

Abortion in Queensland

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University of Queensland Medical School
Herston, Queensland

Convened by:



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Why 'Abortion in Queensland'?

Executive Summary

On 17 October 2008 the *Abortion in Queensland* Conference was held at the University of Queensland. The event was a joint initiative of Children by Choice, Family Planning Queensland, Dr Caroline de Costa of James Cook University Department of Obstetrics and Gynaecology, and Dr Darren Russell of Sexual Health in Cairns.

Abortion in Queensland examined and discussed the current situation of abortion access, provision, policy and law in Queensland today.

Abortion continues to be a significant women's health issue. In Australia, it is estimated that half of all pregnancies are unplanned and half of these are terminated. While there is no consistent national data collection for pregnancy termination, Medicare and state-based data indicates that up to one in three Australian women will experience abortion. In Queensland, estimates based on Medicare claims indicate that over 14,000 women in Queensland access abortion services annually.

In Queensland today:

- Access to abortion services is due to provision by a handful of stand alone private providers with little provision in public hospitals;
- Women on low fixed incomes and those living in rural, regional and remote areas of Queensland have very limited access to abortion services due to cost, distance and travel;
- There is no clear policy or guidelines around the provision of, and access to, abortion services within public health services in Queensland. In particular, access to early abortion in the first trimester is not readily available;
- Surgical and medical pregnancy termination receives little attention in the curriculum of medical schools and teaching hospitals; and
- Providing and accessing abortion is still a criminal offence.

The *Abortion in Queensland* forum was opened by Karen Struthers MP, Parliamentary Secretary to the Minister for Health, and Bonny Barry MP, Parliamentary Secretary to the Minister for Education. A range of international, interstate and Queensland speakers addressed the issues of the history of abortion law and practice in New Zealand; women's experience of abortion; public provision of abortion services in Victoria and the recent legal changes in that state; current legal position of surgical and medical abortion in Queensland; and current provision of abortion in Queensland and access for women, including public hospital provision.

The forum discussed these key questions:

- How do we ensure women can access safe abortion services into the future, including women living in rural, regional areas and women on low incomes?
- Who will be providing abortion services? How will health professionals receive education and training around abortion?
- How should the law regulate abortion – should women and doctors still be subject to criminal penalties?
- Will women have the option of medical abortion using RU486 (mifepristone)?
- What role should government play in the provision and funding of abortion?

The conference participants endorsed six key recommendations for Government and medical and health institutions to ensure that Queensland women can access safe and lawful reproductive health services into the future.

Statement of Recommendations

Endorsed by the participants of
'Abortion in Queensland'

- Abortion must be removed from the Queensland Criminal Code, and remain subject to appropriate health regulations.
- Medical workforce training and succession planning in the area of abortion services and contraception needs to be addressed by teaching institutions, professional medical and nursing bodies, private sectors and the state health department.
- Queensland public health services must take responsibility for ensuring all women in their region have access to abortion services, in particular women in rural, regional and remote areas and women experiencing financial difficulties.
- Abortion services should conform to international best practice guidelines, which include the availability of medical abortion with mifepristone and prostaglandin.
- A broad Sexual and Reproductive Health Strategy must be a priority of the State and Federal Governments. The Strategy must have a multi-layered approach which includes comprehensive access to education, services and information.
- Governments must fund only pregnancy advisory services that are transparent, women-centred, non-directive and provide referrals for all options. Counselling should be optional.

About the Presenters

Karen Struthers MP

Member for Algester

Parliamentary Secretary to the Minister for Health and Ageing

In her role as State Member, Karen has campaigned successfully for road improvements to ease the traffic congestion on major roads like the Acacia Ridge rail crossing, and has devoted many hours to the successful development of two new schools in the area, at Forest Lake and Calamvale. Karen is also a Council Member of Griffith University, Queensland. Prior to entering Parliament, Karen was the Assistant Director at the Queensland Council of Social Service (QCOSS). Karen is also an active member of the Australian Services Union - Clerks. Karen holds a Bachelor of Social Work with Honours from the University of Queensland and a Masters of Public Sector Management with Honours from Griffith University.

Bonny Barry MP

Member for Aspley

Parliamentary Secretary to the Minister for Education and Training, and the Minister for the Arts

Bonny was elected to State Parliament in 2001. She has worked for 20 years as a registered nurse at the Royal Brisbane, Holy Spirit and Prince Charles Hospitals in cancer and palliative care units. She holds a postgraduate certificate in Oncology Nursing and a Bachelor of Nursing Degree. Before entering Parliament, Bonny was employed as the aged-care Professional Nursing Officer for the Queensland Nurses Union. She has a strong professional and personal commitment to the care of older people and the field of aged care. In her working life Bonny has focused strongly on the health care needs of both patients and their community, and of the health professionals who service them. Bonny also has a keen interest in the community in which she and her family live.

Dr Margaret Sparrow

President, Abortion Law Reform Association of New Zealand

Dr Margaret Sparrow is a specialist sexual health clinician who spent 34 years involved with Family Planning NZ, of which she is now an Honorary Vice-President. She spent 17 years as an abortion provider in Wellington, and in 1999 co-founded Istar Ltd, a not-for-profit organisation which imports RU486 into New Zealand.

Dr Maggie Kirkman

Research Fellow and Lecturer, Key Centre for Women's Health in Society, University of Melbourne

Dr Maggie Kirkman is a psychologist with extensive research experience, particularly in psychosocial aspects of

reproduction including infertility, donor-assisted conception, teenage pregnancy, parent-adolescent communication about sexuality, and abortion. She also teaches post-graduate students at the Key Centre for Women's Health in Society, The University of Melbourne. Her publications include three co-authored and two co-edited books, many articles in peer-reviewed journals, and book chapters. Maggie's most recent book is *Telling it Your Way: A Guide for Parents of Donor-Conceived Adolescents* (with Doreen Rosenthal & Louise Johnson). She is co-editor, with Jane Fisher, of a special issue of *Women's Studies International Forum*, "Women and Technologies of Reproduction," published last month.

Dr Heather Douglas

Director of Postgraduate Research Programs, T.C. Beirne School of Law, University of Queensland

Dr Heather Douglas is a Senior Lecturer at the T.C. Beirne Law School, University of Queensland. She researches in criminal law and is particularly interested in the way the criminal law impacts on and constructs women. Her work has been published in Canada, Europe and Australia. Heather was a part-time commissioner with the Queensland Law Reform Commission from 2001-2007. She currently teaches Criminal Law, Criminal Procedure and Evidence and is the author (with Sue Harbidge) of *Criminal Process in Queensland* (Thomson, 2008).

Dr Chris Bayly

Associate Director of Women's Services, Royal Women's Hospital, Melbourne

Dr Chris Bayly is a gynaecologist who has worked at the Royal Women's Hospital, Melbourne for over 20 years in various capacities including clinical care, service development and management. Her clinical experience includes infertility, fertility control and unplanned pregnancy and she is interested in public health and health services research.

Dr Carol Portmann

Director, Maternal Fetal Medicine, Royal Brisbane Women's Hospital

Dr Carol Portmann is a specialist obstetrician with an interest in maternal and fetal medicine. She specialises in tertiary obstetric imaging and preterm delivery, as well as pregnancy loss.

Cait Calcutt

Coordinator, Children by Choice

Cait Calcutt is the Coordinator of Children by Choice, a state-wide counselling and information service for women experiencing unplanned pregnancy. Cait is an experienced advocate on behalf of women's right to decide with an unplanned pregnancy. She was a key member of the successful campaigns to overturn the import restrictions on RU486 (medical abortion) in 2006 and reforming Western Australia's abortion laws in 1998.

Dr Caroline de Costa

Professor of Obstetrics and Gynaecology, James Cook University School of Medicine, Cairns

Dr Caroline de Costa has a life-long interest in improving women's health and in particular Indigenous women's health. She has been active in attempts to bring about reform of abortion laws and improve abortion practice and access. Caroline is now one of the few doctors in the country with the right to prescribe RU486 and has written extensively about medical abortion.

Dr Darren Russell

Director of Sexual Health, Cairns Base Hospital

Dr Darren Russell holds the positions of Clinical Associate Professor in the Department of Population Health at The University of Melbourne, and Adjunct Associate Professor in the Faculty of Medicine, Health and Molecular Science at James Cook University. He is the President of the Australasian Chapter of Sexual Health Medicine of the Royal Australasian College of Physicians, and has an interest in men's health, Indigenous sexual health, HIV/AIDS, and genital herpes infections. Darren has been involved in clinical and epidemiological research, and is a co-editor of the textbook, 'Sexual Health Medicine', and a joint author of 'Talking with clients about sex'.

Dr Michael Carrette

Obstetrician and Gynaecologist

Dr Michael Carrette came to Cairns from London in 1974, after leaving England at a time when it was a routine task for any gynaecologist to perform surgical abortions in any National Health Hospital. His first year in Cairns was spent as O&G registrar at the Base Hospital, and he has operated an Obstetrics and Gynaecology private practice in Cairns since 1975. Michael was visiting Obstetrician and Gynaecologist to the Cairns Base Hospital from 1975 to 1998. His private practice is now at Cairns Private Hospital and Cairns Day Surgery, and he has been performing surgical abortions at Cairns Day Surgery for 10 years - ever since that facility was built. Before that the only two hospitals were those run by the State Health Dept and the Catholic Diocese.

Dr Libby Rimmer

Director, EastCoast Women's Centre

Libby graduated with an MB,BS in 1981 from the University of Queensland, moved to far north Queensland in 1986 and worked in rural, remote and Indigenous communities until establishing a General Practice in the Atherton Tablelands. Libby began working in women's health upon her return to Brisbane in 1990, working at the Fertility Control Clinic, running training with Family Planning Queensland, providing termination services to rural women with Planned Parenthood Australia, and aiding in the establishment of the Sexual Assault Service at the Royal Brisbane Hospital. Libby established the Caboolture Women's Clinic in order to provide reproductive health services for women, including pregnancy termination procedures, before relocating to Nambour in 2001 and setting up the EastCoast Women's Centre. Libby is now the CEO and Medical Director of

the Nambour Day Surgery, where the procedural part of her work is carried out. Libby is also interested in medical ethics and education, and regularly talks to doctors and medical students on the role of GPs in pregnancy terminations, as well as opening her workplace to students to assist in their training.

Jill Michelson

Operations Manager, Marie Stopes International

Jill Michelson comes from a nursing background, working as a nurse and midwife in South Australia and gradually progressing to management positions. She was a General Manager of Private Hospitals in SA, NSW and QLD for 13 years. In 2004, Jill was employed by Marie Stopes International as the State Manager in Queensland, and has since advanced to the role of General Manager, Operations. She has a passion for the Marie Stopes philosophy of 'children by choice, not by chance' and will continue to work towards this goal both within this organisation and in lobbying for appropriate choices in sexual and reproductive health for women in Australia.

Dr David Grundmann

Director, Planned Parenthood Australia

Dr David Grundmann began providing abortion services with Dr Bertram Wainer in Melbourne in 1976, and started the Planned Parenthood of Australia Group in 1983, when abortion services in Queensland were extremely limited. He has devoted his entire medical career to this area of health care and is a former President of ISAD (The International Society of Abortion Doctors) and the past President of the Abortion Providers Federation of Australia.

Opening Address

Karen Struthers MP

Member for Algeester

Parliamentary Secretary to the Minister for Health and Ageing

This room is filled with many dedicated women - and men - who have spent many years supporting women through the difficult experience of terminating pregnancy, and who have tirelessly campaigned for law reform.

Outside are protesters who lack understanding, who lack empathy.

Over one in four Queensland women will experience abortion in their lifetime. Abortion is a subject that has always, and will always, deeply divide the community. Understanding is what is desperately needed.

I congratulate the organisers of today's conference and I encourage all participants to use the opportunity to listen, to learn, and to contribute. In any discussion on a topic like abortion we need balance, fairness and compassion. Given the complex and compelling nature of human sexuality, it is inevitable that unplanned and unwanted pregnancies will continue to occur. And despite the availability of contraceptive agents, a percentage of Australian women will continue to seek safe, legal abortion.

Essentially in Queensland, abortion is illegal unless continuing with the pregnancy would adversely affect the mother's health and wellbeing. While the Criminal Code allows for the termination of pregnancy, it can only be done when, in the opinion of the medical practitioner, continuing with the pregnancy would pose a significant risk to the physical or mental health of the mother.

Any decision to terminate pregnancy rests between the woman and her doctor – and then only in carefully prescribed circumstances.

This Government is not planning to amend abortion law in Queensland in the near future, but many MPs like Bonny Barry and I have been championing the need for law reform – reform to decriminalise abortion and to make the procedure safe and accessible to women in Queensland.

We want to continue working with you to build support within, and outside the Parliament. As you may know, under Labor Party policy, votes on abortion law reform are conscience votes of MPs. It is therefore essential that any Bill to decriminalise abortion has the support of the majority of MPs – both government and opposition.

Welcome Address

Bonny Barry MP
Member for Aspley
Parliamentary Secretary to the Minister for
Education and Training and Minister for the Arts

The story of the fight for women's reproductive health rights is one that continues across the globe.

For years women have sought control over their reproductive health, in particular when dealing with unwanted pregnancies. The use of herbal remedies, gin baths and the dangerous practice of inflicting self harm in order to affect miscarriage, is age old.

Women's reproductive rights were clarified and endorsed internationally by the United Nations in Cairo in 1994 at the International Conference on Population and Development. This included the rights of women '*to decide the number, timing and spacing of children.*' The Beijing declaration in 1995 declared '*the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.*'

Despite these formal declarations many women and girls across the globe still face the dangers of dying from unsafe abortions, inability to access preventative reproductive health care and entrenched poverty arising from the denial of their reproductive health rights.

In our own 'lucky country' Queensland women still face the spectre of criminality each time they seek to exercise those rights in the matter of abortion.

The facts remain that the failure to fully enact the Beijing declaration has meant that women do not have control of their bodies. Control remains in the hands of politicians and those decision makers who are interested in control of women over any declared human rights for women.

Queensland needs to talk about the issue of abortion. We must discuss what needs to be done about ensuring women are able to achieve the basic human right of reproductive health rights.

We are a mature democracy; we can accept that there will be differences in opinion on the issue of abortion. But we must move past these differences and move forward for the sake of women. We must enact in this state, laws that give affect to a woman's human rights on this issue.

Congratulations to all of those women and men who attended and contributed to the recent Conference on Abortion in Queensland, your contributions are vital in achieving empowerment for women not only in Queensland but across the globe.

The Abortion Experience in New Zealand

Dr Margaret Sparrow

President, Abortion Law Reform Association of New Zealand

Honorary Vice-President, Family Planning New Zealand

You might well ask how relevant is the New Zealand experience to your discussions? Although the details are specific to each country, some general principles can be shared.

In the past, New Zealand women frequently risked their health, their fertility and their lives with unsafe procedures. At present in New Zealand abortion is the most common gynaecological procedure and one of the safest - but abortion is still a crime. It should be decriminalised and treated as a women's health issue. Access to medical and surgical abortion must be improved; at present access is very dependent on where a woman lives.

Abortion has been present throughout history and in all cultures. Women often used do-it-yourself medical methods before resorting to more invasive methods. Many were unsafe, many were ineffective. The list of herbals believed to induce abortion is long, and includes ergot, which was known to cause abortions in cattle eating grass affected by the fungus. Before Europeans arrived in New Zealand, Maori women had their own methods using native plants. A somewhat more stylish but rather ineffective method was gin and a hot bath.

Purported abortifacients were often combined as pills or potions. Doctors' names were often used to enhance their credibility – Dr Boxwell, Dr Bonjean. Over-the-counter medicines hinted at their use for “menstrual regulation”. Most cities in NZ had well known pharmacists who dispensed abortifacients. In Christchurch it was George Bettle. His mail order service was advertised widely. In 1956 when I

needed an abortion I wrote away for his mixture. It came in a plain brown wrapper with instructions to take one tablespoon full three times a day - and for me it worked. In legal terms I was committing a crime and liable to a penalty of 7 years jail.

If medications were ineffective, as they often were, other measures included deep pelvic massage, still sometimes used in some cultures and the insertion of various sharp objects. New Zealand women favoured bits of wire, coat hangers, crotchet hooks and knitting needles. Household douching equipment for enemas and “feminine hygiene” also came in useful for abortions. Lysol, Dettol and soap solutions were commonly used. The fictional Vera Drake, in the movie of the same name, used a soap solution and a Higginson's syringe, a common household item for performing enemas. Although the setting was London in the 1950s, it could well have been New Zealand or Australia in the late 19th and early 20th centuries.

A method popular with film script writers was falling down stairs. After Rhett Butler and Scarlett O'Hara have a flaming row in “Gone with the Wind”, Scarlett falls down the stairs and has a miscarriage. Is this a scenario done to death? No. In 2006 the beautiful Gabrielle in “Desperate Housewives” falls down the stairs and has a miscarriage - and so another generation of young women is exposed to this extremely unsafe and unreliable method. Strenuous physical exercise was often recommended, especially skipping or jumping up and down. I tried that too before taking Bettle's mixture.

Each generation adapts whatever is available for its needs. In the sixties, women used large quantities of oral contraceptive pills - the idea being that this might create a hormonal storm and dislodge a pregnancy. What it did was make women very sick. Plastic tubing was also used. Illegal abortionists flourished because self-abortion methods often failed. Medical practitioners acted discreetly and at a price. Rich women might have travelled to another country. Poor women often paid with their lives.

Although the law changed in the United Kingdom in 1967, New Zealand did not follow suit. However, court cases in Melbourne in 1969 and Sydney in 1971 did make a difference. These rulings enabled New Zealand women to travel to Australia for a legal abortion. From 1970 to 1974 many women did just that.

With the feminist movement things began to change. Women began to take more control of their lives. In the seventies, abortion became a public issue. Lobby groups were formed on both sides of the debate. Even in far-off New Zealand, we were heartened by the January 1973 ruling by the Supreme Court in the USA – now sadly under threat – that the right of privacy is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

New Zealand's restrictive abortion laws were challenged for the first time with the opening of the Auckland Medical Aid Centre in 1974. This was a private abortion clinic responding to women's needs and offering for the first time a safe, respectable and affordable abortion service. Opponents of abortion instigated a police raid on the abortion clinic four months after it opened. The abortion provider, Dr Jim Woolnough, who had come to New Zealand from Sydney, was charged on twelve counts of procuring an illegal abortion. After two High Court trials and a hearing in the Appeal Court, Dr Woolnough was acquitted.

New Zealand could have then relied on case law, but that situation did not last for long. The anti-abortion lobby, seeing that the courts would not convict, turned their attention to parliament and changes to the law. Controversy raged, and to quell the debate the Government appointed a Royal Commission. The findings of the Royal Commission were a disappointment. The worst recommendation was for eight to twelve panels set up throughout the country. Fortunately parliament rejected the idea of panels but set up their own peculiar system of certifying consultants to approve abortions.

Initially the 1977 law was so strict that the Auckland clinic closed. An immediate response to the legislation was the setting up of a support system for women, called the Sisters Overseas Service, or SOS. Women were referred to clinics in Sydney and Melbourne and welcomed by support groups operating there. The trans-Tasman traffic was openly acknowledged. Another immediate response was the setting up of a Repeal lobby group. But despite collecting 319,000 signatures on a petition, Parliament swept this under the carpet.

The new law was regarded as unworkable and this proved to be correct. It did not have the support of the medical profession. It was not until the new laws were amended in July 1978 that the trans-Tasman traffic decreased. Women and their doctors learned to negotiate the barriers put up by parliament and made the new system work in their favour. Although on paper we had restrictive legislation with a complicated system of approval, it could be made to work, if given a liberal interpretation.

That brings us up to the present. The *grounds* for abortion are in the Crimes Act and 98-99% are done on the grounds of mental health [there is currently a case going through the High Court and the Appeal Court about this]. Stricter criteria apply after 20 weeks. The *procedures*, overseen by the Abortion Supervisory Committee, are in the Contraception,

Sterilisation & Abortion Act. All abortions must be performed in a licensed institution and approved by two specially appointed doctors known as “certifying consultants”. Self abortion is still an offence but it has been taken out of the Crimes Act and put into the CS&A Act. The penalty is less, no more than a fine of \$200.

A commendable feature of the New Zealand legislation is that we have good statistics. The numbers of abortions being performed each year have steadily risen since 1980, when accurate statistics first became available. In 1980 there were approximately 6,000 per year, and the number has trebled with approximately 18,000 in 2007. There is some leveling off over the last few years. Rates are more important than absolute numbers - these show that the increase has occurred over all age groups with the highest rate in the 20-24 years age group followed by the 25-29 years age group.

Despite deficiencies in the law New Zealand has an excellent safety record. Between 1980 and 2007 there have been over 352,000 abortions with no maternal deaths attributable to the abortion. Most abortions in New Zealand are carried out surgically, but since 2001 medical abortion has also been an option for New Zealand women. In contrast to the old fashioned herbals, modern medical methods have used prostaglandins, which can be used alone but are more effective if combined with methotrexate or mifepristone, which is the preferred drug. Hopefully research will bring us new and better abortifacient drugs.

No pharmaceutical firm was prepared to import mifepristone into New Zealand because it was too controversial, so in February 1999 five experienced operating doctors formed a not-for profit company which we called Istar, after the Babylonian goddess of love, fertility and war. In May 2000 we signed an agreement with Exelgyn, the French manufacturer of mifepristone. The application was quite expensive but since then it has become even more so - a new drug application in New Zealand now

costs nearly \$123,000 and I understand that in Australia the cost is \$178,000. It also takes time, and in our case it took 13 months.

Mifegyne (mifepristone) was approved for use by the Minister of Health and gazetted on 30 August 2001. It was first used for a second trimester abortion in Wellington Hospital in September 2001 but we had a legal problem with early medical abortions, and its use for this purpose was delayed until April 2002 when Wellington was the first to offer a choice.

The legal problem was that under Section 18 of the CS&A Act all abortions must be “performed” in a licensed institution. There were differing legal opinions as to what this actually meant. Medical abortion is a two stage process - first Mifegyne followed a day or two later by the prostaglandin to expel the embryo or fetus. Did it mean both medications had to be taken in a licensed institution, and did the woman need to stay in a licensed institution between pills or until the abortion was complete? The matter had to be resolved in the High Court.

In April 2003 the judge who heard the case ruled that women must take both pills in a licensed institution but there is no requirement to stay there between medications or until the embryo or fetus is expelled. There is no *medical* reason why the second lot of pills, the prostaglandin, should not be self-administered at home, as they are in many countries.

Due to changes in Australian legislation we now supply those doctors who have authorised prescribing rights.

Which brings us to the future: where to from here? The New Zealand laws introduced in 1978 have remained unchanged for 30 years. They were drafted before medical abortion was an option. The procedures are too complicated. Abortion should be the choice of the pregnant woman, not two state-

funded “certifying consultants” costing over \$5 million per year.

Speaking generally, out of date laws should be repealed and new laws should be kept simple - there is no need for grounds, parental consent, approval by one or more doctors, waiting times, or compulsory counselling. Laws should not be a barrier to implementing good practice guidelines. Abortion is not a crime. It is a women’s health issue. Providing ‘grounds’ for abortion is unnecessary. Abortion should be the choice of the pregnant woman for her own good reasons.

In the medical profession abortion is a neglected topic in the curriculum and health professionals involved in abortion care need support. There is a need for more academic interest and research. Claiming a conscientious objection is permitted for genuine reasons but impacts on other staff.

With regard to women's rights, abortion must be the woman's decision. Women are capable of making a responsible decision for themselves and their family. It is not unusual to be both pro-choice and pro-family. There must be respect for autonomy and self-determination rather than a “we know best” attitude, whoever the “we” is – politicians, lobby groups, religious leaders or health professionals.

Nationally and internationally there is now much greater interest in human rights, commonly expressed as a right to life, security and liberty of person. The principle of non-discrimination requires that women’s health needs be met with access to modern advances in health care. Social justice requires accommodating a plurality of views, with respect for difference. Significant human rights cases have been won in international courts in Poland, Peru and Mexico.

We can be heartened by international trends in the last two decades where we have seen increasing liberalisation in the majority of countries where change has occurred, although not in the USA. In

Europe and elsewhere there is an acceptance that safe legal abortion is a sexual and reproductive right. Denial of abortion equates to enforced pregnancy. The provision of safe and dignified healthcare is a public health issue. Individuals including adolescents have a right to information, education and the means of spacing children. The prevention of unplanned pregnancies must be a priority. Earlier this year (16 April 2008) the Parliamentary Assembly of the Council of Europe passed a resolution calling for all 47 member states which have not already done so to decriminalise abortion.

Our efforts can be strengthened by reference to important United Nations Documents which support sexual and reproductive health and which have been ratified by the governments of NZ and Australia. The most important are: CEDAW, The Convention on the Elimination of All Forms of Discrimination against Women, the Cairo conference and the Beijing conference. All of these documents are under regular review and our governments should be held accountable.

Another United Nations initiative has been the Eight Millennium Development Goals with a target date of 2015. This reminds us of women living in less fortunate circumstances, such as in parts of Africa, Asia and South America, where abortion is still illegal and unsafe abortions claim many lives. Goal number Five concerning maternal health seeks to address this problem.

In conclusion, we have moved in my lifetime from a situation where unsafe and illegal abortions have been replaced in New Zealand and Australia by very safe procedures. But there is still room for improvement. It would be good to see abortion accepted more positively, with less stigma attached, less medicalisation, fewer legal barriers and more focused on the needs and rights of women.

Understanding Women's Experiences of Contemplating or Undergoing Abortion

Presented by Dr Maggie Kirkman
Research Fellow and Lecturer,
Key Centre for Women's Health in Society, University of Melbourne

*Paper co-authored by Dr Maggie Kirkman, Dr Heather Rowe, Annarella Hardiman,
Professor Doreen Rosenthal, and Dr Shelley Mallett*

ABSTRACT

This paper reports a project with two components: an audit of a database of women who have contacted the Pregnancy Advisory Service of the Royal Women's Hospital, Melbourne, over one year from October 2006 to September 2007; and interviews with 60 of these women. The audit was designed to learn about the characteristics of women who contact the pregnancy advisory service about their pregnancy, and to inform development of systematic data collection for unplanned pregnancies. This paper contains a brief summary of what we found in the audit, as well as results of the interviews.

The interviews provided insights into women's perspectives of the experience of dealing with a pregnancy that was unplanned or unwanted. The project was designed to contribute to our knowledge of women's experiences. It was funded by the Australian Research Council and VicHealth grants to Professor Doreen Rosenthal, Dr Heather Rowe, and Dr Shelley Mallett of the Key Centre for Women's Health in Society at the University of Melbourne, and Annarella Hardiman of the Royal Women's Hospital. Dr Maggie Kirkman is research director of the project.

A large, representative national survey (Smith, Rissel, Richters, Grulich, & de Visser, 2003) found that 22.6% of women aged 16 to 59 in Australia reported having had an abortion. Despite its frequency, remarkably little research has been conducted on the circumstances under which abortion may be contemplated and what it means in women's lives.

The Royal Women's Hospital has a Pregnancy Advisory Service: an important public health service for women. The Pregnancy Advisory Service is consulted by women seeking help with pregnancies that might be unplanned or unwanted. It provides comprehensive assessment, support, counselling, advocacy, and referral to many more women than can obtain abortions at the hospital, as well as to women who may choose not to have an abortion. As the major public provider of services, the Women's has particular experience with marginalised women, including those with financial and social barriers to access, young and homeless women, those experiencing domestic violence or sexual assault, and newly-arrived women.

Audit

The audit was of data collected by the counsellor/advocates as they spoke to women, usually over the phone but sometimes in person. The data collection instrument was designed as a clinical tool, so women are asked only a few routine questions, such as date of birth. Most responses depend on what emerges from the clinical encounter. The database was designed to aid staff in record-keeping and as a link to hospital patient records. Data are numeric, tick-box, and free-text. Data were de-identified for analysis at the Key Centre. The nature of the data does not permit complex statistical analysis.

Audit results

The women who received pregnancy support from the Women's Pregnancy Advisory Service were aged from 13 to 49, with a mean age of 26.6 years. As found in routinely collected data, women in their twenties constitute the largest group, although there are small proportions at both extremes of the reproductive age range.

More than one in 10 women lived in rural or regional Victoria or interstate. A small percentage of women preferred to use one of 48 languages other than English; 134 (4%) were recorded as using an interpreter. Socioeconomic disadvantage was common among the women: just over half (51.3%) were holders of Health Care Cards, compared with 23% of the Australian population in 2004-2005 (Australian Bureau of Statistics, 2006). Approximately 2% identified themselves as Aboriginal or Torres Strait Islander, compared with an estimate of 0.6% of the Victorian population in 2006 (Australian Bureau of Statistics, 2008). The high percentage of women from outside the Melbourne metropolitan area, who held a Health Care card, identified as Aboriginal or Torres Strait Islander, or required the services of an interpreter,

indicates the barriers to access experienced by many of these women seen by the Pregnancy Advisory Service.

Over 70% of women described their partners as aware (of their pregnancy and associated decisions) and supportive of them. We assessed "Violence" and "Mental Health" from entries in several fields in the database. A woman achieved a score for Violence, which could be past or current, if any one of the following was recorded: an appropriate response to any of five relevant fixed choice categories, or any of the terms "DV", "violence", "safety", "risk", "assault", and "abuse" in the free text. Items relating to violence were scored for 16% of all women. A woman was recorded as having a Mental Health problem for an appropriate response to any of three relevant fixed-choice categories, or for any of the following words in free text boxes: suicide, depression, anxiety, PND, chaotic, self-harm, self-diagnosed, or self-medicated. Mental health problems were recorded for 9.5% of all women.

The results of the audit will, we hope, contribute to understanding women's needs for abortion services in Victoria, and inform planning for systematic data collection. The goal of data collection would not be to monitor women or doctors, but to provide opportunities for evidence-based policy development, service improvements, and preventive initiatives. We are delighted that our paper presenting the results of the audit has been accepted by the Medical Journal of Australia (Rowe, H., Kirkman, M., Hardiman, A., Mallett, S., & Rosenthal, D. (2009). Considering abortion: a 12-month audit of records of women contacting a Pregnancy Advisory Service. *Medical Journal of Australia*, 190(2), 69-72).

Interviews

The broad aim of the interviews was to understand what it means to women to have a pregnancy during which they contemplate or undergo an abortion. The research was approved by the Research and Ethics Committees of the Royal Women's Hospital.

We chose to interview three categories of women because of their significance to the experience of unplanned and unwanted pregnancy. Young women are repeatedly shown to be disadvantaged in avoiding pregnancy and gaining access to abortions, so we included women aged 16 to 18. We invited women who live in rural and regional areas of Victoria to participate, because they also have restricted access to all reproductive health services. The third group consists of women at 12 to 18 weeks gestation; we wanted to learn about the experiences of women who present in their second trimester. Women who were assisted by the Pregnancy Advisory Service and met the selection criteria were asked—once their needs had been met—if they would be willing to be invited for an interview. I telephoned those who agreed between six and twelve weeks later. Interviews were conducted by phone and usually lasted about 20 minutes.

Analysis of the transcripts yielded themes including service provision and women's reasons for having an abortion or continuing a pregnancy. These are what I will describe today, as well as outlining the women's major discursive construction of abortion, which is that it is a difficult solution to a problem. We use pseudonyms in reporting on the 60 women, who were aged 16 to 38. There were 35 from a rural or regional area, 25 aged 16 to 18, and 20 who were 12 to 18 weeks gestation when they contacted the Pregnancy Advisory Service; 17 women were in more than one category. Twenty-two of the women already had children. Five women had chosen to continue their pregnancies; the rest had had an abortion.

Services

I began each interview by asking what services should be available for women with a pregnancy that might be unplanned or unwanted. The women did not, on the whole, reflect on the nature and extent of services available or desirable, apart from as they had experienced them personally. This was not an expression of lack of care for others; abortion is one of those matters where you do not think about the details until you confront the problem, "What do I do now?"

Alison, for example, could not suggest how people could be made more aware of services "because, I suppose, you don't know until you need to look." Women suggested there should be more publicity about services, and that counselling and abortions should be available to all women at a reasonable price. There was almost universal, unsolicited praise for the Pregnancy Advisory Service because of its impartial support and provision of information. However, the heavy demand on the Service meant that some women spent hours on the phone trying to get through.

Three broad levels of assistance were sought by women. Some contacted the Pregnancy Advisory Service already confident in their decision to have an abortion, seeking only an appointment and information. Others were like Belinda, who wanted to "talk through with somebody about it, and make sure I was positive about everything"; the rest sought help with making a decision. Women said that, when seeking advice about an unwanted pregnancy, they should deal with a service that is not anti-abortion, that counsels for all possible outcomes including continuing the pregnancy and abortion, and does not make women feel, as Sara put it, "degraded" or "uncomfortable".

Some women described enforced waiting for abortion as very difficult. Caroline, for example, had struggled to decide what to do about her unplanned pregnancy. Once she had concluded that abortion

was the most responsible outcome for her, Caroline said, “knowing what I had to do, I couldn’t wait for the day. Like, once your decision’s made, you want it done straight away.” Long waiting lists and insufficient services, even at the Women’s, often made a swift conclusion impossible.

One advantage of a large public hospital such as the Women’s was seen to be the absence of anti-abortion protestors. Women could be coming in to hospital “for anything,” with no-one able to guess the procedure. When Daisy went to a private clinic, she found the protestors “really scary”. Once inside, she was happy with the care she received there.

After having an abortion, the support of women who had been through similar experiences was valued by a few women and desired by others. Those who avoided formal post-abortion counselling, such as Emma, said that pregnancy and abortion were too personal to discuss. Their generosity in volunteering for this research must be acknowledged: these women were not all eager to talk about their experiences.

In summary, women thought there should be ready access to information about options and services, impartial counselling, and non-judgmental abortion services. At present, this is not always the case.

I will now turn to women’s reasons for abortion.

Women’s reasons for abortion

I did not ask women directly why they had had an abortion or continued the pregnancy; I did not want to sound accusatory or make them defend themselves. Explanations arose from discussion about the pregnancy and its outcome. In every case, women described making decisions about their pregnancy that took account of their life circumstances. Reasons were usually contingent and multiple, explained throughout the interview

rather than in a brief statement. There were no reasons that distinguished rural/regional women from the rest. Women aged 16 to 18 tended to consider their maturity and their future, but so did older women. Reasons for abortion given by women who presented in the second trimester were similar to those given by women who presented earlier; their ambivalence or difficulty in making a decision, when it occurred, was also similar to women who presented earlier. The only notable difference was in the two women with abusive partners at the time of the current pregnancy. They were delayed, in part, by fear of the partner who was also a reason for the abortion.

Women’s reasons for contemplating or undergoing abortion can be summarised as relating to the woman herself, the potential child, existing children, and her sexual partner and other significant relationships. Although I describe them separately, they are interrelated. The separation is only for conceptual clarity.

Reasons concerning the woman

Thirty women identified their youth and immaturity as important reasons for not committing to motherhood. Not all of them were 18 or younger—the oldest were 22—and not all of the youngest women gave this explanation. One 18-year-old, Rebecca, was happy to have one child but thought a second would overtax her capacity. Prue had had fantasies about the baby, but said she “wouldn’t be mature enough”—at 17—and thought it was better to have an abortion than be a bad mother. The women who were not ready for motherhood often talked about the things they wanted to do before committing to a family, including study, travel, recreation, and just experiencing more of the world. Ophelia said, at 18, she wanted to live “a young life” before becoming a mother.

Women also felt they needed adequate support to be good mothers. Polly, at 33, was breaking up

with her partner, because he did not want children and she did, when she found she was pregnant. She had an abortion rather than experience the emotional and financial struggle of single motherhood. She said, “Surrounded by family and friends, there was a temptation to go ahead. But my mother was a single mother and I’ve just always vowed I’d never be a single mother.”

Reasons concerning the potential child

When women considered the needs of the potential child in deciding on abortion, they often said that a child deserves to be wanted. They thought not only of their personal capacity as mothers, but also of the suitability of their partner as a husband or father, or their lack of a partner and hence father for the child. Women took their financial circumstances into account and decided on an abortion if they thought they could not adequately support the child. In no case was money or unstable housing the sole reason for an abortion; it was part of being unable to provide for a child materially, emotionally, and socially.

Reasons concerning existing children

When women already had children, they were torn between not wanting to overstretch the family’s capacity and envisaging the potential baby pursuing the same developmental goals as their children. Caroline, for example, has three young children, and said, “There’s just not room. Like, we both work full time. I have morning shift, he has afternoon shift. And financially we, like, couldn’t change cars, and move, and all the things that it takes for a fourth. Not only financially, but emotionally.” Caroline found the decision difficult but concluded, “It was the mature decision, I think, and a necessary one.”

Reasons concerning family and community

Women also considered their family and social milieu when making the decision. Ophelia thought it would “ruin” her relationships with her family if they knew she were pregnant. Hanna would have felt “ashamed” to be seen pregnant at university, and confessed to feeling that way about other young women. And Sara thinks young motherhood is stigmatised in small towns like hers.

Jacinta approached the Pregnancy Advisory Service in her second trimester. She said that her family and friends wanted her to have an abortion for reasons given by other women: she was too young to be having a second child at 20, she had no partner, and was not financially independent. However, she did not want to have an abortion and contacted the Pregnancy Advisory Service to seek support in making her own decision. Jacinta was continuing her pregnancy.

Women’s stories

To illustrate the complex and contingent reasons women give for having an abortion, I will tell you about Alison, Sara, and Hanna.

Alison (aged 33)

Alison is an example of the 16% of women identified in the audit as being at risk of violence. She yearned to be a mother but did not want to subject the baby to her partner’s physical and emotional cruelty. Her partner had goaded her into the pregnancy, then vacillated between insisting she have the baby—threatening to harm himself if she ended the pregnancy—and insisting that she abort. Alison was afraid that she would be a weak mother, unable to protect her child, and that her partner would take the child away from her, as he had threatened. Alison said she had spoken to a counsellor at the Women’s because “I was trying to visualise how it would be if I did have the baby, and how he’d be with it all. And because he was under

the impression that, once we had the baby, everything would be fine, and I'd change, and ... my evil ways would disappear; and I just, you know, thought, how is he going to be with me and the baby? ... He was just so controlling that I couldn't see myself being a strong role model to my child. I thought, ... the baby's going to see its mother as just a mess all the time." Demonstrating great strength, Alison left her partner, despite still loving him. She took out a restraining order and had an abortion.

Sara (aged 22)

Sara had a baby when she judged herself to be unready, and decided to abort her second pregnancy. Despite being on the Pill, Sara gave birth soon after her marriage, urged on by the enthusiasm of her husband and extended family. She said, "I was too young to share my body. And obviously, having a baby, your body's not your own any more." Throughout her first pregnancy, she was "quite depressed that I'd done this to myself, that I was very silly and all the rest of it, even though people tried to say, you know, 'You're married, and you've got a home, and that's okay; and your husband's got a good job', but it still wasn't right for me." So Sara was determined not to do it again, "because I'm still trying to come to terms with being a mother. ... Sixteen months later, I'm still having trouble coping. ... And although I wouldn't change having my baby, it would've made life a lot easier if I had've had him long in the future. Not right now."

Hanna (aged 18)

Hanna is a thoughtful young woman who exemplifies other young women's explanations for aborting an unplanned pregnancy. She is too young for motherhood; she wants to complete her studies and travel, to experience independence, and to earn enough money to be financially secure. The only advantage of her unexpected pregnancy was proving she is fertile; the only reason for

continuing the pregnancy would be to see what the baby looked like. Before having children, Hanna wants a stable relationship; she does not want to stay with her current partner "because we have to". Hanna assessed herself as immature and too selfish for motherhood: "I felt like the child was going to take so much away from me. Like I wouldn't have my body, I wouldn't have my freedom, I wouldn't have money, I wouldn't have—like everything was just, 'I wouldn't, I wouldn't,' and it was all about me. And that's how I knew, like, look, it's not right! I'm very selfish at the moment... I don't need kids right now."

Women's dominant discourse: Abortion is a solution to a problem

In the midst of reconciling the many aspects of their complex lives, the major discourse around "contemplating or having an abortion" was: "Abortion is a solution, however difficult, to a complex problem". Women's reasons for seeking abortion indicate some of their problems. They also illustrate some of the ways in which abortion can be seen as a solution. I cannot elaborate on it here, but this discourse encompassed being a responsible woman and mother who took others' needs into account, including those of the potential child. Although abortion is constructed as a solution to a problem, it is not, on the whole, an easy one. Most women found the decision to have an abortion difficult for reasons concerning the fetus, herself, other people including partners and family, and society generally, including the stigmatisation of abortion and women who have them, and vigorous public protests against abortion. There are more details about the difficulties of the abortion decision that I do not have time to discuss today. To illustrate the discourse of abortion as a difficult solution, I will conclude my presentation with another example.

Fenella

Fenella is 21, describing herself as “still a kid myself”, and lives in a rural area. When she discovered her pregnancy, she immediately decided that: “it just wasn’t right for me and my partner at the time. ... Having a kid would have been awesome, but it just would’ve been too hard. ... Like, if we’d been together longer, and like we weren’t in uni and things, it might have been different, but just debt, debt. It wasn’t really an option.” She sees a dilemma confronting young women: “A lot of people turn their noses down at young mothers, but a lot of people turn their noses down or have, you know, avid views on abortion. So it’s a sort of lose-lose situation.”

Fenella and her partner did not tell their families, who would have been upset by the pregnancy, but “I think the abortion would have been the worst thing. Because, like, you think, ‘Oh, it’s my

grandchild, ... what could have been?’ ... They wouldn’t have seen how hard it would’ve been for us, but ... it’s easy when it’s not your body. ... It’s my decision. I’m the one who’s going to have to live with it for the next, you know, 20 years.” It was not only the family’s “religious background” that kept her from telling them, but “also the pressure. ... They would’ve probably left it up to me, but I think it would’ve hurt them and made it harder for me. And we’d have to tell the story again, and it gets upsetting.”

At times Fenella has felt “a bit sad” seeing “little babies”, but concludes, “There was never any doubt in my mind that I was doing the right thing.” For Fenella, as for other women with a badly-timed pregnancy, abortion may be difficult, but it remains a welcome solution.

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Abortion in Australia: Problems and Proposals

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Abortion law in Australia varies between states and territories. Many of the laws are confusing and uncertain in their application and many of the laws are untested. Uncertainty about the law has arguably grown since the introduction of medical abortion. Dwyer and Jackson report that most people support the provision of legalised abortion services and access to relevant services, on the basis that women have the moral capacity and right to make decisions about their reproductive health, and also from the harm minimisation perspective that prohibition has negative health and equity impacts.¹

Arguably the more criminalised abortion is in a jurisdiction, the more difficult it is to ensure that practitioners are properly qualified, regulated and accessible.² Despite these matters, in most states abortion is only lawfully available under certain circumstances.³

While most Australian States and Territories have

seen significant developments in abortion laws over the past 15 years, Queensland's abortion laws, largely drafted in 1899, are the oldest in the country. This article critically examines the Queensland legal position in relation to abortion before turning to a brief overview of particular developments in other States and Territories. This paper does not discuss the Victorian position as this is covered by other presentations at today's forum.

The *Queensland Criminal Code (QCC)* and Abortion:

In Queensland, homicide is defined according to s300 of the *Queensland Criminal Code (QCC)*.

The provision states that unlawful homicide is 'the unlawful killing of another'. Pursuant to s292 QCC a child only becomes a human being capable of being killed when it has 'completely proceeded in a living state from the body of its mother'.⁴ Thus neither women, whose pregnancy is aborted, nor doctors, or others who assist them, can be charged with conventional murder

or manslaughter. However, there are a number of other provisions in the QCC that deal with unborn children.

Section 313(1) QCC creates an offence of killing an unborn child. This offence is relevant to circumstances where the 'child is about to be delivered'. It states:

'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.'

In 1997 Queensland enacted a special offence of assaulting a pregnant woman causing death.

Section 313(2) states:

'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.'

In either case the maximum penalty for offences under s313 is life imprisonment. Given the requirement for unlawful assault in s313(2) it is

unlikely that doctors would be charged pursuant to this provision; presumably it would be argued that the pregnant woman consented to the 'assault' and therefore the assault was not unlawful in the first place. However, of relevance here is that according to the explanatory notes for the 1997 amendment, evidence that, on the balance of probabilities, the woman had, at the material time, been pregnant for 24 weeks or more is prima facie evidence that the child was capable of being born alive.⁵ It is curious to speculate whether this foetal age would be applied to s313(1) QCC in relation to defining the term 'about to be delivered'. If so, it is conceivable that the s313(1)QCC provision could be applied to "late-term" abortions.⁶

**Note: "late-term" in this paper is used to refer to terminations carried out late in the second trimester of pregnancy. The term has no definitive medical definition, and is used by some to mean pregnancies ranging from 20 to 28 weeks gestational age.*

In terms of the criminal liability of doctors carrying out abortions, certainly with respect to a fetus under 24 weeks gestation, and the criminal liability of women who request and allow abortions to take place, the QCC has three relevant provisions. First, s224 QCC sets out the following offence:

‘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.’

The maximum penalty for this offence is 14 years imprisonment. This offence covers both the force used in a surgical operation and presumably any drugs (ie ‘noxious things’) used to ‘procure the miscarriage’. Further, women who permit a doctor to use force or unlawfully administer drugs to procure a miscarriage, or who use self-help measures through force or by unlawfully administering a ‘noxious thing’ to procure abortion, could also be guilty of a lesser offence with a lower penalty of seven years (s225 QCC).⁷

Those who assist in either a surgical procedure or in administering a ‘noxious thing’ knowing that the instruments or drugs they are preparing or supplying will be used to ‘unlawfully’ procure a miscarriage could also be charged with an offence pursuant to s226 QCC.⁸ This offence has a maximum penalty of 3 years. Presumably this provision could be used in relation to employees at a clinic, such as nurses or administrative staff, who

assist in providing abortions to women. It could also be applied to doctors who ‘unlawfully’ prescribe drugs to induce abortion but do not administer them. The difference with this offence compared to the other two is that the prosecution would be required to prove that the person knew what they were doing. This is notoriously difficult in the criminal law as it is a subjective test that seeks to determine what was going on in the mind of the accused at the time of the offence.⁹ The difficulty of proving this element of the offence may explain to some extent why it has not been charged.

The ‘surgical operation’ defence in Queensland:

Doctors who carry out surgical abortions may seek an acquittal on the basis of the defence set out in s282 QCC. It states:

‘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.’

A number of important cases led to the current interpretation of the applicability of, and limits to,

this defence in the context of abortion matters. In 1969 Dr Charles Davidson was charged with abortion-related offences under Victorian law, which at the time was much the same as the current Queensland law.¹⁰ Davidson sought a ruling on what 'unlawfully' meant. The argument flowed from the assumption that given that there was a specific element of 'unlawfully' within the offence, there must then be some cases where carrying out a surgical abortion of a fetus would be lawful.¹¹ The case was decided by Justice Menhennitt. He found 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 by him was (a) necessary to preserve the woman from a serious danger to her life or her physical or mental health (not merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.'¹²

The decision was not appealed. In 1971, in the New South Wales case of *R v Wald*, where the law was also similar to Queensland, a doctor was

charged with unlawful use of an instrument with the intent to procure the miscarriage of a woman.¹³ In that case Justice Levine followed Menhennitt J's earlier ruling. However Justice Levine did introduce some further considerations. He commented that:

'In my view it would be for the jury to decide whether there existed in the case of each woman any economic, social or medical ground or reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her mental or physical health....'¹⁴

In 1986 the Queensland case of *KvT* tested the water on abortion law in Queensland.¹⁵ In this case proceedings were initiated by the father of an expected child against the pregnant woman. The potential father sought injunctive relief to stop the pregnant woman having an abortion. In this case Williams J found that an unborn child is not a subject of the crown that is protected by the *parens patriae* role. In obiter the judge discussed ss224 and 282 QCC and stated that the *Menhennitt ruling* would apply. The decision was appealed but the Supreme Court decision was upheld by the Court of

Appeal.¹⁶

Similarly there was a case, in 1983, involving Dr Bayliss. In this case Dr Bayliss was charged with offences against s224QCC and there was an appeal in relation to bail conditions which were imposed upon him. In the course of discussing the bail matter, McPherson J commented that it was not certain that all or any of the miscarriages procured by Dr Bayliss would be unlawful and that William J's judgement in *KvT* represented the law.¹⁷ These particular charges against Bayliss were ultimately withdrawn so there was no final decision on the offence matter.

It was not until 1986, in Queensland, that the pivotal *Bayliss and Cullen* case was heard.¹⁸ Dr Peter Bayliss, who ran a clinic in Greenslopes, and an anaesthetist, Dawn Cullen, were charged pursuant to s224 QCC and pleaded not guilty on the basis of s282 QCC. In this case Justice Fred McGuire came to the same conclusion as Menhennit J in the *Davidson* case in Victoria 16 years earlier. It was argued by the Director of Public Prosecutions that the *KvT* and earlier *Bayliss* cases were not conclusive on the interpretation of s224 and s282 QCC as the comments on these matters were

merely obiter.¹⁹ However McGuire J found that '*R v Davidson*, as approved in *KvT* and *Re Bayliss*, represents the law in Queensland.'²⁰ While McGuire J effectively followed the Menhennit ruling, it is not clear that he followed the *R v Wald* decision.²¹

In his detailed judgment, McGuire J also discussed the drafting of the QCC. He noted that the drafter of the code, Sir Samuel Griffith, had excluded the proviso of 'acting in good faith for the preservation of the life of the mother and child' from s313 (the killing an unborn child offence) and included it in s282 QCC (the surgical operation defence). According to McGuire J the reason for this is found in Griffith's marginal notes and has support from the writing of other criminal law experts such as Glanville Williams.²² Glanville Williams noted that a mature fetus may be described as an unborn child but that it would be 'odd to speak of a microscopic fertilised ovum in this way.'²³ Thus it was suggested by McGuire J that different stages of development were relevant to the understanding of the s313 QCC and s224 QCC offences. Of final note in relation to the *McGuire* ruling, the judge stated clearly that

s282 QCC defence was not available for 'every inconvenient conception' and that it would apply only in 'exceptional cases', and finally he said that 'the law in this state has not abdicated its responsibility as guardian of the silent innocence of the unborn.'²⁴

This position means that doctors in Queensland operate as gatekeepers to lawful abortion and could in certain circumstances deny a woman's request for an abortion.²⁵ Further, a serious danger to health is not clearly defined.²⁶ McGuire J provided only a general definition for 'serious'. He explained it may mean 'grave', 'irreparable', 'permanent' or 'real or substantial'.²⁷ Despite the apparent similarity of the law in Queensland with the law in Victoria and New South Wales (until recent Victorian reforms), in 2000 it was reported that in practice, access to abortion in Queensland is more restricted than in New South Wales and Victoria. It was surmised that this was because of highly politicised actions in Queensland in relation to abortion and the geographic remoteness of some communities.²⁸

There are some other uncertainties about the current approach to abortion in Queensland. First,

the defence under s282QCC is clearly focused on the carrying out of a 'surgical operation'. There is an interesting exclusion here. The s224QCC offence recognises the possibility of a 'noxious thing' being used to abort the fetus. The three Queensland decisions discussed so far have all focused on abortion as a surgical operation. Similarly the crucial *Menhennit ruling* also focused on the 'use of an instrument'.²⁹ This focus puts in question the lawfulness of medical abortion given recent medical developments that mean abortions can be carried out using drugs, for example mifepristone. Second, given McGuire J's apparent acceptance of the distinction between the indefensible killing of an unborn child and the potentially defensible killing of a 'microscopic fertilised ovum', there continues to be some uncertainty about the lawfulness of post-24 week abortion in Queensland.³⁰ The issue of medical abortion is discussed below.

Medical Abortion in Queensland:

Research suggests that the administration of the drug mifepristone (or RU486) in combination with misoprostol leads to complete abortion in 93-98% of the cases where it is administered.³¹ In 2005 Professor Caroline De Costa and another doctor

applied to the Commonwealth *Therapeutic Goods Administration* (TGA) to administer mifepristone.³² In February 2006 an amendment to the *Therapeutic Goods Administration Act* 1996 (Commonwealth) was passed. The amendment meant that the personal approval of the Commonwealth Minister for Health was no longer necessary in approving the importation of RU486 for the purpose of abortion.³³ The TGA gave the relevant approval to the two Queensland doctors in 2006.³⁴ However, despite being allowed to administer the drug pursuant to Commonwealth law, it was uncertain whether it was lawful to perform abortions using this drug (in conjunction with misoprostol) in Queensland. In response to concerns from the Queensland Branch of the Australian Medical Association, the Queensland Government sought advice from the Crown Law solicitor. The Government then issued a press release in response to the concerns. In part the press release stated that:

‘The registration of doctors to prescribe RU486 in line with recent changes to the Federal laws is now a matter for the Therapeutic Goods Administration...The provision of the authority to prescribe is held by the TGA, a unit of the Australian Government Department of Health

and Aging, and is not a matter for Queensland law...There is no need to change the law for doctors acting within the law.’³⁵

DeCosta has pointed out that misoprostol and methotrexate (another drug which operates in a similar way to misoprostol), are listed for treatment of peptic ulcers and certain cancers. Thus when they are used for abortion they are used ‘off-label’.³⁶ There remains some uncertainty about whether an abortion is ‘lawful’ if carried out medically in Queensland. Further, despite the Queensland Government statement, it is not clear what the position would be if there was a change of government.

In September 2008, the Supreme Court examined this issue.³⁷ The special facts of the case, however, may make it easy to distinguish from future cases of medical abortion. ‘B’ was a twelve year old girl who was approximately 18 weeks pregnant. She was a patient of a public hospital. The father of the child was unknown. Both of the girl’s parents consented to the termination of the pregnancy by the use of the drug misoprostol. Two psychiatrists and an obstetrician examined B and gave evidence that in their opinion the continuation of the pregnancy

would:

‘...pose serious danger to B’s mental health and well-being, beyond the normal dangers of pregnancy and childbirth. In their opinions the termination of her pregnancy is the only way to avert that danger, and it would not be a disproportionate response to that danger.’³⁸

In other words, the psychiatrists were applying the language of the *Menhennit / McGuire* rulings. The State of Queensland (the applicant in the case) approached the court in its *parens patriae* jurisdiction for authorisation of the termination of B’s pregnancy.³⁹ Justice Wilson accepted that the Court had *parens patriae* - supreme parent of children - jurisdiction over B, but not over her unborn child.⁴⁰ The judge accepted that this was a case where B was incapable of giving informed consent and that it was beyond B’s parents’ capacity to consent to the termination. Again, the focus in this case was on the word ‘unlawfully’ in s224 QCC. However Wilson J ruled out the application of the s282 QCC (surgical operation) defence as there were ‘sound reasons for not performing a surgical operation’.⁴¹ Implicitly, Wilson J is saying that medical abortion cannot be understood as a surgical operation. Instead

Wilson J relied on s286 QCC, ‘Duty of person who has care of a child’ which states:

‘(1) It is the duty of every person who has care of a child under 16 years to...
(c) take the action that is reasonable in all the circumstances to remove the child from any such danger;...’

According to Wilson J the danger contemplated by the provision included the danger to a child’s mental health. She also noted that the definitions of ‘a person who has care of a child’ extended to the hospital and doctors who had undertaken B’s care.⁴² Wilson J found that the administration of misoprostol to terminate the pregnancy to avoid danger to B’s mental health, would be lawful.⁴³

Subsequently misoprostol was administered to the girl and after a week of treatment she eventually miscarried. One newspaper article reported that she subsequently had to undergo surgery as a result of complications.⁴⁴ The article also reported that Christine Tippett, president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, stated that the case highlighted

the need for better access to the drug RU486.⁴⁵

The *B* judgment is that of a single judge of the Queensland Supreme Court, and although authoritative, it may not be the last word on whether the term 'surgical operation' in s282 QCC excludes medical abortion. Rules about statutory interpretation provide some options here. Firstly the words should have the meaning that the legislature intended them to have.⁴⁶ In some circumstances, principles of statutory interpretation may suggest that the words should have some other meaning than the one suggested by their literal meaning.⁴⁷ For example the purpose (ie the 'purposive approach') of the s282 QCC provision may be argued to have been to ensure that doctors were provided with a defence when carrying out medical treatments in good faith and with reasonable care in order to preserve the mother's life. It may be argued that to exclude medical abortion from surgical operation would create an inconsistency or ambiguity.⁴⁸ It may be possible to take this approach even if determining that surgical operation encompasses medical abortion results in a 'strained construction' of the phrase, as long as it is not unreasonable or unnatural.⁴⁹

Another possibility is to consider the need to keep legislation up to date, to ensure that the legislation is 'always speaking'.⁵⁰ Legislation operates for many years after it is first passed and the QCC is no exception. A recognised issue in statutory interpretation is whether or not in particular cases a word or phrase can extend to activities that were unknown when the legislation was drafted. Although surgical abortion was known at the time of drafting, arguably medical abortion was unknown (or at least not practiced by doctors) when the QCC was drafted. Previous examples where legislation has been interpreted in order to keep it up to date have included interpreting 'vehicle' to include 'motor car' and 'machine made copy' to include 'electronic copy'.⁵¹ Pearce and Geddes suggest that the question to ask is 'would the legislature have intended to include the activity or thing in the expression if it had known about it?'⁵² Either of these approaches would appear to bring Queensland into line with most other jurisdictions (save perhaps for NSW) where there is generally no distinction between medical or surgical abortion.

A problem with both the 'purposive' and 'always speaking' approaches to interpretation might be the reference to 'noxious substances' in relation

to abortion in other provisions in the QCC, including s224.⁵³ This suggests that the possibility of using poison (ie medicine, or at least non-surgical means) to induce abortion was already known and thus there was a deliberate intention to exclude medical abortion from the defence provision in s282 QCC.⁵⁴ This analysis demonstrates that although there are arguments that could be made in defence of a doctor charged with carrying out a medical abortion, the position is unclear.

Abortion in Other Australian Jurisdictions:⁵⁵

The law on abortion in New South Wales is similar to Queensland; however it is clear that the Levine judgment in *R v Wald* is applied. The difference to Queensland, then, is that in NSW the judge can take into account economic and social grounds as well as medical grounds, in consideration of the danger to the woman's health if the pregnancy was not aborted.⁵⁶ In a 2006 case Dr Sood was convicted of an offence equivalent to s224 QCC,⁵⁷ because the jury accepted that the doctor had 'unlawfully' terminated a pregnancy. It was accepted that the doctor failed to make necessary enquiries in relation to the impact of the pregnancy on the

woman. Dr Sood had given the woman some medication and the woman had miscarried at home.⁵⁸ The judge applied the *Menhennitt ruling* as developed in *R v Wald* and *Superclinics*.⁵⁹

In the Northern Territory the law was reformed in 2006, and the circumstances where abortion is lawful are set out in the *Medical Services Act* (NT) ('MSA'). Abortions performed outside of these provisions are a criminal offence.⁶⁰ Abortion is allowed up to fourteen weeks if two doctors agree that the birth or the continued pregnancy would cause greater harm to the woman than the abortion, or that the child would be physically handicapped because of physical or mental abnormalities (s11(1) MSA). Abortion is lawful up to 23 weeks if it is necessary to prevent serious harm to a woman's mental or physical health (s11(3) MSA), and it is lawful at any time to preserve the woman's life (s11(4) MSA). In all circumstances there must be appropriate consent and treatment must be carried out in good faith with reasonable care (s11(4)MSA).

Since 1998 in Western Australia abortion is a crime unless authorised by s334 of the *Health Act*

1911 (WA).⁶¹ Abortions can be performed up to 20 weeks where:

- the woman has given informed consent; or
- the woman will suffer serious personal, family or social consequences if the abortion is not performed; or
- serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or
- the pregnancy is causing serious danger to the woman's physical or mental health.'⁶²

Lawful abortion after 20 weeks gestation requires the agreement of two medical practitioners that the mother or the fetus has a 'severe medical condition' that justifies the procedure.⁶³ Unlawful abortions attract heavy financial penalties if performed by a medical practitioner and possible jail terms if performed by a person who is not a medical practitioner.⁶⁴ Where a person is charged with unlawful abortion there is a general defence where the person administers surgical or medical treatment to a person or the unborn child for the preservation of the mother's life.⁶⁵

In Tasmania unlawful abortion is an offence under the Criminal Code, but since 2001 the code

specifies circumstances where an abortion may be lawful.⁶⁶ It is lawful where two medical practitioners agree that continuing the pregnancy would involve greater risk to the woman's physical or mental health than termination.⁶⁷ There is an offence of 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 a child had been born alive.'⁶⁸ A defence is available in circumstances where the accused can show that the actions were taken in good faith to preserve the mother's life before or during childbirth.⁶⁹

In South Australia unlawful abortion continues to be a criminal offence with a maximum penalty of life imprisonment; the offence also applies to the woman seeking abortion.⁷⁰ However legislation specifically states that abortion is lawful where, in the opinion of two medical practitioners:

- continuing the pregnancy would involve greater risk of injury to physical or mental health of the woman,⁷¹ ;or
- involve greater risk to the life of the woman than the termination; or
- there is substantial risk that the child, if born, would suffer from such physical or mental abnormality as to be seriously handicapped.'⁷²

Importantly, in considering risks to the woman's health or life the medical practitioners can take into account the pregnant women's 'actual or foreseeable environment'.⁷³ This is potentially very broad and would perhaps include the potential depression associated with poverty of single motherhood. Where an abortion is necessary to save the life or to prevent grave physical or mental injury to the woman, the opinion of only one medical practitioner is necessary.⁷⁴ Where a child is capable of being born alive (ie 28 weeks or more of gestation⁷⁵), risk of health or life of the woman is not enough to make an abortion lawful. In these circumstances there is a higher requirement that the abortion is carried out to save the woman's life.⁷⁶ Generally there is no duty to participate in an abortion if the practitioner has a conscientious objection, however there is a duty to assist where the abortion will save the women's life or prevent grave injury to her mental or physical health.⁷⁷ The provisions do not make any distinction between medical or surgical abortion. Recently five doctors in South Australia obtained authorisation to prescribe RU486 for first trimester abortion, second trimester abortion and cervical priming prior to surgical abortion in the first and second trimesters.⁷⁸

The law in the ACT was reformed in 2002. The *Crimes (Abolition of Offence of Abortion) Act 2000* ACT effectively decriminalised abortion. Abortion is now regulated in the *Health Act 1993* ACT. Abortion must be carried out in an approved medical facility by a doctor and abortion is defined broadly – using an instrument, administering a drug or 'any other means'.⁷⁹ In the ACT there is no duty to assist in carrying out an abortion.⁸⁰ There is also an offence of child destruction where a person 'unlawfully' prevents a child being born alive or contributes to its death by an act or omission during its birth retained in s42 *Crimes Act 1990* ACT. 'Unlawfully' is not defined. An offence of intentionally or recklessly causing grievous bodily harm to child before it is born alive, during childbirth is incorporated in s43 *Crimes Act 1990* ACT.

Clearly abortion law throughout Australia is inconsistent and sometimes confusing.⁸¹ New developments in Victoria underscore the divergences and emphasize the need for some consistent approach in Australia.

Conclusion

In Queensland the law on abortion remains uncertain, especially in relation to medical abortion and “late-term” abortion. In this state the medical profession remains as the gatekeeper, making the final decision about whether the risk to a woman’s life or health is high enough to justify abortion. Even if the practitioner is satisfied the medical professional is still at risk of prosecution. In Queensland, access to medical practitioners is

problematic in many rural areas. To add to this concern, abortions are almost never carried out in public hospitals in Queensland, which means that women have to pay private practitioners for abortions. The rural/city divide and the issue of cost disadvantage many women as compared to their urban/wealthier counterparts. The Victorian reforms discussed elsewhere offer a hopeful and fair model for Queensland to work towards.

See generally Lachlan J de Crespigny and Julian Savulascu, ‘Abortion: Time to Clarify Australia’s Confusing Laws’ (2004) 181 (4) *Medical Journal of Australia* 201 esp 202; see also Andrew Pesce, ‘Abortion Laws in Australia: Time for Consistency?’ (2006) 29 (2) *UNSW Law Journal* 224 at 225.

1. Judith M Dwyer and Terri Jackson, ‘Unwanted Pregnancy, Mental Health and Abortion: Untangling the Evidence’ (2008) 5 (2) *Australia and New Zealand Health Policy* 1. See Jonathan Kelly and M D R Evans, ‘Trends in Australian Attitudes to Abortion, 1984-2002’ (2003) 6 (3) *Australian Social Monitor* 45 for a survey of attitudes in particular contexts. See also Children by Choice Fact Sheet which states that 60% of Queenslanders believe that abortion should be legal (2008) <http://www.childrenbychoice.org.au/nwww/campabortlaw.htm>. (visited 29 October 2008).
2. Office of Women’s Policy, Report of the Taskforce on Women and the Criminal Code (Qld Govt, 2000) at 355.
3. Andrew Pesce, ‘Abortion Laws in Australia: Time for Consistency?’ (2006) 29 (2) *UNSW Law Journal* 224 at 224.
4. The QCC does not define ‘living state’ so the Common law definition of life remains relevant and life is usually associated with brain or heart activity; see for example *R v Iby* (2005) NSWCCA 178.
5. *Criminal Law Amendment Bill*, Explanatory Notes (1997) at 12.
6. A person who endeavours to conceal the birth of a child by disposing of the body can also be charged with an offence and faces a maximum penalty of two years imprisonment (s314 QCC).
7. Section 225 QCC: ‘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.’
8. Section 226 QCC ‘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.
9. See for example *R v Wilmott (No.2)* [1985] 2 Qd R 413
10. Curiously it seems that the case did not involve an actual abortion; the informant whose name appeared on the warrant had never had an abortion. It seems she changed her mind. See Gideon Haigh, *The Racket: How Abortion became Legal in Australia*, MUP, 2008 at 126 (footnote)

11. See Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negligence of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229 at 231.
12. *R v Davidson* [1969] VR 667 at 671.
13. *R v Wald* (1971) 3 NSWDCR 25, see also then s83 *Crimes Act* 1900 (NSW) (a similar offence to Queensland's s224QCC).
14. *R v Wald* (1971) 3 NSWDCR 25 at 29.
15. *K v T* [1983] 1 Qd R 396.
16. *Attorney General (Ex rel Kerr) v T* [1983] 1 Qd R 404 at 405.
17. *Re: Bayliss* (unreported Supreme Court of Queensland, OS No 376 of 1985, 24 May 1985)
18. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8
19. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 30
20. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 30, 45; *Bayliss & Cullen* has subsequently been cited as the authoritative position in Queensland, see for example *Veivers v Connolly* [1995] 2 QdR 326 at 330 re: a medical negligence action in relation to lost opportunity to abort a handicapped child. See also *Grundmann v Georgeson* [1996] QCA 189 (18 June 1996).
21. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 26; *R v Wald* (1971) 3 DCRNSW 25. Note Rankin argues that Levine J's ruling in *R v Wald* was not dismissed as incorrect, see Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negligence of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229 at 236. See also Office of Women's Policy, *Report of the Taskforce on Women and the Criminal Code* (Qld Govt, 2000) at 357. Note that Newman J in *Ces and Another v Superclinics (Australia) Pty Limited and Others* (1995) 38 NSWLR 47 followed *R v Wald* but the *Superclinics* case was a civil one on negligence.
22. *R v Davidson* [1969] VR 667 at 671.
23. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 37
24. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 37, quoting from Glanville Williams' *Textbook on Criminal Law* (2ed. 1983) at 292.
25. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 45.
26. See Andrew Pesce, 'Abortion Laws in Australia: Time for Consistency?' (2006) 29 (2) *UNSW Law Journal* 224 at 225.
27. Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negligence of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229 at 237.
28. *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 at 45.
29. Office of Women's Policy, *Report of the Taskforce on Women and the Criminal Code* (Qld Govt, 2000) at 357.
30. *R v Davidson* [1969] VR 667 at 671.
31. Given the Explanatory notes for s313(2) QCC; Criminal Law Amendment Bill, Explanatory Notes (1997) at 12.
32. Caroline DeCosta, 'Medical Abortion for Australian Women: It's Time' (2005) 183 (7) *The Medical Journal of Australia* 378 at 379. See also L Cheng, et al, 'Intervention for Emergency Contraception' (2004) 3 *Cochrane Database of Systematic Reviews* 1-1102.
33. See Caroline DeCosta, 'Medical Abortion for Australian Women: It's Time' (2005) 183 (7) *The Medical Journal of Australia* 378.
34. Caroline DeCosta and Naomi DeCosta 'medical Abortion and the Law' (2006) 29 (2) *UNSW LJ* 218 at 219.
35. Caroline De Costa, *RU486: The Abortion Pill* (Boolarong Press, Salibury, 2007) at 78.
36. Joint Statement of Premier of Queensland, Anna Bligh and Justice and Attorney General, Linda Levarch, 'Queensland Doctors and the Prescription of RU486', 24 April 2006, available at <http://www.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=45774>
37. Caroline De Costa, *RU486: The Abortion Pill* (Boolarong Press, Salibury, 2007) at 78.

38. State of Queensland v B, by her Litigation Guardian [2008] QSC 231.
39. State of Queensland v B, by her Litigation Guardian [2008] QSC 231 at [12].
40. State of Queensland v B, by her Litigation Guardian [2008] QSC 231 at [2].
41. *State of Queensland v B, by her Litigation Guardian* [2008] QSC 231 at [5]; referring to *K v T* [1983] 1 QdR 396 at 400-401.
42. State of Queensland v B, by her Litigation Guardian [2008] QSC 231 at [21].
43. State of Queensland v B, by her Litigation Guardian [2008] QSC 231 at [22] citing State of Queensland v Nolan [2002] 1 Qd R 454 at [22].
44. State of Queensland v B, by her Litigation Guardian [2008] QSC 231 at [23].
45. Julie-Anne Davies, 'Late-Term Desperation' *The Australian* 13 October 2008, p7.
46. Julie-Anne Davies, 'Late-Term Desperation' *The Australian* 13 October 2008, p7.
47. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 25.
48. *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355 at 384 per McHugh, Gummow, Kirby, Hayne JJ.
49. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 27; referring to *Mills v Meeking* (1990) 169 CLR 214 at 235 per Dawson J.
50. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 36; referring to *Kelly v R* (2004) 205 ALR 274 at 300-301. See also s14A Acts Interpretation Act 1954 Qld-prefer a purposive approach, note this Act applies to Acts passed after 1991.
51. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 125.
52. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, Lexis Nexis, 2006, 123.
53. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 126.
54. Also s225 QCC.
55. The maxim: Expressio unius est exclusio alteriau (an express reference to one matter indicates that other matters are excluded). See D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, Butterworths, LexisNexis, 2006, 139.
56. For a good summary see Victorian Law Reform Commission, *Law of Abortion: Final Report* (VLRC, Melbourne,2008) at 21-24.
57. *R v Wald* (1971) 3 NSWDCR 25
58. See *R v Sood* *2006+ NSWSC 1141;s83 Crimes Act 1900 'Administering Drugs etc to a Woman with Intent.'
59. See Stefania Siedlecky, 'Banning Abortion: What's Going On?' (2007) 85 *New Doctor* 15 at 16.
60. *R v Sood* (Ruling No 3) [2006] NSWSC 762; *Ces and Another v Superclinics (Australia) Pty Limited and Others* (1995) 38 NSWLR 47 and *R v Wald* (1971) 3 NSWDCR 25; *R v Davidson* [1969] VR 667 at 671.
61. S208B; 208C *Criminal Code* (NT)
62. And see also s199 *Criminal Code Act Compilation Act 1913* (WA)
63. Victorian law Reform Commission, *Law of Abortion: Final Report* (VLRC, Melbourne,2008) at 23; see s334(3)*Health Act 1911* WA.
64. Victorian law Reform Commission, *Law of Abortion: Final Report* (VLRC, Melbourne,2008) at 23; see s334(7)*Health Act 1911* WA. The relevant practitioners are drawn from a committee, de Crespigny and Savulescu have identified problems with this approach, see Lachlan J de Crespigny and Julian Savulascu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181 (4) *Medical Journal of Australia* 201 at 203.
65. Doctors may receive fines up to \$50,00; see s199(2) *Criminal Code Compilation Act 1913* WA; other may be sentenced to up to 5 years imprisonment; see s199(3) *Criminal Code Compilation Act 1913* WA.
66. See s259 *Criminal Code Compilation Act 1913* WA

67. ss134-135, 164 *Criminal Code Act 1924 Tas*
68. s164(9) *Criminal Code Act 1924 Tas*. There are also requirements in relation consent and to counselling.
69. s165(1) *Criminal Code Act 1924 Tas*.
70. s165(2) *Criminal Code Act 1924 Tas*.
71. Including where a woman performs her own abortion, s81 *Criminal Law Consolidation Act 1935 SA*. Procurement of substances or instruments knowing they will be used for an unlawful abortion is also an offence punishable by 3years imprisonment, see s82 *Criminal Law Consolidation Act 1935 SA*.
72. Woman includes women of any age. See s82A(10) *Criminal Law Consolidation Act 1935 SA*.
73. s82A *Criminal Law Consolidation Act 1935 SA*.
74. s82A(3) *Criminal Law Consolidation Act 1935 SA*; reminiscent of the *R v Wald* (1971) 3 NSWDCR 25 judgement.
75. S82A(1)(b) *Criminal Law Consolidation Act 1935 SA*.
76. This is a rebuttable presumption that prima facie a child of 18 weeks gestation is capable of being born alive; see s82A(7) & (8) *Criminal Law Consolidation Act 1935 SA*.
77. s82A(7) *Criminal Law Consolidation Act 1935 SA*.
78. S82A (5)-(6) *Criminal Law Consolidation Act 1935 SA*.
79. Correspondence with Cait Calcutt.
80. ss81-82 *Health Act 1993 ACT*.
81. s84 *Health Act 1993 ACT*

Improving Abortion Care: A Victorian Perspective

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This paper was presented within a week of the passage of Victoria's Abortion Law Reform Bill, which is a dramatic step forwards in providing a framework in which to consider abortion as a health issue. The paper outlines some of the requirements for, barriers to and progress in developing excellence in care for women considering and having abortions.

Breaking News: Abortion Law Reform in Victoria

The Abortion Law Reform Bill 2008 was passed by Victoria's Legislative Council on 10 October 2008 and by its Legislative Assembly four weeks previously.

Its main provisions are that:

- Abortion is removed from the Crimes Act (except where performed by an unqualified person).
- A registered medical practitioner may perform an abortion on a woman who is not more than 24 weeks pregnant.
- After 24 weeks abortion may be performed by a medical practitioner only if there is a reasonable belief that it is appropriate in all the circumstances including current and future medical, physical, psychological, social; and another medical practitioner is consulted
- Conscientious objectors must refer to another health professional who does not have such objection.

In late 2007, the Victorian Attorney-General requested the Law Reform Commission (LRC) to provide advice on options to clarify the law on abortion and remove it from the Crimes Act; these options were to reflect current community standards, without altering current clinical practice.

The Law Reform Commission published an information paper, undertook consultations and received submissions, which resulted in a comprehensive report tabled in May 2008, which is detailed and balanced and is an important resource for other jurisdictions.

The Abortion Law Reform Bill was tabled in August and scheduled for a conscience vote. There was extensive community and parliamentary debate, with most of the issues raised having been addressed in the LRC's report. Editorials in both local major daily newspapers supported law reform.

Abortion Services At The Royal Women's Hospital

"Sex and Suffering", Janet McCalman's history of women's health and the Royal Women's Hospital, records the desperation of women and harms caused by unsafe abortion in the days prior to the Victorian Menhennitt ruling in 1969, which defined lawful abortion. There was debate at the Women's and some concern about the potential workload, but the Pregnancy Advisory Service was established in 1975 to meet the Hospital's responsibility to the community and public patients. Attempts by the Pro-Life Alliance to stack the Board and prevent the Hospital from providing abortion services failed.

The Pregnancy Advisory Service incorporates a telephone intake service and medical services. The intake service provides needs assessment and counselling and makes referrals according to each woman's needs for counselling, internal or external medical services and other support or assistance. This role extends state-wide and beyond.

Medical services include integrated clinic abortion and contraception services, medical assessment and opinions as needed and abortion procedures if indicated, as well as follow up and further counselling.

Achieving Optimal Care in Abortion Services

In order to provide optimal health care in any area we need to address all its dimensions including:

- Service development
- Audit and review of practice
- Research and improvement of knowledge
- Training, mentoring and supervision
- Prevention and health promotion

Some of the barriers, requirements and progress in each of these dimensions in respect of abortion services are outlined below.

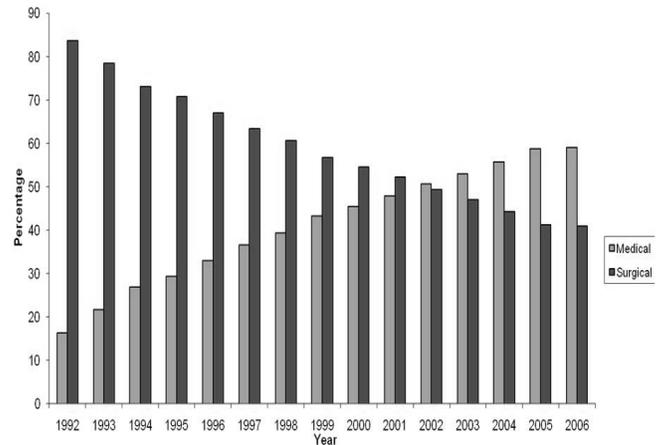
Service Development

Efforts in service development are very dependent on local interest and in Australia, are largely informed by international rather than Australian-derived information and research. Persuasive powers, persistence, energy and support are needed by clinicians seeking to improve abortion care.

Lack of access to medical abortion is a major service gap in Australia. When choice between medical and surgical abortion is available, half of all women will prefer medical and half surgical abortion. For instance, in Scotland 60% of all abortions are now done medically, with even higher proportions prior to ten weeks of pregnancy. The latter has steadily increased since the introduction

of medical abortion with mifepristone to the United Kingdom in 1991 (figure 1).

Figure 1: Abortions performed in Scotland by method, 1992-2006^p



¹ Refers to therapeutic abortions notified in accordance with the Abortion Act 1967.
^p Provisional.
 Source: Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967
 ISD Scotland

Medical abortion is not routinely available in Australia, because mifepristone (colloquially known as RU486), which is a drug essential to the established best regimens of medical abortion, is not generally available in Australia, as a result of a political decision made in the mid 1990s.

Since the parliamentary debate and passage of the Bill amending the Therapeutic Goods Act in 2006, mifepristone can again be considered by our regulatory authorities by the same processes and standards as other drugs, examining the medical evidence regarding safety and efficacy of use. These processes have led to a number of practitioners being authorised to prescribe mifepristone for women with the greatest clinical need, although we must wait for a successful pharmaceutical company application before this method will be broadly available to women on the basis of preference. Providers are considering the changes which will be needed to introduce medical abortion as an option equitably available throughout the state and country.

Service implications of the introduction of medical abortion.

The introduction of medical abortion with mifepristone does not appear to result in changes in abortion rates, although presentation may be encouraged earlier in pregnancy and better geographical access may be achieved. Some changes are required to the organisation and structure of clinical services, with some variations in costs, which depend on local factors but are likely to be comparable overall. More women are able to have their preferred method; choice of method is valued by women and may improve satisfaction with treatment.

Audit and Review of Practice

Reliable data are needed for appropriate service planning and development. There is no national monitoring of abortion rates, although there has been formal regulated monitoring in South Australia for many years. This has been more recently introduced in Western Australia and the Australian Capital Territory.

In the other states, there have been estimates based on Health Insurance Commission (Medicare) data for private patients and hospital admissions for public patients, information which is collected for other purposes and is known not to give a complete or accurate picture. This is in part because the Medicare item includes miscarriages and is not specific to induced abortion, and because it is known that not all women claim Medicare entitlements regarding abortions.

The Australian Institutes of Health and Welfare have published a report examining current sources of data and available methods for estimating abortion rates. It is understood that Victoria's Department of Human Services (DHS) has been collecting data from health services with a view to accurate

monitoring of abortion numbers, although these have not been published as yet.

Research

A limited literature search suggests that articles on abortion published by Australian authors tend to focus on legal and health services policy, access issues and audit data, much of which originates in South Australia. There appears to be a relative deficiency of clinical research. Political objection to Australian participation in a World Health Organization study of RU486 in the early 1990s led to interruption of the research (which was eventually resumed and completed) and national review of institutional ethics committees, an experience which was very discouraging for researchers interested in this area, as well as prospective funders and approvers of such research.

Signs have been more optimistic recently, with Victoria's DHS commissioning research on pregnancy advisory services and the Australian Research Council funding a grant to research women's experiences of abortion. The introduction of medical methods presents new imperatives as well as options for research.

Training, Mentoring and Supervision

There has been limited emphasis on abortion services in undergraduate and postgraduate curricula for health professionals. What does exist is very hospital and individual dependent. To improve this requires a supportive environment, addressing any complacency that abortion will somehow be adequately dealt with by others and tackling any personal distaste for the subject or sense that others may not approve of participation.

Teaching in this area is supported by the increasing availability of information tools and guidelines and a growing number of fora at which it is acceptable to

discuss abortion as a health issue, including conferences and in house sessions. There is still work needed to develop policies to ensure adequate training of health professionals for the future and stronger mentoring programs. There are also challenges internationally to ensure that this area of care has adequate priority in training programs and to ensure that complacency is not a problem.

Australian practitioners now learn about unsafe abortion from history books and the international literature; those who cared for damaged and dying women in the wards until 1970 never became complacent, but it is understandable that with generally reasonable access to safe services, abortion does not carry the same sense of urgency for younger practitioners.

It is deeply troubling to hear from people still working in very adverse conditions in other parts of the world, and we must consider their experience in supporting the development of ongoing and better services both in Australia and elsewhere.

Prevention and Health Promotion

Primary prevention of abortion is dependent on community, home and school education, which includes sex education, preparation and empowerment for healthy respectful relationships, ready availability of and good information about reliable contraception, and access to emergency contraception.

Secondary prevention of poor outcomes of abortion requires early referral, access to safe non-judgmental services, equitable access to antenatal diagnostic services and support and multidisciplinary care for the most disadvantaged.

These matters would be ideally supported by a state-wide or national strategy for education and health promotion in sexual and reproductive health. It is a positive step that Victoria's Department of

Human Services has identified sexual and reproductive health as a health promotion priority and that there is now some community discussion about a national strategy.

A Case Study in Excellence: What Can Be Achieved

A colleague and I recently visited a hospital in Scotland with a particular aim of seeing a medical abortion service in operation. This unit consistently publishes high quality research and audit reports, which have been instrumental in establishing best practice and very useful to us in planning our own service.

The service did not appear to have access problems. Almost all abortions in Scotland are done within National Health Service hospitals and supply matches demand. If a pregnant woman wants to consider abortion, she has only to make a telephone call to the service and an appointment will be available. The full range of methods is offered in the first trimester, although medical abortion is the only option thereafter. Clinical details of every case, such as drug doses, time to abortion, pain relief needed and so on are recorded and analysed, as well as information being provided for national monitoring. There are ongoing research projects into a range of aspects of clinical care and all of this feeds into service development and continuing education.

We gained an impression that there was more ready involvement of staff including trainees in the abortion service than we are accustomed to, but there are some challenges in recruitment and succession planning.

There was an overwhelming impression of calm, compared to what we are used to. Women were dealing with the same range of issues and distress in their personal lives that are seen in Victoria, but the removal of the angst around whether a service

could be offered reasonably promptly and within her means seemed to remove a lot of the stress from the consultation and from the providers. We also had an impression of less hostility and resistance to the provision of abortion services than we are used to. All of this left the practitioners free to concentrate on the content of the health care rather than dealing with extraneous issues, and they had energy left to do research.

We postulate the following factors as facilitating and/or contributing to the relatively favourable climate we observed in this Scottish abortion service:

- The legal status of abortion is clear and not generally a source of anxiety to practitioners, although there are strong arguments for some change and considerable debate around this in the United Kingdom.
- Government policy requires regional health services to provide or arrange for abortion services for residents, so health services must meet the demand.
- Monitoring is mandated and results in annual published reports, some data from which are included in this paper.
- There are government-sponsored prevention and health promotion strategies in place.
- The senior clinicians and academics in this service saw abortion services as important, warranting investment in clinical excellence and research.

It should be noted that these observations reflect a three-day visit to one unit and should not be over-interpreted as representative of Scotland. Indeed there is published work reporting that services in Scotland are somewhat variable and depend on local organizational culture and leadership: however the interest in examining service improvements itself tells a story of a climate which fosters inquiry and evaluation. The experience of this visit provides many aspirations for Australian services.

What Have We Achieved at the Women's?

We implement evidence-based care drawing on RCOG, RANZCOG and other relevant published literature and guidelines for practice. We use these to develop information resources for women. A number of our staff have been authorised by the Therapeutic Goods Administration to prescribe mifepristone for those with the greatest medical need. We contribute to professional and collegiate activities in this area and have been active in advocacy, contributing to Senate inquiries on transparency in counselling, RU486 and Medicare item 16525 as well as providing information and advocacy throughout the Victorian law reform process.

It is my experience that it has become both more comfortable and more frequent than in the past for the Women's Hospital to include abortion issues in routine professional education and clinical discussion sessions.

A Personal Reflection

In Victoria the 1960s were an era of unsafe abortion, resulting in death and damage to women; at the Royal Women's Hospital there was an infection ward where women were treated after unsafe abortion and clostridial infection was relatively common. Abortion was surrounded with corruption until case law changed things in 1969.

The 1970s saw the establishment of safe abortion services in hospitals, including the Women's, and the reduction of mortality and morbidity rates.

In the 1980s, while I was doing my specialist training, the Menhennitt ruling was still fresh and I recall a high level of participation by hospital staff in abortion services. It seems to me that those teaching us still remembered the 60s and abortion was seen as part of comprehensive care.

In the 1990s however, abortion seems to have increasingly become a poor relation, excluded from general health care approaches, with resistance and hostility to this subject affecting health professionals. Evidence-based medicine was developing, but not so consistently applied to abortion care, and the important development of mifepristone was denied to Australian women.

In the new millennium, discourse seems to be refocussing on the health aspects of abortion, with the development of guidelines and professional statements providing accurate information to support evidence-based policy and practice, and some diminution in the traction of misinformation.

In my view, we are turning a corner towards the best possible health services for women considering abortion, as evidenced by:

- Government and DHS support for good practice through law reform and the identification of sexual and reproductive health as a health promotion priority
- Parliamentary and community debate repeatedly affirming recognition of abortion as a health issue

- The development of evidence based policy positions by professional organizations
- A greater openness about abortion supporting discussion and debate, including at fora such as the one convened by Children by Choice.

Conclusion

It is essential that we build on the growing recognition of abortion as a health issue and on the momentum of these policy developments. When we have a legislative, policy and practice framework that truly treats abortion as a health issue, we can expect to have prevention rather than prohibition, we will optimize access to maximize safety, we will have a choice of methods, not restriction, we will have data, monitoring and research rather than guesswork on which to base planning for the future, we will have robust training and staff support for future safe service provision and we will truly approach best practice in clinical care. Victoria's Abortion Law Reform Act 2008 has provided a sound basis on which to build.

Resources

- 1 Victorian Law Reform Commission website: <http://www.lawreform.vic.gov.au/wps/wcm/connect/Law+Reform/Utility/Home/>
- 2 Abortion Law Reform Act 2008 <http://www.legislation.vic.gov.au/>
- 3 McCalman J. Sex and suffering: women's health and a women's hospital. Melbourne: Melbourne University Press; 1998.
- 4 Abortions Data 2006. NHS National Services Scotland. 2007. Available from: <http://www.isdscotland.org/isd/1918.html> Pregnancy Outcome in South Australia 2005.
- 5 Jones R, Henshaw S. Mifepristone for early medical abortion: experiences in France, Great Britain and Sweden. *Perspectives on Sexual & Reproductive Health*. 2002 May-Jun;34(3):154-61.
- 6 Pregnancy Outcome Unit, South Australian Department of Health. 2006. Available from: <http://www.dh.sa.gov.au/pehs/pregnancyoutcome.htm>
- 7 Grayson N, Hargreaves J, Sullivan E. Use of routinely collected national data sets for reporting on induced abortion in Australia. Sydney: AIHW National Perinatal Statistics Unit; 2005.
- 8 Scientific developments in relation to the Abortion Act 1967. House of Commons. 2007. Available from: <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>.
- 9 Foy R, Penney G, Grimshaw J, Ramsay C, Walker A, MacLennan G, et al. A randomised controlled trial of a tailored multifaceted strategy to promote implementation of a clinical guideline on induced abortion care. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2004 Jul;111(7):726-33.
- 10 Say L, Foy R. Improving induced abortion care in Scotland: enablers and constraints. *Journal of Family Planning & Reproductive Health Care*. 2005 Jan;31(1):20-3
- 11 World Health Organisation. Safe abortion: technical and policy guidance for health systems. Geneva: WHO; 2003 http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf
- 12 Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Termination of pregnancy: a resource for health professionals: RANZCOG; 2005 <http://www.ranzcog.edu.au/womenshealth/termination-of-pregnancy.shtml>
- 13 Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion. London: RCOG; 2004. <http://www.rcog.org.uk/index.asp?PageID=662>

Therapeutic Abortion Provision

Dr Carol Portmann

Clinical Director, Maternal Fetal Medicine,
Royal Brisbane and Women's Hospital

Therapeutic termination of pregnancy - distinct from what is termed 'social' termination – implies that a condition is present for which termination is a reasonable therapy. These conditions can include fetal abnormality, a maternal medical disorder, a serious maternal psychiatric disorder, or exposure to teratogens, chemicals or other agents which may interfere with normal fetal development, such as drugs, environmental chemicals, and some infections.

There is no standard definition for 'social' terminations, which are not commonly performed in Queensland public hospitals for three reasons: the fact that termination of pregnancy (TOP) is still included in the Queensland Criminal Code; the lack of medical practitioner providers in the public system; and the availability of private TOP services.

Both therapeutic and 'social' abortion procedures must meet Queensland Criminal Code requirements to be performed legally, proving that no private clinics are performing unlawful abortions. There is no legal reason a 'social' TOP procedure could not be performed in a Queensland public hospital - only historical and cultural issues prevent this from happening.

The fact that lawful abortion occurs in Queensland is proof that in some cases, continuing pregnancy can be a greater risk to a mother's life and wellbeing than termination. It is worth noting that the common law rulings around therapeutic termination do not outline any specific fetal indications that must be present to justify termination, nor do they set down any gestational age limits.

At the Royal Brisbane and Women's Hospital (RBWH), diagnosis of a condition which could lead to a therapeutic TOP is followed by counselling, where the patient is fully informed of her options and the risks associated with all of them, in order to enable informed consent. If she decides to go ahead with a TOP, two medical practitioners must support the request, and the Executive Medical Services must support the request before the procedure can go ahead. Social work and nursing support systems are put in place for when the procedure has been performed.

Of the terminations performed in RBWH on therapeutic grounds, 95% are for fetal abnormalities and 4% for maternal medical conditions, leaving less than 1% which are performed for maternal psychiatric disorder. 'Fetal abnormality' can cover many varied conditions, from lethal defects to a reasonable suspicion of an abnormal outcome. Significant physical disability, moderate to severe intellectual disability and poor quality of life are also grounds for a therapeutic TOP for fetal abnormality. Conditions include Down syndrome, spina bifida, anencephaly, and trisomy 18/13. Diagnosis for fetal anomalies is made after in-depth tests, including ultrasounds, karyotyping and MRIs, and in consultation with geneticists, neonatologists and paediatric surgeons. Psychiatrists, obstetric physicians and other specialists in radiation, oncology, infectious diseases and pharmacology may also be involved in diagnosis, depending on the condition/s present.

Counselling is offered and available through various channels, including GPs, obstetricians, and

maternal fetal medicine specialists. Ultimately, it is the service provider's responsibility to counsel the patient about the risks of termination compared to the expected outcomes of pregnancy.

Referrals of patients seeking a therapeutic TOP can come from a number of quarters, including GPs, private obstetricians or radiologists, other public hospitals and sometimes religious public hospitals. There are various methods of performing terminations, many of which are used in therapeutic termination provision. Dilation and curettage (D&C) is most commonly used for gestational ages under 14 weeks, while some centres will perform a dilation and evacuation (D&E) from 14 to 18 weeks. Medical abortion using misoprostol is used from 14-22 weeks, with the RBWH using feticide for pregnancies over 22 weeks.

In reality, therapeutic terminations are available up to 20 weeks gestational age in most secondary hospitals in Queensland, for most moderate to severe conditions. Some hospitals will provide therapeutic TOP at 20-22 weeks, but most 'late-term' therapeutic TOP is done at the RBWH.

There are difficulties in defining 'late-term' TOP as there is no standardised usage. No gestational age limit is defined within the Queensland Criminal Code. Most Queensland public hospitals use the regulations on whether births are reported or not as a guideline on what they term 'late' TOP - births, including stillborns and terminations, prior to 20 weeks gestational age do not have to be registered, whereas those born after 20 weeks do. This has led to some hospitals using 20 weeks and over as their definition of 'late' TOP.

At the RBWH, terminations performed at up to 22 weeks gestational age do not require the procedure to be carried out via feticide, whereas it is recommended for those over 22 weeks. This has led to 'late-term' being generally applied to any TOP over 22 weeks, and it is sometimes used to describe any pregnancy approaching viability. Within the Queensland public hospital system, the

definition varies but is generally used to refer to 20-22 weeks gestational age and over.

When considering a post-22 weeks TOP, there are legal and moral indicators that must be taken into account by any facility. Legally, there is a requirement to ensure that termination poses less substantiated risk to maternal wellbeing than continuing with the pregnancy. At the RBWH, psychiatric and social work evaluations of the patient are carried out prior to the procedure being performed. Two obstetricians must support the request for a TOP, one of whom will perform the feticide. An ethics committee must then agree on the procedure.

Post-22 weeks TOP is considered at the RBWH if the expected fetal outcome is poor, though not necessarily lethal, and if there is a probable risk to the maternal medical, emotional, social and psychological wellbeing if the patient continues with the pregnancy. Late TOP may also be carried out for the selective reduction of multiple births, as well as for conditions that are only uncovered by tests late in the pregnancy, including fetal tumours or brain injury, cardiac defects, or chromosomal abnormalities. Full evaluations are carried out on a case by case basis, which can take up to two weeks depending on the circumstances.

There are several challenges in the system facing the provision of therapeutic TOP. There is a lack of standardisation of what constitutes grounds for therapeutic TOP, as well as the referral procedure and the method of processing. These inconsistencies between different doctors and districts can create confusion as to what a therapeutic TOP is and the best way to access one. The uncertain legal status of abortion and the fact it remains in the Criminal Code adds to confusion in the profession. Lack of education and training in abortion provision poses constant challenges, as does the lack of interested medical staff fully trained in TOP procedures. Conscientious objection versus duty of care is also an issue which continues to divide the health sector.

Abortion Access in Queensland

Cait Calcutt
Coordinator
Children by Choice

In regional, rural and remote Queensland, women experiencing unplanned pregnancy and considering abortion experience serious disadvantage. The lack of provision of first trimester pregnancy termination by Queensland Health means women can only access early abortion in three locations outside the South East corner of the state and the out-of-pocket cost is significantly higher in these areas, with minimum cost over \$500.

For some women the cost and travel to access abortion services means they are forced to continue with an unwanted pregnancy. In a wealthy OECD country such as Australia, where a large, high quality publicly funded health and welfare system exists, this situation is both bizarre and unacceptable. CbyC is active in raising awareness with governments of the need to address this issue, but we also need the help of our supporters.

Recently an indigenous woman living in a community in northern remote Queensland contacted CbyC for assistance. She was a young single mother who had only recently discovered that she was pregnant and at the end of her first trimester. Three women's services and Children by Choice were able to provide some monies to assist with the termination, but even after significant time and energy devoted by workers we were unable to reach the entire fee and hoped that an exceptional fee reduction could be made for the young woman. However the young woman, without a private car, could not find transport in time to get to the abortion

service, which was a hundreds of kilometres away. Her only possibility was to travel to Brisbane – this was not possible due cost, transport, distance and accommodation. She had no choice but to continue with an unwanted pregnancy.

CbyC's Women's Access Fund, or WAF, is a donation fund set up to help women in situations like these access procedures. The demand on WAF has been growing consistently over recent years, but the current financial climate has affected it severely. Between July 1 and November 30 2007, CbyC had assisted 63 women to pay for abortion procedures with WAF funds. The same period in 2008 has seen 116 women assisted by WAF—almost double the number of last year.

Most women relying on WAF for assistance are trapped in a cycle of poverty and welfare dependence, with almost half relying on the sole parent pension while others are on unemployment benefits or low, casual wages. For some, the cost of the termination may represent all of their fortnightly income. Most of these women have no savings, little available financial support from family and friends, are reliant on public transport, and much of their fixed income is spent on the increasing cost of housing. Very few welfare agencies are willing and able to provide emergency relief and financial assistance to economically disadvantaged women seeking abortion.

Developments in Medical Abortion

Dr Caroline de Costa

Professor in Obstetrics and Gynaecology

James Cook University

What are the implications for other states, now that abortion has been decriminalised in Victoria?

While South Australia and Western Australia have updated abortion law in recent years (although leaving it within criminal legislation) the Queensland Criminal Code (1899) and the New South Wales Crimes Act (1900) contain wording on abortion that harks back to the English Offences Against the Person Act of 1861 (which was supposed to protect women from unsafe abortionists, though it singularly failed to do so.) In both Queensland and New South Wales abortions are performed in clinics and hospitals under the common-law protection afforded by the Menhennitt ruling in Victoria (1969), the Levine and Kirby rulings in New South Wales (1971 and 1994) and the McGuire judgment in Queensland (1986.) These (it is assumed) make abortion lawful if the doctor performing the procedure has an honest belief that the woman's life or physical or mental health would be at risk if the pregnancy continued; the doctor must also believe that the risks to the woman from the abortion itself are in proportion to the risks to be averted if the pregnancy continued.

The Queensland legislation poses particular problems for abortion providers in that state as the defence to a charge of performing an unlawful abortion only allows a 'surgical operation' to be performed; at the time of drafting of the Code medical abortion was unknown. The New South Wales legislation (and the Victorian legislation that has just been rescinded) was less specific, allowing both 'instruments' and 'substances' for the lawful performance of abortion. The Queensland

government attempted to clarify and legitimate the situation in a statement from the Premier and the Attorney-General in 2006, declaring that the fact of the Therapeutic Goods Administration (TGA) having approved the use of a drug (such as RU486) for the purpose of abortion made the use of the drug lawful in Queensland, but this has not been tested in court. Queensland doctors continue to find themselves in a grey area when they perform abortion, despite their holding an honest belief that a woman's best interests are being served by the procedure. Some 14,000 surgical abortions are performed each year in Queensland, but the size and geography of the state mean that women in rural and remote areas experience great difficulty accessing surgical abortion.

The overturning of the Harradine amendment in Federal Parliament in February 2006 meant drug companies could apply to the TGA to manufacture and/or market RU486 (mifepristone) in Australia, without the personal permission of the Minister for Health being required. However to date none has made such an application, probably because of the political controversy that has surrounded the drug (despite its safety, effectiveness and acceptability to women having been amply demonstrated in overseas studies) and because such applications entail hefty fees.

Since July 2006 a colleague and I in Cairns have had TGA approval to use mifepristone under the Authorised Prescriber legislation which permits doctors in private practice to import drugs unavailable in Australia but available overseas, for their own patients in situations which are 'life-

threatening or otherwise serious.’ We must comply with both the TGA regulations and Queensland law which means that we have performed only a small number of medical abortions using mifepristone in Cairns. Doctors in Victoria, NSW and WA have obtained similar TGA approval and have similarly performed small numbers of procedures.

South Australian doctors have recently gained similar TGA Authorised Prescriber approval; they have not yet started to use the drug but expect to do so in early 2009. The wording of South Australia abortion legislation means that RU486 will be much more widely available there than it has so far been in other states – in fact to any woman undergoing an abortion who chooses medical rather than surgical methods. The change in Victorian law means that Victorian doctors are also able to apply for this wider use of mifepristone – at least four are known to have commenced such applications.

Since the overturning of the Harradine amendment Australian women have become increasingly aware

of the advantages of medical rather than surgical abortion – and are voting with their feet. Many clinics and private practitioners in Victoria, NSW and Queensland, unable to access mifepristone, now offer methotrexate for early medical abortion; this drug, easily available nationally, has been shown in overseas studies to be safe and quite effective, but inferior to mifepristone. So women undergoing methotrexate abortion are being offered second-best treatment for reasons that are essentially political.

It is recognised that Queensland women in some cases travel outside the state for abortions. In the case of South Australia a two-month residence requirement means that abortion ‘tourism’ to that state is not possible. Queensland abortion law is currently the most restrictive in Australia, and its effects are particularly harsh for women in rural and remote parts of the state. There is an urgent need to decriminalise abortion in Queensland (and in New South Wales) and to bring about uniformity in both law and practice across the country.

This paper has also been published by online media service Crikey, at www.crikey.com.au.

Challenges and Issues in Abortion Provision

Panel Discussion

Panel Chair: **Dr Darren Russell**
Director of Sexual Health, Cairns Sexual Health Service

Panel Members: **Jill Michelson**,
General Manager, Operations, Marie Stopes International

Dr Caroline de Costa
Professor of Obstetrics and Gynaecology, James Cook University

Dr Michael Carrette
Obstetrician and Gynaecologist

Dr David Grundmann
Planned Parenthood Australia

Dr Libby Rimmer
Eastcoast Women's Centre

In this session, panel members, all involved in the provision of abortion services to Queensland women, discussed the issues and challenges in delivering those services on a day-to-day basis. This was an open floor session and participants had the opportunity to ask questions of the panel members. The issues raised in the discussion were as follows.

Geographic Isolation

One of the major factors that influence access to abortion services for Queensland women is geography. The sheer size and remote nature of some health districts across regional Queensland mean many women have little or no access to local medical services, and may have to travel vast distances simply to see a GP. With surgical terminations only available in larger regional centres (Rockhampton, Townsville and Cairns are the only towns outside the southeast corner where procedures are available), the cost and

inconvenience of travel adds to the often high cost of the procedure itself.

In many cases it is not financially viable for two people to travel from a remote town to a larger centre in order for a woman to access an abortion, but Queensland Health policy states that anybody receiving surgery under anaesthetic must be picked up by a support person and is under no circumstances to drive themselves. However, no financial assistance is provided to support people for travel expenses, often leaving the woman to travel alone. One panel member spoke of driving

women home personally after giving them a termination, putting themselves and their staff members at risk of prosecution for doing so.

Women in small or Indigenous communities also face problems with privacy, which can prevent them seeking to access a termination. Stigmatisation of abortion is still a very real issue for many women, in metropolitan or remote areas of Queensland, resulting in many women desiring to keep the procedure a secret. This desire for privacy is leading more and more women, particularly those in remote areas, to seek out medical abortion rather than opt for the surgical procedure.

Legal Uncertainty and Medical Abortion

Medical abortion, relying as it does on abortifacient drugs, can be carried out anywhere where there are facilities to care for women if they miscarry, making it much more suitable for women in regional and remote areas without access to specialised abortion clinics. Several providers reported a large increase in the number of women enquiring about medical abortion services, as the public becomes more aware of it as an option. With training, medical abortion could provide a partial solution to the lack of abortion services for regional and remote areas, as it would make it easier for doctors who are uncomfortable or unskilled in surgical abortion to provide termination procedures.

One of the problems with medical abortion is that the supply has not followed increased demand. This is partly due to the lack of practitioners and agencies prescribing or distributing methotrexate for abortion. There is an opportunity for private clinics especially, along with Sexual Health and Family Planning, to apply through Queensland Health, but so far not many are doing so.

There are also questions around the legality of medical abortion, as covered by Dr Heather Douglas' earlier presentation (see page 25). This

uncertainty is affecting the willingness of GPs and clinics to get involved in the area, as the legal status of medical abortion has not yet been clearly defined and they would be at risk of prosecution. One provider referred to the provision of medical abortion, particularly in regard to mifepristone, being the 'Sword of Damocles' for GPs, and noted that even lawyers themselves were unsure of the situation.

Mifepristone, or RU486, is still only able to be prescribed by a small amount of doctors who have applied to the Therapeutic Goods Administration for permission and had their applications approved, as discussed by Dr Caroline de Costa (see page 51). This means the drug, which has been shown in studies to be more effective than methotrexate with fewer side effects, is technically available for Australian women, but access to it is limited, particularly in Queensland. Restrictions in this state mean that licensed doctors are only able to prescribe Mifepristone where continuing the pregnancy would create a life-threatening or similarly serious situation. It is not currently available freely or as another option for women seeking abortion in Queensland, although providers stated that it was the preferred drug for medical abortion and as soon as it becomes available widely that is what will be used.

This has created what one provider referred to as a 'two-tier' system for medical abortion in Queensland, where methotrexate is the second choice for providers but the only drug they can prescribe with relative freedom. Providers explained their decision to use methotrexate, despite the increased effectiveness of mifepristone, by stating that as mifepristone was on extremely limited availability, it was important to provide at least one option for medical abortion, even if it was not the best product possible.

Legality of abortion is a continuing issue for both providers and the women seeking to access terminations each year. It was raised again and

again as a major obstacle in delivering adequate and accessible services, and impacts on many other aspects of service provision.

While there is an unclear legal status on abortion, problems in training and recruitment, public acceptance of abortion as a women's health issue, and access to services and information, will remain. The recent reforms in Victoria, decriminalising abortion up to 24 weeks, were raised as proof of what decriminalisation can accomplish - the legislation has had the immediate effect, according to those involved in the sector in that state, of allowing issues like training and access to be discussed in the open, as legitimate issues. Decriminalisation also has the potential to do much to overcome unwillingness of some sectors of the public to see abortion as a women's health issue.

Succession Planning and Training

Succession planning was among the biggest concerns raised by providers during the panel discussion. There are several overlapping causes of this, including the unclear legal status of abortion, surgical as well as medical, throughout Queensland. Issues with legality as well as the continued stigmatisation of abortion make it difficult to attract new doctors to the profession, and all providers emphasised the need for an industry-based training system for new graduates. The difficulty of classifying abortion provision under one of the larger umbrellas of medical practice, such as general practice, or obstetrics and gynaecology, creates a lack of educational pathways for graduates as well as problems in recruiting. Providers would ultimately like to see a cooperative system set up between hospitals, medical education and training institutes, and private clinics, to ensure new graduates are being trained in the sector. The academic community must engage with private practitioners to provide a training ground for young doctors prepared to work in the area.

Providers also outlined what they referred to as a lack of support from the rest of the medical community, with one panel member noting that no representatives from the Australian Medical Association or the Royal Australian College of General Practitioners were present at the conference. Although the Royal Australian and New Zealand College of Obstetricians and Gynaecologists has shown greater support to abortion providers in recent years, the Queensland branch of the AMA continues to distance itself from the discussion. One panel member stated that these official bodies, as well as more conservative individual members of the profession, will continue to avoid being associated with abortion until it is decriminalised, due to fear of litigation.

Attitudes

Attitudes of Australians, and Queenslanders in particular, were raised as an issue which continues to cause problems across a number of areas, including succession planning. Several providers spoke of the need to provide abortion services in the context of women's health, and the importance of decriminalisation in changing public attitudes towards abortion. Queensland's conservative views on abortion combined with the fact that the procedure is still included in the state's Criminal Code, mean abortion provision is seen as something of a controversial issue, not as a health issue. Providers are seen as mavericks within the medical profession, according to one panel member, not only as bad doctors but as questionable people. While this stigma is attached to medical professionals in the sector, attracting new recruits will be made increasingly difficult.

This stigma also means that abortion provision as a whole is not an issue often addressed, particularly through official channels, and several providers noted the importance of personal networking as a means of disseminating information to others in the health sector. As there is no clear legal standing on

abortion, the issues of different types and methods of abortion and their suitability or availability are often left up to individual interpretation. Providers argue this is too subjective, and that only decriminalisation can undo this current state of affairs.

Licensing Restrictions

All abortion providers in this state who provide surgical abortions must be licensed by Queensland Health, something which is adding an increased cost burden to the sector. Licensing is becoming an increasingly difficult area to negotiate, with providers commenting on the growing number of restrictions being applied to new agencies applying for operating licences. Licensing restrictions have also prevented Queensland providers from performing post-20 week terminations, meaning women seeking those procedures have to go through the public system or travel to Victoria.

The licensing restrictions require a large operating theatre and equipment which ensures patient safety but also results in increased costs, with one provider estimating the price of a termination had risen 30% in recent years.

Medicare

The lack of Medicare funding for abortion procedures was also raised as a concern, particularly given the recent attacks on funding by Tasmanian senator Guy Barnett. Senator Barnett has targeted the Medicare item number relating to second trimester abortions in the cases of fetal abnormality, fetal death or life-threatening maternal illness, and at the time of this conference the future of his Senate motion to disallow this funding is uncertain.

Post Script: Senator Barnett's motion was later withdrawn from the Senate and referred to the Senate Committee for Finance and Public Administration for consideration.

The Committee refrained from making a recommendation either for or against the withdrawal of funding, commenting only that better data collection on pregnancy terminations was necessary in order to better inform policy decisions.

Senator Barnett did not reintroduce the motion into the Senate.

Qualitative Evaluation

All participants were provided with the opportunity to evaluate the conference, both as individual presentations and the day as a whole.

Overall the feedback was remarkably positive, with every presentation being ranked 'Above Average' or higher by participants. Some of the comments received during the evaluation process are below.

All sessions were very useful. The passion of the speakers and the work they do inspired me – how lucky is Queensland to have such people willing to take risks for something they believe in!

Every session was relevant to my work. I thought the opening addresses from Karen Struthers and Bonny Barry were very good, they set the tone and context and I enjoyed their humour very much.

Excellent forum. Critical for providers to advocate for women. Rich contribution to safe and effective best practice.

Spot on, well explained and all sides and points of view were covered.

It was a great advance that the conference was held publicly and supported by CbyC, FPQ and the Medical School. Now for the law change!

The best conference I have attended in a very long while. Thankyou.

The speakers at this forum have been invaluable in the standard of information provided. The historical, present and futurist perspectives which were explained and identified have been insightful and motivating.

Very balanced, comprehensive, thoughtful discussion.

Provided a very good overview of the current situation in Queensland and Australia and the urgent need to reform the abortion laws.

Very informative. Animated presenters. Highlighted the urgency of increased training needs for service delivery.

Excellent to have a collection of like-minded professionals to support each other.

Informative, evidence-based presentations. Increased my knowledge of abortion in Australia. Very timely to hold this conference in Queensland.

Very educational, particularly around the law.

Panel discussion was very good and raised a lot of issues I had no idea about. It is great to see such a devoted group of providers.

It was important to have discussion and highlight the issues for the providers. They are inspirational, what a courageous group of people.