sup> HRC General Comment No 34, above n 131, [34], quoting from Human Rights Committee, *General Comment No 27: Freedom of movement (article 12)*, 173rd sess, UN Doc CCPR/C/21/Rev.1/Add.9 (1 November 1999) [14] and citing Human Rights Committee, *Views: Communication No 1157/2003*, 87th sess, UN Doc CCPR/C/87/D/1157/2003 (10 August 2005) (*Coleman v Australia*).

## OVERVIEW TABLES

[109] The following tables briefly summarise key aspects of the WHO Safe Abortion Guidance, the United Nations OHCHR information series on abortion and United Nations treaty body jurisprudence and guidance.<sup>146</sup>

### Decriminalisation of abortion

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Criminal offences for the woman	[4.1]–[4.2]: International and regional human rights bodies increasingly recommend that States reform laws that criminalise medical procedures only needed by women and that punish women who undergo those procedures, including abortion. Restricting legal access to abortion does not decrease the need for abortion but is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Given the clear link between access to safe abortion and women's health, it is recommended that laws and policies should protect women's health and their human rights.	Criminalisation of health services that only women require, including abortion, is a form of discrimination against women. Treaty bodies have requested States to decriminalise abortion and remove punitive measures for women who undergo abortion.	Criminalisation of abortion may amount to cruel or inhuman treatment. (1)  Punitive measures imposed on women who undergo abortion should be removed. (2, 4, 9)
Criminal offences for the provider		Criminalisation of doctors who provide abortion services violates women's rights. Treaty bodies have expressed concern about the criminalisation of health care providers who offer abortion services. Imposing a legal duty on doctors to report cases of women who have undergone abortion may violate women's right to privacy.	Imposing a legal duty on health providers to report cases of women who have undergone abortion may violate women's right to privacy. (5)

### Legal grounds for abortion

[110] The WHO has explained that '[e]vidence increasingly shows that, where abortion is legal on broad socioeconomic grounds and on a woman's request, and where safe services are accessible, both unsafe abortion and abortion-related mortality [death] and morbidity [injury] are reduced'.<sup>147</sup>

<sup>146</sup> See WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012); and Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (2015) <<http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>>.

<sup>147</sup> WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 90.

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Threat to life	[4.2.1.1]: This is consistent with the human right to life, which requires protection by law, including when pregnancy is life-threatening or a pregnant woman's life is otherwise endangered. Both medical and social conditions can constitute life-threatening conditions.	Ensuring women's rights requires access to abortion where there is a threat to the woman's life. Treaty bodies have requested States to legalise abortion in cases where the pregnancy endangers the life of the woman.	Abortion should be decriminalised to allow access to abortion where the pregnancy endangers the woman's life. (7, 11, 12, 16, 17, 19, 20, 21, 23)
Threat to health (physical or mental)	[4.2.1.2]: This fulfils women's human rights. Physical health includes conditions that aggravate pregnancy and those aggravated by pregnancy. Mental health includes psychological distress or mental suffering caused by, eg, coerced sexual acts and diagnosis of fetal impairment. Social circumstances are also taken into account. The WHO defines 'health' as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'; this is to be implied in the interpretation of laws that allow abortion on this ground.	Ensuring women's rights requires access to abortion where there is a threat to the woman's health. Treaty bodies have requested States to legalise abortion in cases where the pregnancy endangers the health of the woman. Health has been understood broadly to include mental health.	Abortion should be decriminalised to allow access to abortion where the pregnancy endangers the woman's health. (7, 11, 12, 16, 17, 23)
Where pregnancy results from rape or incest	[4.2.1.3]: Protection of women from cruel, inhuman and degrading treatment requires access to safe abortion services on this basis. Some countries require evidence of the criminal act, which can delay and restrict access. Administrative requirements should be minimised and clear protocols established to facilitate prompt referral and access.	Ensuring women's rights requires access to abortion where the pregnancy is the result of rape or incest. Treaty bodies have requested States to decriminalise abortion when the pregnancy results from rape or sexual abuse.	Denying access to abortion where the pregnancy is the result of rape is cruel, inhuman or degrading treatment, and a violation of the right to privacy. (25)  Abortion should be decriminalised to allow access to abortion in such cases. (5, 7, 8, 9, 11, 12, 13, 14, 16, 17, 18, 20, 23)
Where there is fetal impairment	[4.2.1.4]: Some countries specify the kinds of impairment, and others specify lists of impairments. Lists tend to be restrictive and a barrier to access. In some countries, the law does not refer directly to fetal impairment but health protection or social reasons are interpreted to include distress caused by the diagnosis of fetal impairment. A woman is entitled to know the status of her pregnancy and to act on this information.	Treaty bodies have recommended ensuring access to abortion services in cases of fetal impairment, while also putting in place measures to ensure the elimination of discrimination against persons with disabilities.	Denying access to abortion in cases of fatal fetal impairment is cruel, inhuman or degrading treatment, and a violation of the right to privacy. (24, 26, 27)  Abortion should be decriminalised to allow access to abortion in cases of severe fetal impairment. (8, 9, 14)  However, distinctions based solely on disability should be removed. (22)

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
For economic or social reasons	[4.2.1.5]: This is interpreted by reference to whether continued pregnancy would affect the actual or foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health.		
On request	[4.2.1.6]: This recognises the woman's free choice. Most countries that allow abortion on this ground also set gestational limits.		
Gestational limits	[4.2.1.7]: Gestational limits can have negative consequences for women who have exceeded the time limit. They can force women to seek services from unsafe providers or providers in other countries (or to resort to unsafe self-induced methods). As well as legal gestational limits, some services can restrict access with limits that are not evidence-based, eg, offering outpatient services only up to 8 weeks when they could safely be provided up to 12–14 weeks.		

### Other requirements or restrictions

[111] The WHO has explained that there are a range of 'laws, policies and practices that restrict access to abortion information and services', including prohibiting access to information, requiring third party authorisation, restricting available methods of abortion, restricting the range of providers and facilities, misrepresenting health information, excluding coverage under health insurance, failing to guarantee confidentiality and privacy, and restrictive interpretation of legal grounds:<sup>148</sup>

These barriers contribute to unsafe abortion because they:

- deter women from seeking care and providers from delivering services within the formal health system;
- cause delay in access to services, which may result in denial of services due to gestational limits on the legal grounds;
- create complex and burdensome administrative procedures;
- increase the costs of accessing abortion services; [and]
- limit the availability of services and their equitable geographic distribution.

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WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 94.

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Access to information	<p>[4.2.2.1]: Information about safe, legal abortion is crucial to protect women's health and human rights. Many women and health-care providers do not know what the law allows. Fear of violating the law has a chilling effect. States should provide clear guidance on how legal grounds for abortion are to be interpreted and applied, as well as information on how and where to access lawful services.</p> <p>[4.2.2.7]: Women have a right to be fully informed of their health care options. Information must be complete, accurate and easy to understand, and be given in a way that facilitates free and fully informed consent and respects the woman's dignity and privacy. See also [2.1.8.2].</p>		
Third party authorisation	<p>[4.2.2.2]: Third party authorisation should not be required for women to obtain abortion services. The requirement for authorisation by a spouse or hospital authorities may deter or delay access and violate the right to privacy and access to health care on the basis of equality of men and women.</p>	<p>Steps should be taken to remove barriers to the provision of abortion services, including third party authorisation provisions.</p>	<p>Third party authorisation requirements for access to abortion services should be removed. (2, 4)</p>
Consent for minors	<p>[4.2.2.2]: Parental authorisation, often based on an arbitrary age limit, denies the recognition of evolving capacities of young women. To protect the best interests and welfare of minors, and taking into consideration their evolving capacities, policies and practices should encourage, but not require, parents' engagement through support, information and education.</p>	<p>The CRC Committee has especially emphasised the right of the child, in accordance with evolving capacities, to confidential counselling and access to information, and has recommended that States consider allowing young people, in accordance with their evolving capacities, to consent to reproductive health services.</p>	<p>Third party authorisation requirements for access to abortion services, such as parental consent for young people capable of consenting in accordance with their evolving capacities, should be removed. (2, 4, 6)</p>
Special personnel and facilities	<p>[4.2.2.4]: Restrictions on the range of providers or facilities that are legally authorised to provide abortion reduce the availability of services and their equitable geographic distribution, causing women to travel greater distances and incur greater costs and delays. The regulation of facilities and providers should be evidence-based to protect against over-medicalised, arbitrary or otherwise unreasonable requirements.</p>		

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Conscientious objection	[4.2.2.5]: Freedom of thought, conscience and religion is protected, but can be limited where necessary to protect the fundamental human rights of others. Laws and regulations should not entitle providers and institutions to impede women's access to lawful health services. Health care providers who claim conscientious objection must refer the woman to another provider or, if that is not possible, provide abortion to save the woman's life or prevent damage to her health.	Conscientious objection cannot be allowed to prevent women or adolescent girls from accessing health services. The CEDAW Committee has stated that, if health providers refuse to perform services based on conscientious objection, measures should be taken to ensure that women are referred to alternative health providers.	Conscientious objection must be regulated so that it does not inhibit access to abortion services (including by requiring referrals to other providers) or to emergency services. (2, 4, 9, 10, 15)  Adolescent girls should not be deprived of information or services due to providers' conscientious objections. (6)
Counselling and waiting periods	[2.1.8.1]: Counselling should be offered, but many women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counselling. Provision of counselling to women who desire it should be voluntary, confidential, non-directive and by a trained person.  [4.2.2.6]: Waiting periods should not jeopardise women's access to safe, legal abortion services. States should consider eliminating waiting periods that are not medically required.  [2.3]: Women should also receive appropriate post-abortion care, including being offered contraceptive counselling.	The CEDAW Committee has explained that the legal framework for access to abortion must include a mechanism for rapid decision-making, with a view to limiting risks to the woman's health.	Biased counselling and mandatory waiting periods for abortion should be removed. (4)  Health care providers should be in a position to supply full information on safe abortion services without fear of criminal sanction. (27)

## Accessibility

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Accessibility and availability	[4.2.2.9]: The respect, protection and fulfilment of human rights require that governments ensure that lawful abortion services are accessible in practice.  [4.3]: An enabling environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care.  [3.3.1] and [3.6.2]: Access should not be denied or delayed because of a woman's inability to pay; and health facilities should have appropriate referral mechanisms.	Where abortion is lawful, procedures must be put in place for making abortion services safe and accessible to all women without discrimination. Legal reform alone is not enough to fulfil human rights obligations.	A core obligation under the ICESCR is to guarantee universal and equitable access to sexual and reproductive health services, and to take measures to prevent unsafe abortions. (4)  Services must be accessible and affordable for rural women. (3)  The right to life requires measures to prevent life-threatening clandestine abortions. (5)

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Safe access zones			Third parties should be prohibited and prevented from imposing practical barriers to services, such as physical obstruction of facilities, dissemination of misinformation and harassment or violence targeting women seeking abortion services. (4)

## Table notes—

1. CEDAW Committee General Recommendation No 35, above n 21
2. CEDAW Committee General Recommendation No 24, above n 9
3. CEDAW Committee General Recommendation No 34, above n 49
4. ESCR Committee General Comment No 22, above n 14
5. HRC General Comment No 28, above n 61
6. CRC Committee General Comment No 15, above n 72
7. CEDAW Committee Concluding Observations on Angola, above n 55
8. CEDAW Committee Concluding Observations on the Dominican Republic, above n 56
9. CEDAW Committee Concluding Observations on Peru, above n 10
10. CEDAW Committee Concluding Observations on Poland, above n 47
11. ESCR Committee Concluding Observations on Costa Rica, above n 55
12. ESCR Committee Concluding Observations on Nepal, above n 55
13. ESCR Committee Concluding Observations on Chile, above n 56
14. ESCR Committee Concluding Observations on the United Kingdom, above n 56
15. ESCR Committee Concluding Observations on Poland, above n 47
16. HRC Concluding Observations on the Philippines, above n 67
17. HRC Concluding Observations on the Dominican Republic, above n 67
18. HRC Concluding Observations on Guatemala, above n 67
19. HRC Concluding Observations on Panama, above n 67
20. CRC Committee Concluding Observations on Chile, above n 79
21. CRC Committee Concluding Observations on Chad, above n 79
22. CRPD Committee Concluding Observations on Spain, above n 116; CRPD Committee Concluding Observations on Hungary, above n 117; CRPD Committee Concluding Observations on Austria, above n 117
23. *TPF v Peru*, UN Doc CEDAW/C/50/D/22/2009
24. *Huamán v Peru*, UN Doc CCPR/C/85/D/1153/2003
25. *VDA v Argentina*, UN Doc CCPR/C/101/D/1608/2007
26. *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013
27. *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014



# Appendix D

## Development and moral status of the fetus

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### STAGES OF FETAL DEVELOPMENT

[1] A number of stages in the progression of a woman's pregnancy and the process of fetal development can be identified, including the following:<sup>1</sup>

- fertilisation and formation of the zygote;
- formation of the blastocyst;
- implantation;
- embryo; and
- fetus.

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<sup>1</sup> See, eg, J Oats and S Abraham (eds), *Llewellyn-Jones Fundamentals of Obstetrics and Gynaecology* (Mosby Elsevier, 9th ed, 2010) ch 3–4; M Permezel, S Walker and K Kyprianou (eds), *Beischer & MacKay's Obstetrics, Gynaecology and the Newborn* (Elsevier Australia, 4th ed, 2015) ch 2; M Hill, *Embryology* (2017) <[https://embryology.med.unsw.edu.au/embryology/index.php/Main\\_Page](https://embryology.med.unsw.edu.au/embryology/index.php/Main_Page)>; H Marcovitch, *Black's Medical Dictionary* (A&C Black Publishers, 42nd ed, 2009); E Martin, *Concise Medical Dictionary* (Oxford University Press, 9th ed, 2016).

		<b>Weeks after fertilisation</b>	<b>Gestational weeks<sup>2</sup></b>	
Fertilisation and formation of the zygote	The sperm fuses with the egg (or ovum) to form the first diploid cell, called the zygote. <sup>3</sup>	Day zero	Week 2	1st trimester (gestational weeks 1–12)
Formation of the blastocyst	The zygote is propelled along the woman's fallopian tube and cell division begins leading to the formation of a mass of cells, with a fluid-filled cavity, called the blastocyst.	Week 1	Week 3	
Implantation	The blastocyst undergoes a process of attaching to the uterine lining, and begins differentiating into different cell structures which will develop into the embryo and the placenta.	Week 2 <sup>4</sup>	Week 4	
Embryo	The stage of development from implantation until the seventh or eighth week after fertilisation when the main organs have formed.	Week 3–8	Week 5–10	
	<ul style="list-style-type: none"> <li>• 4–5 mm, about 1.3 g</li> </ul>	Week 4	Week 8	2nd and 3rd trimesters (gestational weeks 13–27 and 28–40)
	<ul style="list-style-type: none"> <li>• 10–12 mm. The connection between the fetal and placental circulation has been established.</li> </ul>	Week 5	Week 7	
	<ul style="list-style-type: none"> <li>• 20–25 mm. The embryo begins to show a distinctly human form.</li> </ul>	Week 6	Week 8	
Fetus	The stage of development from the eighth to tenth week after fertilisation to birth. During this period, placental development is completed and the fetus undergoes extensive growth and ongoing differentiation and growth of organ systems.	Week 8–38	Week 10–40	
	<ul style="list-style-type: none"> <li>• 8–9 cm, 30–60 g</li> </ul>	Week 12	Week 14	
	<ul style="list-style-type: none"> <li>• The woman may sense the movements of the fetus from about this time</li> </ul>	Week 18	Week 20	
	<ul style="list-style-type: none"> <li>• 15–25 cm, 170–340 g</li> </ul>	Week 20	Week 22	
	<ul style="list-style-type: none"> <li>• 32–35 cm, 1360–1820 g</li> </ul>	Week 28	Week 30	
	<ul style="list-style-type: none"> <li>• 45–60 cm, &gt;3200 g<sup>5</sup></li> </ul>	Week 38	Week 40	

**Table 1: Fetal development<sup>6</sup>**

<sup>2</sup> See 'gestation' in the Glossary to this Report.

<sup>3</sup> 'Diploid' meaning having two sets of chromosomes, in contrast to 'haploid' cells that contain only a single set of chromosomes.

<sup>4</sup> Beginning at six to eight days after fertilisation and usually completed by about the ninth or tenth day after fertilisation.

<sup>5</sup> Weight at 40 weeks is likely to depend on the level of obesity in the particular population, and will generally be greater, on average, than 3200 g. In 2015, the average live birth weight of Australian infants was 3342 g: Australian Institute of Health and Welfare, *Australia's mothers and babies, 2015—in brief* (2017) 22.

<sup>6</sup> With particular reference to Hill, above n 1; read together with Oats and Abraham, above n 1, ch 3–4; Permezel, Walker and Kyprianou, above n 1, ch 2; and Marcovitch, above n 1, definition of 'fetus'. The stages of fetal development involve processes, rather than discrete events: see, eg, A Mauron, 'Embryo and Fetus' in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 711, 712.

[2] At 23 to 25 weeks gestation,<sup>7</sup> the sustainability of the life of the fetus, if born pre-term, is uncertain. In Queensland, life sustaining interventions are not generally recommended for an infant born at less than 24 weeks.<sup>8</sup>

[3] The term 'conception' is not precise. It is commonly used to refer to the onset of pregnancy, either at fertilisation or implantation or both.<sup>9</sup> It 'signifies the complex set of changes which occur in the ovum and in the body of the mother at the beginning of pregnancy'.<sup>10</sup>

## DIFFERENT VIEWS ABOUT THE MORAL STATUS OF THE FETUS

[4] Determining the moral status of the fetus or unborn child is contentious. It cannot be resolved by medical facts.<sup>11</sup>

The answer to that question—which deals with the moral status of the fetus—is arrived at by a process that entwines medical facts with experiences, values, religious and philosophical beliefs and attitudes, perceptions of meaning, and moral argument. Such a process extends beyond the special competency of medicine.

<sup>7</sup> Between 23 weeks zero days and 25 weeks six days gestation: the 'threshold of viability' in Queensland: see the Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014) [5.7] discussed in Chapter 3 above.

<sup>8</sup> Ibid. There is general international consensus about the concept of different 'zones' in determining the threshold of viability for the care of extremely preterm infants. See, eg, A Janvier and JD Lantos, 'Variations of practice in the care of extremely preterm infants' in DS Diekema, MR Mercurio and MB Adam (eds), *Clinical Ethics in Pediatrics: A Case-Based Textbook* (Cambridge University Press, 2011) 95:

The first zone is that in which good outcomes are likely and thus, the initiation of intensive care is generally considered morally obligatory. A second zone is often called 'the grey zone'. In the grey zone, outcomes are considered sufficiently ambiguous or uncertain that both intensive care and comfort care are considered two ethically defensible options. Finally, there is a third zone in which newborns are not considered viable and in which intervention is considered 'non-beneficial'.

Those authors observe (at 94–5) that, in most industrialised countries, 'the "physiological" lower limit of viability' is generally 22 weeks, but that there is 'tremendous variation' in survival rates between countries at 22 to 25 weeks and between the 'borders of the grey zone':

Unlike the physiological limit of viability, which is the same around the globe, the borders between these three zones are fuzzy, elastic, and subjective. The policies of most industrialised countries vary considerably, with the borders of the grey zone ranging somewhere between 21 and 26 weeks, depending on where the baby is born.

A comparison of international guidelines, published in 2008, found that intensive care is generally considered justifiable from 25 weeks, compassionate (or palliative) care at 22 weeks or less, and an individual approach at 23 to 24 weeks consistent with the parents' wishes and the infant's clinical conditions: MS Pignotti and G Donzelli, 'Perinatal Care at the Threshold of Viability: An International Comparison of Practical Guidelines for the Treatment of Extremely Preterm Births' (2008) 121(1) *Pediatrics* e193. In 2005, a multi-disciplinary forum in the Australian Capital Territory and New South Wales adopted a consensus statement that the 'grey zone' is between 23 weeks and 25 weeks 6 days: K Lui et al, 'Perinatal care at the borderlines of viability: a consensus statement based on a NSW and ACT consensus workshop' (2006) 185(9) *Medical Journal of Australia* 495.

<sup>9</sup> See, eg, the definitions of 'conception' given in *Medical Dictionary* (2017) <<http://medical-dictionary.com/results.php>>; MedlinePlus, *Medical Dictionary* (Merriam-Webster, 2017) <<http://c.merriam-webster.com/medlineplus/conception>>.

<sup>10</sup> Marcovitch, above n 1, definition of 'conception'.

<sup>11</sup> A Rosenfeild and S Iden, 'Abortion: I Medical Perspectives' in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 1.

[5] There is a diversity of views about the moral status, or personhood, of the fetus. The Law Reform Commission of Canada, in its working paper on crimes against the fetus, helpfully summarised the range of views in this way:<sup>12</sup>

Some see the fetus as a miniature person alike in all respects but ease of visibility to a newborn baby and want the law to put it on the same footing as the latter without distinguishing between born and unborn children. Others regard it as a non-person and want the law to reflect what they perceive as overwhelming differences between those merely undergoing biological development in the womb and those participating in social relations outside it, especially in cases of conflict between fetal and other human interests. Yet others take a halfway position and look upon fetuses as potential persons, in some respects like, but in others unlike, persons, ie, special cases which are more than just collections of human cells but for most of the time less than what ordinarily count as persons. (notes omitted)

[6] Within this broad spectrum, a number of positions can be identified, outlined below.<sup>13</sup>

[7] In part, the diversity of views arises because ‘the fetus is significantly unlike other entities of moral concern’ and its relationship with the pregnant woman is in many ways unique.<sup>14</sup> Some commentators have suggested that, although a consensus is lacking, it can be agreed that the fetus is a living human entity and that decisions about it must be taken responsibly.<sup>15</sup>

### From conception

[8] At one end of the spectrum is the view that the fetus is a person deserving full protection from the moment of conception or fertilisation. Some of the arguments made in support of this view are that the genetic makeup of the physical organism is complete by conception, the human fetus is a whole organism rather than a collection of cells, and conception is the clearest point in fetal development to indicate the beginning of life.

[9] On the other hand, it is argued that personhood is created by psychological wholeness and experiential capacity rather than genetic identity, the fetus is not necessarily a complete organism at conception given the proportion of early development devoted to creation of the placenta and amniotic sac, and conception is a process that occurs over time and so does not provide a clear line.

<sup>12</sup> Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper No 58 (1989) 9.

<sup>13</sup> The outline at [8]–[20] below is informed, in particular, by the summaries in J Herring, *Medical Law and Ethics* (Oxford University Press, 6th ed, 2016) 329–42; and E Wicks, *Human Rights and Healthcare* (Hart Publishing, 2007) 184–7. See also, eg, A Marzilli, *Fetal Rights: Point/Counterpoint* (Chelsea House Publishers, 2006); and LSM Johnson, ‘Abortion: II Contemporary Ethical and Legal Aspects: A. Ethical Perspectives’ in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 8–17.

<sup>14</sup> Johnson, above n 13, 8. See also, eg, C Mackinnon, ‘Reflections on Sex Equality Under Law’ (1991) 100(5) *Yale Law Journal* 1281, 1316.

<sup>15</sup> See, eg, Wicks, above n 13, 186–7.

## The potentiality view

[10] A related argument in favour of treating the fetus as a person from the moment of conception is that, even if the fetus is not a person at conception, it has the potential to become a person and should therefore be treated as if it were a person.

[11] On the other hand, it is argued that we do not usually treat someone who has the potential to be something as if they have already achieved that status. The 'potentiality' problem has been described in this way:<sup>16</sup>

It might appear that one could in such circumstances appeal to a notion of potentiality in order to argue that since fetuses ... are potential persons, they must *eo ipso* be accorded the rights and standing of persons. ...

[However], [i]f X is a potential Y, it follows that X is not a Y. If fetuses are potential persons, it follows clearly that fetuses are not persons. As a consequence, X does not have the actual rights of Y, but only potentially has the rights of Y. ...

Undoubtedly, the language of potentiality is itself misleading, for it is often taken to suggest that an X that is a potential Y in some mysterious fashion already possesses the being and significance of Y. It is therefore perhaps better to speak not of X's being a potential Y but rather of its having a certain probability of developing into Y.

## From birth

[12] At the other end of the spectrum is the view that personhood does not begin until (or even after) birth. In support of this view it is said that this is the point at which the fetus becomes a child with a separate existence from its mother and is able to engage with the world, and provides a clear and unambiguous boundary. It also fundamentally changes the relationship between the woman and the child.

[13] On the other hand, it is argued that birth is simply an arbitrary event and there may be no real distinction between a later term or fully developed fetus that is yet to be born and one that is born, even if kept alive in an incubator.

## At viability

[14] In between these two extremes of 'from conception' and 'from birth', there are numerous other views.

[15] One such view, historically, was that the fetus attains personhood upon 'quickenings'. This referred to the time at which the pregnant woman could first feel the movements of the fetus.

[16] A commonly held view today is that the fetus should obtain protection upon viability. Viability is the time at which the fetus, if born prematurely, is capable of existing independently. Proponents of this view see viability as marking a transition

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<sup>16</sup> HT Engelhardt, *The Foundations of Bioethics* (Oxford University Press, 1986) 110–11.

from being an entity dependent for its survival on the woman to one that is capable of independent life.<sup>17</sup>

Once a fetus is capable of being born alive and has the potential to survive independently of its mother's body, there is a strong argument that the issue is no longer one internal to the mother but rather one which the state and its laws should regulate. If the fetus has a good chance of a life outside the mother's womb it should not at that stage be destroyed within the mother, especially if there is no good reason to do so.

[17] However, it has been observed that viability lacks certainty; 'it is a shifting boundary dependent upon the state of modern technology and its availability to a particular fetus'.<sup>18</sup>

### Developmental or gradualist view

[18] An alternative view is the recognition that the status of the fetus changes during pregnancy such that the older and more developed the fetus becomes, the greater respect and protection it should obtain. This view:<sup>19</sup>

denies that a bright line can be drawn at any particular point in natural development when the fetus acquires moral standing. The developmental view hinges on the continuity of fetal development, and the difficulty of non-arbitrarily picking out properties that qualify some fetuses, but not others, as persons. Since infants are generally regarded as persons with a right to life, and the difference between a late term fetus and a neonate—particularly in the case of viable premature infants—is merely a matter of location, it appears that in the continuous process of embryonic and fetal development, there is no non-arbitrary place to draw a line where personhood begins. This view is in line with the intuition, shared by many on both sides of the abortion conflict, that fetal life becomes increasingly important as gestation continues, but that it is impossible to say with certainty when, exactly, a fetus becomes a person. The inherent vagueness of [this view] is an obstacle to translating it into practical ... public policies, however.

### Other views

[19] There are other views. One approach is to shift the focus of discussion away from the status of the fetus in isolation to the relationship between the fetus and the woman. This emphasises the interdependence of and connection between the fetus and the woman, who 'are both two and one'.<sup>20</sup>

[20] Another approach is to consider the fetus the 'property' of the pregnant woman who should therefore be protected against third parties but not against the actions of the woman herself.

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17 Wicks, above n 13, 185.

18 Ibid. See also n 8 above.

19 Johnson, above n 13, 8.

20 Herring, above n 13, 340.

# Appendix E

## Comparative guide

	ACT	VIC	TAS	NT	WA	SA	NSW	QLRC's draft Bill
<b>Termination lawful on request</b>	✓	✓ up to 24 weeks	✓ up to 16 weeks					✓ up to 22 weeks: Draft Bill cl 4
<b>Termination lawful if medical practitioners satisfied of certain matters</b>		✓ after 24 weeks, if appropriate in all the circumstances	✓ after 16 weeks, if risk to physical or mental health	✓ up to 14 weeks, if appropriate in all the circumstances; or at any time if emergency	✓ up to 20 weeks on specified grounds; after 20 weeks, if woman or fetus has severe medical condition	✓ if risk to life or health, fetal abnormality; or if emergency	✓ if risk to life or health: <i>common law</i>	✓ after 22 weeks, if in all the circumstances, it should be performed; or if emergency: Draft Bill cl 5(1)(a), (2)-(3)
<b>More than one medical practitioner, or a committee, must be satisfied</b>		✓ after 24 weeks, at least two registered medical practitioners	✓ after 16 weeks, two medical practitioners, one of whom is a specialist	✓ after 14 weeks and up to 23 weeks, at least two suitably qualified medical practitioners; except in emergency	✓ after 20 weeks, two medical practitioners from an appointed panel	✓ two medical practitioners; except in emergency		✓ after 22 weeks, two registered medical practitioners; except in emergency: Draft Bill cl 5(1)(b), (2)-(3)
<b>Offences for unlawful termination</b>	✓ but not for a doctor or if carried out at an approved facility	✓ but not for a medical practitioner or other registered health practitioner; or the woman	✓ but not for a medical practitioner; or the woman	✓ but not for a medical practitioner or other qualified person; or the woman	✓ but not for a medical practitioner	✓	✓	✓ but not for a registered medical practitioner or other registered health practitioner; or the woman: Draft Bill cll 9, 21
<b>Conscientious objection by medical practitioners recognised</b>	✓	✓ except in emergency	✓ except in emergency	✓ except in emergency	✓	✓ except in emergency		✓ except in emergency: Draft Bill cl 7
<b>Medical practitioners who object to refer woman to other provider</b>		✓	✓	✓				✓ refer woman, or transfer her care, to another registered medical practitioner or health service provider who can perform: Draft Bill cl 73
<b>Counselling requirement</b>					✓ referral to counselling to be offered			
<b>Safe access zones</b>	✓	✓	✓	✓			✓	✓ Draft Bill cll 10-14

\* This table provides a brief comparative guide to the provisions the Commission recommends in this Report, reflected in the draft Termination of Pregnancy Bill 2018, and the legislative requirements in other jurisdictions



## **Appendix F**

### **Draft Termination of Pregnancy Bill 2018**

The draft Termination of Pregnancy Bill 2018 gives effect to the recommendations made in this Report.





Queensland

# Termination of Pregnancy Bill 2018

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Termination of Pregnancy Bill 2018

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**2018**

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**A Bill**

for

**An Act about the termination of pregnancies, and to amend this Act, the Criminal Code, the *Guardianship and Administration Act 2000* and the *Police Powers and Responsibilities Act 2000* for particular purposes**

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**The Parliament of Queensland enacts—**

## **Part 1 Preliminary**

### **1 Short title**

This Act may be cited as the *Termination of Pregnancy Act 2018*.

### **2 Definitions**

The dictionary in schedule 1 defines particular words used in this Act.

### **3 Purposes**

The purposes of this Act are—

- (a) to enable reasonable and safe access by women to terminations; and
- (b) to regulate the conduct of registered health practitioners in relation to terminations.

## **Part 2 Performance of terminations by registered health practitioners**

### **4 Termination by medical practitioner at not more than 22 weeks**

A medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant.

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**5 Termination by medical practitioner after 22 weeks**

- (1) A medical practitioner may perform a termination on a woman who is more than 22 weeks pregnant if—
  - (a) the medical practitioner considers that, in all the circumstances, the termination should be performed; and
  - (b) the medical practitioner has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed.
- (2) In considering whether a termination should be performed on a woman, a medical practitioner must consider—
  - (a) all relevant medical circumstances; and
  - (b) the woman's current and future physical, psychological and social circumstances; and
  - (c) the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination.
- (3) Also, a medical practitioner may, in an emergency, perform a termination on a woman who is more than 22 weeks pregnant if the medical practitioner considers it is necessary to perform the termination to save the woman's life or the life of another unborn child.

**6 Registered health practitioners who may assist**

- (1) A medical practitioner may assist in the performance of a termination on a woman by another medical practitioner.
- (2) A nurse, midwife or pharmacist may, in the practice of his or her health profession, assist in the performance of a termination on a woman by a medical practitioner.
- (3) However, subsections (1) and (2) do not apply in relation to a termination that the assisting medical practitioner, nurse, midwife or pharmacist knows, or ought reasonably to know, is being performed by the medical practitioner other than under section 4 or 5.

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- (4) A reference in this section to assisting in the performance of a termination by a medical practitioner includes dispensing, supplying or administering a termination drug on the medical practitioner's instruction.

**7 Registered health practitioner with conscientious objection**

- (1) This section applies if—
  - (a) a person asks a registered health practitioner to—
    - (i) perform a termination on a woman; or
    - (ii) assist in the performance of a termination on a woman; or
    - (iii) make a decision under section 5 whether a termination on a woman should be performed; or
    - (iv) advise the person about the performance of a termination on a woman; and
  - (b) the practitioner has a conscientious objection to the performance of the termination.
- (2) The registered health practitioner must disclose the practitioner's conscientious objection to the person.
- (3) If the request is by a woman for the registered health practitioner to perform a termination on the woman, or to advise the woman about the performance of a termination on the woman, the practitioner must refer the woman, or transfer her care, to—
  - (a) another registered health practitioner who, in the first practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of the termination; or
  - (b) a health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.

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- (4) This section does not limit any duty owed by a registered health practitioner to provide a service in an emergency.

**8 Compliance with this part relevant to professional conduct**

In deciding an issue under an Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner—

- (a) performs a termination on a woman other than as authorised under section 4 or 5; or
- (b) assists in the performance of a termination on a woman other than as authorised under section 6; or
- (c) contravenes section 7.

*Note—*

The Health Practitioner Regulation National Law (Queensland) and the *Health Ombudsman Act 2013* include provisions about the conduct and performance of health practitioners.

**Part 3 Protection from criminal responsibility**

**9 Woman does not commit an offence**

Despite any other Act, a woman who consents to, assists in, or performs a termination on herself does not commit an offence.

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## **Part 4                      Safe access zones**

### **Division 1                Preliminary**

#### **10        Purpose**

The purpose of this part is to protect the safety and well-being, and respect the privacy and dignity, of—

- (a) persons accessing services provided at termination services premises; and
- (b) persons who are employed to provide services at termination services premises or otherwise need to access the premises in the course of their duties or responsibilities.

#### **11        Meaning of *termination services premises***

In this part—

*termination services premises*—

- (a) means premises at which a service of performing terminations on women is ordinarily provided; but
- (b) does not include a pharmacy.

#### **12        Meaning of *safe access zone***

- (1) A place is in the *safe access zone* for termination services premises if the place is—
  - (a) in the premises; or
  - (b) not more than the prescribed distance from an entrance to the premises.
- (2) Unless a distance is prescribed under subsection (3), the prescribed distance for subsection (1)(b) is 150m.
- (3) A regulation may prescribe a distance for subsection (1)(b) for stated termination services premises.

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- (4) The Minister may recommend to the Governor in Council the making of a regulation under subsection (3) only if satisfied that, having regard to the location of the premises, a prescribed distance of 150m is insufficient, or greater than is necessary, to achieve the purpose of this part in relation to the premises.

## Division 2                      Offences

### 13            Prohibited conduct in safe access zones

- (1) A person's conduct in the safe access zone for termination services premises is *prohibited conduct* if the conduct—
- (a) relates to terminations or could reasonably be perceived as relating to terminations; and
  - (b) would be visible or audible to another person in, or entering or leaving, the premises; and
  - (c) would be reasonably likely to deter a person mentioned in paragraph (b) from—
    - (i) entering or leaving the premises; or
    - (ii) requesting or undergoing a termination; or
    - (iii) performing, or assisting in the performance of, a termination.
- (2) A person's conduct may be prohibited conduct whether or not another person sees or hears the conduct or is deterred from taking an action mentioned in subsection (1)(c)(i) to (iii).
- (3) A person must not engage in prohibited conduct in the safe access zone for termination services premises.
- Maximum penalty—20 penalty units or 1 year's imprisonment.
- (4) Subsection (3) does not apply to a person employed to provide a service at the termination services premises.

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**14 Recording persons in or near termination services premises**

- (1) This section applies in relation to a recording (a *restricted recording*) that—
- (a) is an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises; and
  - (b) contains information that identifies, or is likely to lead to the identification of, the person.

- (2) A person must not, without reasonable excuse, make a restricted recording of another person without the other person's consent.

Maximum penalty—20 penalty units or 1 year's imprisonment.

- (3) A person must not, without reasonable excuse, publish or distribute a restricted recording of another person without the other person's consent.

Maximum penalty—20 penalty units or 1 year's imprisonment.

- (4) In this section—

*distribute* includes—

- (a) communicate, exhibit, send, supply or transmit (including by live streaming), whether or not to a particular person; and
- (b) make available for access, whether or not to a particular person; and
- (c) enter into an agreement or arrangement to do a thing mentioned in paragraph (a) or (b); and
- (d) attempt to distribute.

*publish* means publish to the public by television, radio, the internet, newspaper, periodical, notice, circular or other form of communication.

*visual recording* includes a photograph.

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## **Part 5                      Amendment of Acts**

### **Division 1                Amendment of this Act**

#### **15      Act amended**

This division amends this Act.

#### **16      Amendment of long title**

Long title, from ‘, and to amend’—  
*omit.*

### **Division 2                Amendment of Criminal Code**

#### **17      Code amended**

This division amends the Criminal Code.

#### **18      Omission of ss 224–226**

Sections 224 to 226—  
*omit.*

#### **19      Amendment of s 282 (Surgical operations and medical treatment)**

(1) Section 282(1)—

*omit, insert—*

- (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or unborn child if performing the operation or providing the

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treatment is reasonable, having regard to all the circumstances of the case.

(1A) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of a person or unborn child in an emergency if it is necessary to perform the operation or provide the treatment to save the mother's life or the life of another unborn child.

(2) Section 282(4), definitions *medical treatment*, *patient* and *surgical operation*—

*omit.*

(3) Section 282(4)—

*insert—*

***medical treatment***, for subsection (1), does not include medical treatment provided by an unqualified person that is intended to adversely affect an unborn child.

***surgical operation***, for subsection (1), does not include a surgical operation performed by an unqualified person that is intended to adversely affect an unborn child.

***unqualified person*** has the same meaning as in section 319A.

## 20 Amendment of s 313 (Killing unborn child)

Section 313—

*insert—*

(1A) A person does not commit an offence against subsection (1) by performing a termination, or assisting in the performance of a termination, under the *Termination of Pregnancy Act 2018*.

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**21 Insertion of new s 319A**

After section 319—

*insert—*

**319A Termination of pregnancy performed by unqualified person**

- (1) An unqualified person who performs a termination on a woman commits a crime.

Maximum penalty—7 years imprisonment.

- (2) An unqualified person who assists in the performance of a termination on a woman commits a crime.

Maximum penalty—7 years imprisonment.

- (3) A reference in subsection (2) to assisting in the performance of a termination includes—

(a) supplying, or procuring the supply of, a termination drug for use in a termination; and

(b) administering a termination drug.

- (4) In this section—

***midwife*** means a person registered under the Health Practitioner Regulation National Law to practise in the midwifery profession, other than as a student.

***nurse*** means a person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student.

***pharmacist*** means a person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession, other than as a student.

***termination*** means an intentional termination of a pregnancy in any way, including, for example, by—

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- (a) administering a drug; or
- (b) using an instrument or other thing.

**termination drug** means a drug of a kind used to cause a termination.

**unqualified person** means—

- (a) in relation to performing a termination on a woman—a person who is not a medical practitioner; or
- (b) in relation to assisting in the performance of a termination on a woman—a person who is not—
  - (i) a medical practitioner; or
  - (ii) a nurse, midwife or pharmacist providing the assistance in the practice of his or her health profession.

**woman** means a female person of any age.

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### **Division 3                      Amendment of Guardianship and Administration Act 2000**

#### **22        Act amended**

This division amends the *Guardianship and Administration Act 2000*.

#### **23        Amendment of s 71 (Termination of pregnancy)**

Section 71(1), from ‘is necessary’—  
*omit, insert—*

may be performed by a medical practitioner under the *Termination of Pregnancy Act 2018*.

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**Division 4                      Amendment of Police Powers and  
Responsibilities Act 2000**

**24      Act amended**

This division amends the *Police Powers and Responsibilities Act 2000*.

**25      Amendment of s 30 (Prescribed circumstances for  
searching persons without warrant)**

Section 30—

*insert—*

- (j) the person has committed, is committing, or is about to commit, an offence against the *Termination of Pregnancy Act 2018*, section 13 or 14.

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## Schedule 1 Dictionary

### section 2

*employ* includes engage, whether or not for payment.

*entering* includes attempting to enter.

*leaving* includes attempting to leave.

*midwife* means a person registered under the Health Practitioner Regulation National Law to practise in the midwifery profession, other than as a student.

*nurse* means a person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student.

*pharmacist* means a person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession, other than as a student.

*pharmacy* means premises in which a pharmacy business within the meaning of the *Pharmacy Business Ownership Act 2001* is carried on.

*premises* means a building or part of a building.

*registered health practitioner* means a person registered under the Health Practitioner Regulation National Law to practise a health profession, other than as a student.

*safe access zone* see section 12.

*termination* means an intentional termination of a pregnancy in any way, including, for example, by—

- (a) administering a drug; or
- (b) using an instrument or other thing.

*termination drug* means a drug of a kind used to cause a termination.

*termination services premises* see section 11.

*woman* means a female person of any age.

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