

Health (Abortion Law Reform) Amendment Bill 2016

Report No. 33, 55th Parliament

**Health, Communities, Disability Services and Domestic and Family
Violence Prevention Committee**

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Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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Abbreviations and glossary

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
the Bill	Health (Abortion Law Reform) Amendment Bill 2016
clinical guideline	Queensland Health Clinical Guideline <i>Therapeutic termination of pregnancy</i>
the Crimes Act	<i>Crimes Act 1958</i> (Vic)
the Criminal Code	<i>Criminal Code Act 1899</i>
CSCF	<i>Clinical Services Capability Framework</i>
first Bill	Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (see page 8 of this report)
FLPs	Fundamental Legislative Principles
NAAPOC	National Alliance of Abortion and Pregnancy Options Counsellors
the POQA	<i>Parliament of Queensland Act 2001</i>
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Glossary

Abortifacient

A pharmaceutical drug that induces abortion.

Conscientious objection

A health practitioner refusing to perform, or assist in performing, a recognised treatment on the basis of sincerely-held beliefs or moral concerns.

Foetal abnormality

A term used to describe a positive test or indication of a genetic or other condition in the foetus during pregnancy.

Gestation

The measure of the progress of a pregnancy, in terms of weeks, from the first day of a woman's last menstrual period.

Gillick competence

The legal concept used to determine whether a child is able to consent to medical treatment.

Medical abortion

The use of pharmacological drugs, most commonly mifepristone and misoprostol, to terminate a pregnancy.

Mifepristone

A pharmaceutical drug administered to induce an abortion, most commonly used as the first step in a sequence of two drugs (followed by misoprostol).

Misoprostol

A pharmaceutical drug administered to induce an abortion, most commonly used as the second step in a sequence of two drugs (following mifepristone).

Surgical abortion

The use of trans-cervical procedures, most commonly suction or curettage, to terminate a pregnancy.

Chair's foreword

On behalf of the Health, Communities, Disability Services and Domestic and Family Violence Committee of the 55th Parliament, I present this report on the committee's examination of the Health (Abortion Law Reform) Amendment Bill 2016.

The committee's task was to consider the policy to be given effect by the Bill, and whether the Bill has sufficient regard to the fundamental legislative principles in the *Legislative Standards Act 1992*. The fundamental legislative principles include whether legislation has sufficient regard to the rights and liberties of individuals and to the institution of Parliament.

The committee's examination of abortion law reform Bills has been protracted, spanning ten months. Between May and August 2016 the committee examined the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 concurrent with a broader terms of reference received from the Legislative Assembly. Shortly before the committee tabled its report on the first Bill and terms of reference in August 2016, Mr Pyne MP introduced the Bill which is the subject of this report.

As stated in my previous foreword, any public discourse regarding abortion law can be expected to attract a high level of interest. Community opinions about abortion are divergent, and often based on deeply held values. The committee has carefully considered the views put to it in submissions and public hearings. The committee has sought at all times to be respectful of the range of opinions presented to it.

This report summarises the main issues considered by the committee in its examination of the Bill. The committee did not reach agreement on whether or not to recommend that the Bill should be passed.

Chapter 2 of the report provides a brief summary of the policy context for this Bill. That context includes the current provisions of the Criminal Code regarding abortion, which the earlier Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 proposes to omit. Chapter 2 also summarises current regulation and standards for abortion services in the public and private sectors, and the law of informed consent.

Subsequent chapters explain each of the main clauses in the Bill, outline any current Queensland regulation of the issues in the Bill and the equivalent law in other jurisdictions. Each chapter also outlines the main issues considered in the committee's inquiry on the Bill.

Readers may also like to refer to the committee's earlier report *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland* which considers a wider range of issues than those covered in this report. That report is available on the committee's webpage, and print copies are available from the committee secretariat.

The committee received over 1,200 submissions to this inquiry, and over 2,600 across the two bill inquiries. On behalf of the committee, I thank those individuals and organisations who lodged written submissions and appeared at the committee's public hearings.

The committee also wishes to acknowledge the assistance provided by Hansard and committee staff.

Finally, I would like to thank my fellow committee members, past and present, for their contributions during the examination of the Bill.

I commend this Report to the House.



Leanne Linard MP
Chair

1. Introduction

1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the committee) is a portfolio committee of the Legislative Assembly.¹ The committee's areas of portfolio responsibility are:

- Health and ambulance services
- Communities, women, youth and child safety
- Domestic and family violence prevention, and
- Disability services and seniors.²

The committee is responsible for examining each bill in its portfolio areas to consider:

- the policy to be given effect by the legislation; and
- the application of fundamental legislative principles (FLPs).³

Further information about the committee's work can be found [here](#).

1.2 Referral and committee's process

On 17 August 2016, the independent Member for Cairns, Mr Rob Pyne MP, introduced the Health (Abortion Law Reform) Amendment Bill 2016 (the Bill) into the Legislative Assembly. The Bill was referred to the committee on 17 August 2016, and the committee was required to report to the Legislative Assembly by 17 February 2017.

During its examination of the Bill, the committee:

- was briefed on the Bill by Mr Pyne MP on 21 September 2016
- invited submissions from stakeholders; 1,252 submissions were received and accepted by the committee, and are published on its [website](#). The committee declined to accept some submissions that contained offensive or unparliamentary language.
- held public hearings on 27 and 28 October 2016 and 7 November 2016 to hear from invited witnesses, a list of the witnesses who appeared at the hearings is at **Appendix A**.

The material published in relation to this inquiry is available on the committee's [website](#).

1.3 Outcome of committee considerations

Standing Order 132(1) requires the committee to recommend whether the Bill should be passed.

After its examination of the Bill and consideration of the information provided by Mr Pyne MP, submitters and witnesses at its public hearings, the committee was not able to reach agreement on whether or not the Bill should be passed.

¹ *Parliament of Queensland Act 2001*, (POQA) section 88 and Standing Order 194.

² POQA, s 88 and Standing Orders, so 194 and schedule 6.

³ POQA, s 93(1).

2. Policy context for the Bill

2.1 Committee consideration of Abortion (Woman’s Right to Choose) Amendment Bill 2016

In 2016, the committee considered and reported on the Abortion (Woman’s Right to Choose) Amendment Bill 2016 (the first Bill) and inquiry terms of reference referred to it by the Legislative Assembly. The independent Member for Cairns, Mr Rob Pyne MP, introduced the first Bill into the Legislative Assembly in May 2016 and the committee’s report was tabled in August 2016. The first Bill proposes to omit sections 224, 225 and 226 from the Criminal Code (see below for details of those sections).

The committee’s earlier report, on the inquiry terms of reference referred by the Legislative Assembly and the first Bill, includes discussion of some policy matters that are relevant to this Bill, namely conscientious objection and ‘safe-access zones’ around health facilities.

This report summarises the committee’s consideration of a second Bill, the Abortion (Woman’s Right to Choose) Amendment Bill 2016.

2.2 Resolution of the Legislative Assembly that both Bills will be debated together

On 29 November 2016, the Legislative Assembly agreed to postpone debate of the first Bill until the committee reported on the Health (Abortion Law Reform) Amendment Bill 2016, so that it and the Abortion (Woman’s Right to Choose) Amendment Bill 2016 could be debated together. The Legislative Assembly decided that the bills will be treated as cognate bills for their remaining stages, as follows:

- (a) Second reading debate, with separate questions being put in regard to the second readings
- (b) The consideration of the bills in detail together, and
- (c) Separate questions being put for the third readings and long titles.

The timing of debate of the Bills was also decided by the Legislative Assembly. The cognate bills will:

... be brought on for debate on the next sitting Wednesday evening following the tabling of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee report on the Health (Abortion Law Reform) Amendment Bill and every subsequent sitting Wednesday evening until the bills are finally dealt with by the House.⁴

Debate of both the Abortion (Woman’s Right to Choose) Amendment Bill 2016 and the Health (Abortion Law Reform) Amendment Bill 2016 is therefore scheduled to commence on the evening of Wednesday 1 March 2017, which is the next sitting Wednesday following tabling of this report.

2.3 Current Queensland abortion law

2.3.1 Criminal Code

Offences for procuring an abortion

Three sections of the Criminal Code create offences about abortion as set out below.

- **Section 224, Attempts to procure abortion** is the principal offence and provides that:

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.⁵

⁴ Queensland Parliament, Record of Proceedings, 29 November 2016, p 4581.

⁵ *Criminal Code*, s 224.

- **Section 225, The like by women with child** applies to women who intend to procure a miscarriage:

*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.*⁶

- **Section 226, Supplying drugs or instruments to procure abortion** applies to a person who supplies things such as drugs or instruments, knowing it is intended to procure a miscarriage:

*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.*⁷

These sections of the Criminal Code create offences for ‘unlawful’ procurement of an abortion. While the inclusion of the word ‘unlawful’ in the provisions has been interpreted to mean there are circumstances where an abortion is lawful, the Criminal Code does not specify when an abortion may be lawful.

Defence for abortion related offences

Section 282 (1) of the Criminal Code provides a defence for persons who procure an abortion. It states that:

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

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

*if performing the operation or providing the medical treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.*⁸

2.3.2 Judicial interpretation of the abortion provisions of the Criminal Code

The key judicial ruling in Queensland is *R v Bayliss and Cullen*, in which two doctors were charged under section 224 of the Criminal Code. Judge McGuire of the District Court determined that the inclusion of ‘unlawfully’ in section 224 criminalised only those procedures that had not been performed lawfully.⁹

Judge McGuire confirmed that the Menhennitt ruling (a Victorian case, *R v Davison*) applies in Queensland.¹⁰ Consequently, the section 282 defence has been interpreted to mean that an abortion will not be unlawful where the accused honestly believes on reasonable grounds that an abortion is:

- necessary to preserve the woman from serious danger to her life, or physical or mental health, and
- not out of proportion to the danger intended to be averted by the abortion.¹¹

⁶ *Criminal Code*, s 225.

⁷ *Criminal Code*, s 226.

⁸ *Criminal Code*, s 282(1).

⁹ *R v Bayliss and Cullen* (1986) 8 Qld Lawyer Reps 8, 45, cited in Katherine Kerr, ‘Queensland Abortion Laws: Criminalising One in Three Women’, *QUT Law Review*, 14(2), 2014, p 21.

¹⁰ (1986) 6 QLR 8.

¹¹ Queensland Health, *Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013.

The committee's report on the first Bill and terms of reference outlined the Australian case law relevant to interpretation of the provisions of the Criminal Code. This report provides less detail, and readers may wish to refer to the committee's earlier report.¹²

2.3.3 Current law not directly amended by this Bill

The current Bill, the Health (Abortion Law Reform) Amendment Bill 2016, does not directly amend the current law about abortion in the Criminal Code. Hence, there is potential for uncertainty in the law.

As a general proposition, the committee notes the possibility for legislation to impliedly amend or repeal earlier legislation. This question is not settled and if it arises it may ultimately be a question to be determined by a court.

Professors of Law, Lindy Willmott and Ben White, joint directors of the Australian Centre for Health Law Research at Queensland University of Technology (QUT), gave evidence to the committee about legal uncertainty. Professor White noted that there 'is no specific provision' in the current Bill repealing the provisions of the Criminal Code. He suggested that it would be an impediment to knowing and acting on the law if legislation about abortion was in both the Criminal Code and the Health Act.¹³

In addition, Professor Willmott highlighted possible uncertainty about the legal implications, if the first Bill (repealing provisions of the Criminal Code) is not passed and the current Bill is passed:

*If there is any possibility of uncertainty that would not be a good way forward. We have been considering how this [Bill] would work with the current [Criminal Code] if this were the only bill. We have been working with legislation for quite some time and if we are struggling to work out what the implications would be, I do not think that is ideal.*¹⁴

Professor Willmott said that, in her view, if the first Bill did not pass and the current Bill passed:

*...it would have the effect that it would be more difficult in Queensland for a person in the first 24 weeks gestation period to obtain a termination than after 24 weeks. My understanding is that if this bill were passed [and the first bill amending the Criminal Code was not passed], the Criminal Code would continue to govern a woman in the first 24 weeks. Abortion would be unlawful under 224 and 226 and the defence would be in section 282. If you were post 24 weeks, my understanding is that this new bill would operate.*¹⁵

2.4 Regulation of abortion services in Queensland

2.4.1 Regulatory requirements - public hospitals that provide abortions

Limited abortion services are provided in Queensland public hospitals. Most of the abortions performed are for foetal abnormalities, maternal illness or complications, and the public hospital system's role in 'early therapeutic terminations is probably limited.'¹⁶

Abortion services in public hospitals are provided in accordance with the current law, the Queensland Health *Clinical Services Capability Framework* (CSCF) and Queensland Health guidelines, which include *Therapeutic termination of pregnancy*.

The Queensland Health CSCF is a suite of documents describing clinical and support services by service capability level, categorised from 'Level 1' to 'Level 6'. For specific clinical services (eg intensive care,

¹² Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland* <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2016/5516T1337.pdf>

¹³ Public hearing, 28 October 2016, transcript p 68.

¹⁴ Public hearing, 28 October 2016, transcript p 69.

¹⁵ Public hearing, 28 October 2016, transcript p 69.

¹⁶ Queensland Health, Queensland Maternity and Neonatal Clinical Guideline: *Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, https://www.health.qld.gov.au/_data/assets/pdf_file/0018/140733/g-ttop.pdf

surgery, pathology) the CSCF describes minimum capability requirements for that service by capability level. The minimum capability requirements include workforce requirements, risk considerations and support service requirements, which determine which facilities have the capability to deliver particular clinical services.

The guideline *Therapeutic termination of pregnancy* includes a summary of the law, individual case considerations and guidance about psychological support, patient assessment, decision-making processes, clinical care, and post-termination care.

2.4.2 Licensing requirements - private hospitals and day hospitals that provide abortions

Private hospitals and private day hospitals are required to be licensed under the *Private Health Facilities Act 1999*. A private 'day hospital' is one where diagnostic, surgical or other procedures are performed involving the administration of a general, spinal or epidural anaesthetic or sedation.¹⁷

All private hospitals and day hospitals (abortion clinics) that provide surgical abortions in Queensland are licensed under the *Private Health Facilities Act 1999*. Licensed facilities must comply with standards made under that Act, including a 'specialty health services' standard that applies to termination of pregnancy.

In addition to the requirement to be licensed under Queensland legislation, these health facilities must be accredited in accordance with national standards of the Australian Commission on Safety and Quality in Health Care (ACSQHC).

Private hospitals and abortion clinics must also comply with the same standards as public sector hospitals, including:

- the Queensland Health *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* and the *Companion Document for Licensed Private Health Facilities*¹⁸
- Queensland Health guidelines, including *Therapeutic termination of pregnancy*,¹⁹ and
- appropriate college and professional body guidelines.

2.4.3 Decision-making counselling

Counselling to support pregnant women in their decision-making generally involves providing information and discussing with them the three available options – to continue with the pregnancy to parent, to continue with the pregnancy to adoption, and abortion.

The World Health Organisation recognises that providing information and offering counselling is very important to support women considering their options, and to ensure decisions are made free of pressure or coercion. Voluntary, confidential and non-directive counselling should be provided to all women who desire it. 'Many women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counselling.'²⁰

The Queensland Health guideline *Therapeutic termination of pregnancy* advises health practitioners that good practice includes supporting decision-making by providing accurate, impartial and easy to understand information about the three pregnancy options. It also advises that confidential, non-judgmental support and counselling, with an appropriately-trained person who is familiar with issues surrounding abortion and has no vested interest, should be offered to all women.²¹ The Royal

¹⁷ *Private Health Facilities Act 1999*, ss 9-10.

¹⁸ Queensland Health, *Clinical Services Capability Framework*, www.health.qld.gov.au/system-governance/licences/private-health/cscf/default.asp.

¹⁹ Queensland Health, Queensland Maternity and Neonatal Clinical Guideline: *Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, https://www.health.qld.gov.au/_data/assets/pdf_file/0018/140733/g-ttop.pdf

²⁰ World Health Organisation, *Safe abortion: technical and policy guidance for health systems*, World Health Organisation, Geneva, 2012, p 36.

²¹ Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, pp 8-13.

Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also recognises that offering counselling and support for women making decisions regarding pregnancy is best practice.²²

A range of service providers offer information and counselling about pregnancy options; they include not-for-profit organisations, family planning centres, and health practitioners. Information and counselling services are offered face to face and by telephone.

Women are not required to participate in decision-making counselling. They may choose to utilise counselling to support their decision-making process or they may choose to make their decision independently with the support of significant people in their lives.

2.5 Law of informed consent

2.5.1 Common law legal obligations

As with all medical treatment, informed consent is legally required before an abortion is performed. Health practitioners have a legal obligation, under the common law, to obtain the patient's consent prior to performing any medical treatments.²³ Consent will only be valid if it is voluntary,²⁴ and not obtained fraudulently or with reckless indifference.²⁵

The woman must be provided with sufficient information to make an informed decision about whether to consent to an abortion, including advice about the material risks or possible complications associated with the procedure and the likelihood of complications occurring, and alternative treatment options.²⁶

The standard of information that must be provided, as established by *Rogers v Whitaker*,²⁷ is what a reasonable person in the patient's position would want to be told, or what the health practitioner should reasonably know that a particular patient would want to be told. This legal standard recognises that it is the patient's decision to undergo a procedure, and it is the patient who ultimately bears the burden of the risk, so to make an informed decision they need to know the material risks that may be involved in the treatment.

Failure to obtain the patient's consent, or to provide sufficient information, particularly about the material risks of the treatment, may form the basis of criminal or civil liability, and professional disciplinary action.²⁸

The common law requirements for informed consent apply to all health practitioners in public and private health settings.

2.5.2 Professional guidelines

The Queensland Health *Guide to Informed Decision Making in Healthcare* describes informed consent as:

*...the two-way communication process between a patient and one or more health practitioners that is central to patient-centred healthcare. It reflects the ethical principle that a patient has the right to decide what is appropriate for them, taking into account their personal circumstances, beliefs and priorities.*²⁹

²² RANZCOG, College Statement: *Termination of pregnancy*, C-Gyn 17, March 2013, p 4.

²³ *Rogers v Whitaker* (1992) 175 CLR 479.

²⁴ *Norberg v Wynrib* (1992) 2 SCR 226.

²⁵ *Dean v Phung* (2012) NSWCA 223.

²⁶ *F v R* (1983) 33 SASR 189, p 192 confirmed in *Rogers v Whitaker* (1992) 175 CLR 479, p 490.

²⁷ *Rogers v Whitaker* (1992) 175 CLR 479, p 490.

²⁸ Queensland Health, *Queensland Health Guide to Informed Decision Making in Healthcare*, Queensland Government, Brisbane, 2012, p 2.

²⁹ Queensland Health, *Queensland Health Guide to Informed Decision Making in Healthcare*, Queensland Government, Brisbane, 2012, p 2.

The Queensland Health guide outlines the principles health practitioners must comply with to obtain a patient's informed consent:

- the patient has the capacity to make a decision and is not affected by drugs or alcohol
- the consent is voluntarily given, and free from manipulation, or undue or coercive influences
- the discussion is transparent, well balanced, and involves two-way communication
- the information is provided in a manner the patient is able to clearly understand
- the patient is advised in simple terms of:
 - the diagnosis
 - the treatment, including the benefits, side effects, recovery, and alternative treatments
 - the material risks associated with the treatment, alternative treatments and no treatment
 - any significant long term physical, emotional, mental, social, sexual or other expected outcomes
- the patient has sufficient time to consider and clarify any information.³⁰

The Queensland Health guide emphasises the importance of information and discussion with patients to enable fully informed decision-making:

*Informed consent is not simply about getting a patient's signature on the consent form. It is about the entire interactive communication process for ensuring a patient fully understands the proposed healthcare and has, where appropriate, supportive information to make an informed decision whether to agree or not.*³¹

*Where patients are given information in writing, or through other media, it is not sufficient to rely only on this material. In the interests of best practice, health practitioners should still discuss the significant or material risks with the patient and provide them with an opportunity to have any questions answered.*³²

Specifically in relation to obstetric and gynaecological treatment in Australia, the RANZCOG statement *Consent and provision of information to patients in Australia regarding proposed treatment* summarises the applicable legal principles and guidelines for informed consent. The statement addresses competence to consent and the duty to inform patients of risks, stating:

The law requires that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment.

*A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, OR if the medical doctor is aware, or should be reasonably be aware, that the particular patient, if warned of the risk, would be likely to attach significance to it.*³³

³⁰ Queensland Health, *Queensland Health Guide to Informed Decision Making in Healthcare*, Queensland Government, Brisbane, 2012, p 2.

³¹ Queensland Health, *Queensland Health Guide to Informed Decision Making in Healthcare*, Queensland Government, Brisbane, 2012, p 2.

³² Queensland Health, *Queensland Health Guide to Informed Decision Making in Healthcare*, Queensland Government, Brisbane, 2012, p 2.

³³ RANZCOG, *Consent and provision of information to patients in Australia regarding proposed treatment*, July 2016, p 3.

3. Overview – Health (Abortion Law Reform) Amendment Bill 2016

3.1 Objective of the Bill

Mr Rob Pyne MP, independent Member for Cairns, introduced the Bill into the Legislative Assembly on 17 August 2016.

The objective of the Bill, as outlined in the Member's introductory speech and the explanatory notes, is to improve clarity for health practitioners and patients regarding abortions. The explanatory notes state that 'it is evident that practices in Queensland around medical termination of pregnancy are inconsistent and confusing'. The Bill seeks to ensure clear and uniform processes, particularly regarding 'when care can be imparted' to avoid prolonged approval and ethics processes.³⁴

Judge McGuire commented on the uncertainty of the current law in his ruling on *R v Bayliss and Cullen*:

*This ruling serves to illustrate the uncertainty of the present abortion laws of Queensland. It will require more imperative authority (either the Court of Appeal or Parliament) to effect changes if changes are thought to be desirable or necessary with a view to amending and clarifying the law.*³⁵

Stakeholders' views about the effect of uncertainty of the law were canvassed in the committee's report on the first Bill and terms of reference.³⁶

Bill proposes to amend the Health Act

To achieve the stated objective of the Bill, it proposes to amend the *Health Act 1937* (the Health Act) to reform the law relating to abortion by inserting a new Part 3 in that Act. The proposed amendments in the Bill are discussed in the following chapters of this report and concern:

- who may lawfully perform an abortion (proposed section 20) – chapter 4
- abortion after 24 weeks gestation (proposed section 21) – chapter 5
- conscientious objection and health practitioner's duty to perform or assist with an abortion only to save a woman's life or prevent serious physical injury to a woman (proposed section 22) – chapter 6
- patient protection or prohibition of certain behaviour within a zone around an abortion facility, (sometimes called 'safe-access' zones) and publication of images of persons entering or leaving an abortion facility (proposed sections 23 to 25) – chapter 7.

3.2 Consultation during development of the Bill

The explanatory notes state:

*This issue [abortion] has been debated for many years and never more widely than in 2016. Passionate individuals and organisations have had their say and while further consultation will take place while the Bill is in Committee, the main task will be consolidating and organising the results of existing consultation, which has been wide and extensive.*³⁷

During a public briefing to the committee on 21 September 2016, Mr Pyne MP indicated that the Bill was a result of local community consultation both in his electorate and more widely, and that a working group was involved in the development of the Bill.³⁸

³⁴ Explanatory notes, p 1.

³⁵ *R v Bayliss and Cullen* (1986) 9 Queensland Lawyer Reports 8, p 124.

³⁶ The committee's report on the first Bill and terms of reference can be found at

<http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2016/5516T1337.pdf>

³⁷ Explanatory notes, p 1.

³⁸ Public briefing transcript, Brisbane, 21 September 2016, pp 3 – 4.

4. Who may perform an abortion – proposed section 20

4.1 Overview of the proposed new section

Proposed section 20, inserted by clause 4 of the Bill, would make it an offence for anyone other than a doctor, or registered nurse administering a drug at the direction of a doctor, to perform an abortion. A registered nurse is defined in the Bill as a person registered under the Health Practitioner National Law to practice in the nursing or midwifery profession or as a midwife, other than as a student.

The offence, if any other person performed an abortion, would attract a maximum penalty of 10 years imprisonment. However, proposed subsection 20(3) creates an exception to that offence. It provides that a woman who performs an abortion on herself, or who consents to or assists in an abortion on herself does not commit an offence against proposed section 20.

4.2 Current regulation and rules in Queensland

4.2.1 Who may perform an abortion

Under the Criminal Code any person who unlawfully administers a poison or noxious thing, or uses any force or other means with the intent of procuring an abortion commits an offence.³⁹ Supplying drugs, unlawfully, to procure an abortion is also a criminal offence.⁴⁰ As noted in chapter 2, a defence is available under section 282 of the Criminal Code for health practitioners who perform an abortion where they honestly and reasonably believe an abortion is necessary to prevent serious danger to the woman's physical or mental health.⁴¹ This defence only applies to health practitioners, anyone who is not a health practitioner who performs an abortion in any circumstance commits an offence.

Surgical abortion

Who may perform a surgical abortion is currently regulated by legislative restrictions on who may call themselves a doctor, medical practitioner or surgeon, and by the credentialing of those health practitioners and the definition of their scope of practice in a particular hospital or health facility.

Health practitioners, in public and private health facilities, must be credentialed for the scope of clinical practice in which they can provide safe, high quality health care. The ACSQHC defines credentialing as:

...the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments. These processes are generally mandatory for specialist medical practitioners in the public and private hospital sector.

Health services (public and private) follow the ACSQHC Standard for Credentialing and Defining the Scope of Clinical Practice,⁴² and Queensland Health's Clinical Services Capability Framework (CSCF).⁴³

Credentialing regulates which clinicians are authorised to perform procedures, and the CSCF regulates requirements for clinics and hospitals to provide clinical services such as surgery (eg workforce requirements, access to related services).

³⁹ *Criminal Code*, s 224.

⁴⁰ *Criminal Code*, s 226.

⁴¹ *Criminal Code*, s 282, and Queensland Health, *Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013.

⁴² Australian Commission on Safety and Quality in Health Care, *Standard for Credentialing and Defining the Scope of Clinical Practice*, Commonwealth of Australia, 2004.

⁴³ Queensland Health, *Clinical Services Capability Framework*, www.health.qld.gov.au/system-governance/licences/private-health/cscf/default.asp.

Medical abortion

The drugs used for medical abortions, like all medications, are classified under the *Standard for the Uniform Scheduling of Medicines and Poisons* in accordance with the recommended level of control on their public availability. The abortifacients, mifepristone and misoprostol, are classified as Schedule 4 drugs, which in Queensland are defined as restricted drugs.⁴⁴

Restricted drugs may only be administered, dispensed, issued, prescribed or sold by a person who is authorised to do so under the Health (Drugs and Poisons) Regulation 1996.⁴⁵ Persons authorised to administer restricted drugs include doctors, registered nurses, nurse practitioners and midwives.⁴⁶ Drug therapy protocols outline the circumstances and conditions under which nurse practitioners and midwives may administer or prescribe restricted drugs.⁴⁷ Additionally, pharmacists may dispense and sell restricted drugs, and in hospital pharmacies may supply them on instruction from a doctor or nurse practitioner.⁴⁸

Therefore, under the current regulations, doctors, registered nurses, nurse practitioners and midwives may administer mifepristone and misoprostol. Pharmacists are also currently authorised to dispense, sell, and in hospital pharmacies to supply, mifepristone and misoprostol.

4.2.2 Woman procuring her own abortion

A woman who unlawfully administers to herself a poison or noxious thing, or uses any force or other means with intent to procure her own abortion commits an offence under section 225 of the Criminal Code. Allowing another person to administer such a thing or means, or to use force with the intention of procuring her own abortion is also an offence.⁴⁹ There is no legal defence for a woman seeking an abortion, the section 282 defence does not apply to a woman procuring her own abortion.⁵⁰

4.3 Regulation in other jurisdictions

4.3.1 Victoria

In Victoria an abortion may legally be performed by a registered medical practitioner,⁵¹ which is defined as a medical practitioner registered to practice in the medical profession under the *Health Practitioner Regulation National Law (Victoria) Act 2009*.⁵²

Any registered pharmacist or registered nurse who is legally authorised to supply an abortifacient, may administer or supply the drug if the woman is not more than 24 weeks pregnant.⁵³ If the woman is more than 24 weeks pregnant, a registered pharmacist or registered nurse may only administer or supply an abortifacient if they are employed or engaged by a public hospital, private hospital or day procedure centre, and they have written direction from a registered medical practitioner.⁵⁴

⁴⁴ *Poisons Standard November 2016*, sch 4, Health (Drugs and Poisons) Regulation 1996, app 9.

⁴⁵ Health (Drugs and Poisons) Regulation 1996, s 146.

⁴⁶ Health (Drugs and Poisons) Regulation 1996, ss 161, 167 and 175.

⁴⁷ Queensland Health, *Drug Therapy Protocol – Nurse Practitioners*, April 2014, Queensland Health, *Drug Therapy Protocol – Midwife*, July 2016.

⁴⁸ Health (Drugs and Poisons) Regulation 1996, s 171.

⁴⁹ *Criminal Code*, s 225.

⁵⁰ Katherine Kerr, 'Queensland abortion laws: Criminalising one in three women', *QUT Law Review*, 2014, 14(2), p 22.

⁵¹ *Abortion Law Reform Act 2008* (Vic), ss 4, 5.

⁵² *Abortion Law Reform Act 2008* (Vic), s 3, *Health Practitioner Regulation National Law (Victoria) Act 2009*.

⁵³ *Abortion Law Reform Act 2008* (Vic), s 6.

⁵⁴ *Abortion Law Reform Act 2008* (Vic), s 7.

Any person who is not qualified who performs an abortion is guilty of a crime and liable for a maximum penalty of 10 years imprisonment.⁵⁵ However, there is an exemption in the *Crimes Act 1958* specifying that a woman who consents to or assists in the performance of an abortion on herself is not guilty of an offence.⁵⁶

4.3.2 New South Wales

The law in New South Wales is similar to the current Queensland law. Under the *Crimes Act 1900* (NSW) abortion is unlawful, however, judicial decisions mean that abortion is lawful with the woman's consent if a doctor has an honest belief based on reasonable grounds that the procedure is necessary to preserve the woman from serious danger to her life, or physical or mental health. Those grounds may be medical, economic or social. The abortion procedure must not be out of proportion to the danger intended to be avoided.⁵⁷

4.3.3 Tasmania

In Tasmania an abortion may legally be performed by a medical practitioner,⁵⁸ it is a criminal offence for anyone else to perform an abortion.⁵⁹ A medical practitioner is defined as 'a person registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession'.⁶⁰

There is express legal protection which specifies that a woman who consents to, assists in or performs an abortion on herself is not guilty of a crime or any other offence.⁶¹

4.3.4 Australian Capital Territory

An abortion may be legally performed in the Australian Capital Territory by a doctor.⁶² Any person who is not a doctor who performs an abortion is liable for a maximum penalty of 5 years imprisonment.⁶³

There is no specified exception to exclude from liability a woman who performs an abortion on herself.

4.3.5 Western Australia

In Western Australia abortion is a criminal offence unless it is performed by a medical practitioner.⁶⁴ A medical practitioner is defined as 'a person registered under the Health Practitioner Regulation National Law (Western Australia) in the medical profession'.⁶⁵ Any person who is not a medical practitioner who performs an abortion is guilty of a crime and is liable for a maximum penalty of 5 years imprisonment.⁶⁶

There are no specified exceptions excluding liability for an offence for a woman who performs an abortion on herself.

4.3.6 South Australia

Procuring an abortion is a criminal offence in South Australia, however in prescribed circumstances a legally qualified medical practitioner may lawfully perform an abortion.⁶⁷ A legally qualified medical

⁵⁵ *Crimes Act 1958*, s 65(1).

⁵⁶ *Crimes Act 1958*, s 65(2).

⁵⁷ NSW Health, *Framework for Terminations in New South Wales Public Health Organisations*, http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_022.pdf

⁵⁸ *Reproductive Health (Access to Termination) Act 2013* (Tas), ss 4-5.

⁵⁹ *Criminal Code Act 1924* (Tas), s 178D.

⁶⁰ *Acts Interpretation Act* (Tas), s 46.

⁶¹ *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 8.

⁶² *Health Act 1993* (ACT), s 81.

⁶³ *Health Act 1993* (ACT), s 81.

⁶⁴ *Criminal Code Act Compilation 1913* (WA), s 199.

⁶⁵ *Health Act 1911* (WA), s 3.

⁶⁶ *Criminal Code Act Compilation 1913* (WA), s 199.

⁶⁷ *Criminal Law Consolidation Act 1935* (SA), s 82A.

practitioner is defined as ‘a person registered under the Health Practitioner Regulation National Law to practice in the medical profession’.⁶⁸

There are no specified exceptions excluding liability for a woman who performs an abortion on herself.

4.3.7 Northern Territory

Procuring an abortion is a criminal offence in the Northern Territory,⁶⁹ however in prescribed circumstances a medical practitioner may lawfully perform an abortion.⁷⁰ A medical practitioner is defined as ‘a person registered under the Health Practitioner Regulation National Law to practise in the medical profession’.⁷¹

4.4 Issues considered during the inquiry

4.4.1 Legislating who may perform an abortion

The majority of submitters and witnesses who made representations about who may perform an abortion agreed that only qualified, experienced and competent health practitioners should perform abortions.⁷²

However, concerns were raised that the Bill provides that only a doctor, or a registered nurse administering an abortifacient, may legally perform an abortion.⁷³ For example, Reproductive Choice Australia stated:

*We recommend against limiting the type of health professional who can provide abortion care services. The scope of practice for health professionals, particularly nurse practitioners, changes over time and this law may not be appropriate in years to come.*⁷⁴

In particular, concerns were raised regarding whether pharmacists could be exposed to legal liability for dispensing or supplying abortifacients. It was noted during a public hearing that legislation in Victoria specifically includes pharmacists and nurses. In response to questions on this issue, Professor Lindy Willmott stated:

*One of the challenges in drafting legislation is thinking about where you are drawing lines and not unintentionally leaving out people who may be deserving of protection under the law. In relation to medical terminations we considered that pharmacists may have some involvement.*⁷⁵

As noted above (4.2.1), nurse practitioners are currently authorised to administer or supply mifepristone and misoprostol under their defined scope of practice, without the written direction of a doctor.⁷⁶ Midwives are similarly authorised to administer or supply misoprostol without the written direction of a doctor (it should be noted that misoprostol is also used for clinical purposes other than abortion).⁷⁷ The Bill could potentially create a conflict between the existing authorities for nurse practitioners and midwives to administer or supply abortifacients, and may prevent the continuation of those authorities in relation to those drugs.

The Bill also does not provide any protection from a criminal offence for a pharmacist who dispenses or supplies mifepristone and misoprostol. To meet the Bill’s objective of improving clarity for health

⁶⁸ Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011 (SA), s 3.

⁶⁹ *Criminal Code Act (NT)*, ss 208B and 208C.

⁷⁰ *Medical Services Act (NT)*, s 11.

⁷¹ *Interpretation Act (NT)*, s 3.

⁷² See for example submissions 45, 702, 871, 880, 904, 1024, 1209 and 1267.

⁷³ See for example submissions 871, 880, 904, 1024 and 1267.

⁷⁴ Submission 1209, p 1.

⁷⁵ Public hearing transcript, Brisbane, 28 October 2016, p 69.

⁷⁶ Health (Drugs and Poisons) Regulation 1996; Queensland Health, *Drug Therapy Protocol – Nurse Practitioners*, April 2014.

⁷⁷ Health (Drugs and Poisons) Regulation 1996; Queensland Health, *Drug Therapy Protocol – Midwife*, July 2016.

practitioners, some amendments may be needed to clarify whether pharmacists would be permitted to continue to dispense and sell, and in hospital pharmacies to supply, abortifacients.⁷⁸

4.4.2 Criminal liability for a woman procuring her own abortion

Views diverged on whether a woman should be legally protected from an offence for performing an abortion on herself, or consenting to or assisting in the performance of an abortion on herself. Proposed section 20(3) provides that a woman would not commit an offence by performing an abortion on herself or consenting to or assisting in an abortion on herself.

Medical abortion generally uses a combination of mifepristone and misoprostol, most often in early pregnancy, and commonly on an outpatient basis under medical supervision. Some submitters supported proposed section 20(3) on the basis that it would clarify the law in relation to medical abortion. The RANZCOG submission stated that '[w]here a woman elects to have a medical abortion, it may be perfectly appropriate for her to self-administer the medication under medical supervision'.⁷⁹

Some submitters expressed the view that legislation that provides that a woman who procures her own abortion is not criminally liable 'flies in the face of common sense'⁸⁰ and would permit 'backyard abortions'.⁸¹ Concerns were also raised that such an exception is contradictory to the requirement that only a qualified health practitioner may perform an abortion.⁸²

Submitters also suggested that the offence in the Criminal Code acts as a 'deterrent to women self-administering [an abortion] without any medical supervision',⁸³ and that amending the legislation was unnecessary as 'in the 117 years of this law's existence, no woman who has had an abortion has ever been jailed or even convicted'.⁸⁴

Other submitters supported the amendment in proposed section 20(3) to specify that a woman does not commit an offence by performing, consenting to or assisting in the performance of an abortion on herself.⁸⁵ One submitter stated the amendment 'would support the dignity and privacy of the woman and concerned others when she has made the very personal decision to have an abortion'.⁸⁶

True Relationships and Reproductive Health raised some doubt as to whether proposed section 20(3) would protect a woman against prosecution in circumstances similar to the case of *Leach v Brennan*. Their submission stated that the provision:

*... could potentially protect a woman against allegations of illegal procurement, such as the Cairns case of R v Leach and Brennan (2010). This protection is essential for women to safely access and administer of [sic] medical abortion.*⁸⁷

In response to a question about subclause 20(3) Professor Lindy Willmott raised concerns that the provision may be too narrow to protect a woman from prosecution:

I certainly see a need for any amendment to make it clear that women would not be committing an offence to procure their own abortion. We raise a concern that subclause (3) appears to protect a woman only if the procedure was terminated by someone who was not qualified to do so – that is, within the ambit of clause 20.

⁷⁸ Health (Drugs and Poisons) Regulation 1996, s 171.

⁷⁹ RANZCOG, submission 908, p 2.

⁸⁰ Donna Purcell, submission 811, p 1.

⁸¹ Australian Christian Lobby, submission 1033; Jenny Conomos, submission 1083.

⁸² See for example submissions 42, 874, 875, 898, 900, 1040 and 1083.

⁸³ John and Susan Kirk, submission 1006, p 2.

⁸⁴ Margaret Farley, submission 859, p 2. See also submissions 539, 811, 836, 856, 867, 884, 1214, 1006, 1030 and 1031.

⁸⁵ See for example submissions 565, 904, 908, 1012, 1014, 1021, 1042 and 1267.

⁸⁶ NAAPOC, submission 904, p 1.

⁸⁷ True Relationships and Reproductive Health, submission 1014, p 2

It was also submitted that clarity 'would be best achieved by decriminalising abortion in Queensland by removing [the offence] from the Criminal Code',⁸⁸ and that if the Bill was passed without removing the offence from the Criminal Code, uncertainty regarding criminal liability may remain.⁸⁹

⁸⁸ Lindy Willmott, Ben White and Penny Neller, submission 1267, p 3.

⁸⁹ See for example submissions 1014 and 1267.

5. Abortion after 24 weeks gestation – proposed section 21

5.1 Overview of the proposed new section

The Bill proposes to introduce specified requirements for abortions after 24 weeks gestation. Under proposed new section 21, if a woman is more than 24 weeks pregnant a medical practitioner may only perform, or direct a registered nurse to perform, an abortion if:

- the doctor reasonably believes the continuation of the pregnancy involves a greater risk of injury to the woman’s physical or mental health than if the pregnancy were terminated, and
- the doctor has consulted at least one other doctor who concurs.

The Bill does not introduce an offence for failing to comply with the requirements of proposed section 21. A note in the Bill states that a failure to comply with the section is not an offence but may be behaviour that is subject to the Health Practitioner Regulation National Law or the *Health Ombudsman Act 2013*. Action under those Acts has the potential to result in disciplinary action against a medical practitioner. The explanatory notes state that proposed section 21 draws on the Victorian legislation.

5.2 Current regulation and requirements in Queensland

As outlined in chapter 2 of this report, the Queensland Criminal Code makes abortion unlawful, except in circumstances set out in court judgements which have interpreted the Criminal Code.

Clinical guidelines currently regulate the procedural requirements for all abortions (in both public and private hospitals and clinics) including those performed after 24 weeks gestation.⁹⁰ (See section 2.4.2 of this report for a summary of the requirements for licensed private health facilities). All abortions after 24 weeks gestation in Queensland are performed in public hospitals.

The clinical guidelines suggest that in all cases ‘two medical specialists, one of whom must be a specialist obstetrician, consider the circumstances of each individual case’. One specialist should be the practitioner relevant to the particular case. Where there are complex issues, such as late gestation, the guideline suggests a case review with the involvement of the treating obstetrician and another health practitioner such as a social worker, general practitioner, psychiatrist, maternal foetal medicine specialist or paediatrician.⁹¹ The local facility approval requirements, should also be considered such as approval from the Executive Director of Medical Services.⁹²

5.3 Regulation in other jurisdictions

5.3.1 Victoria

In Victoria specific requirements apply to abortion after 24 weeks gestation. A registered medical practitioner may perform an abortion on a woman who is not more than 24 weeks pregnant on request.⁹³ After 24 weeks, an abortion may only be performed where the practitioner:

- reasonably believes that the abortion is appropriate in the circumstances, and
- has consulted at least one other practitioner who also reasonably believes the abortion is appropriate in the circumstances.⁹⁴

In considering whether abortion is appropriate, the practitioner must consider the relevant medical

⁹⁰ Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013.

⁹¹ Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 9.

⁹² Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 9.

⁹³ *Abortion Law Reform Act 2008* (Vic), s 4.

⁹⁴ *Abortion Law Reform Act 2008* (Vic), s 5(1).

circumstances and the woman's current and future physical, psychological and social circumstances.⁹⁵

5.3.2 New South Wales

As noted in section 4.3.2, New South Wales law is similar to current Queensland law. Under the *Crimes Act 1900* (NSW) abortion is unlawful, however, judicial interpretation means that abortion is lawful if the procedure is necessary to preserve the woman from serious danger to her life, or physical or mental health.⁹⁶ Like Queensland, the law does not differentiate according to the period of gestation.

5.3.3 Tasmania

Specific requirements apply in Tasmania after gestation of 16 weeks. A medical practitioner may perform an abortion on a woman who is not more than 16 weeks pregnant on request.⁹⁷

After 16 weeks, an abortion may only be performed where the medical practitioner, and one other medical practitioner, reasonably believes continuing the pregnancy would involve greater risk of injury to the woman's physical or mental health than if an abortion were performed. In assessing the risk, they must have regard to the woman's physical, psychological, economic and social circumstances. At least one of the medical practitioners must specialise in obstetrics or gynaecology.⁹⁸

5.3.4 Western Australia

Western Australian law applies different requirements for abortion after 20 weeks gestation. Prior to 20 weeks gestation, an abortion may be performed if continuing the pregnancy will cause the woman to suffer serious personal, family or social consequences or result in serious danger to the woman's physical or mental health.⁹⁹

After 20 weeks, an abortion may only be performed where two medical practitioners, who are members of a panel appointed by the Minister, have agreed that the woman, or the unborn child, has a severe medical condition that, in the clinical judgment of the practitioners, justifies the procedure.¹⁰⁰

5.3.5 South Australia

South Australia has different requirements for abortions depending on whether a child is capable of being born alive, which is deemed to occur from 28 weeks gestation. In circumstances where the foetus has not yet become a child capable of being born alive, an abortion may be performed if:

- a legally qualified medical practitioner, and one other practitioner, have personally examined the woman and are of the opinion that:
 - the continuation of the pregnancy involves greater risk to the woman's life, or injury to her physical or mental health, than if an abortion were performed, or
 - there is a substantial risk that if an abortion was not performed, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.
- a legally qualified medical practitioner is of the opinion that an abortion is immediately necessary to save the woman's life, or prevent grave injury to her physical or mental health.¹⁰¹

In circumstances where the foetus has become a child capable of being born alive, including from 28 weeks gestation, an abortion may be performed only to preserve the woman's life.¹⁰²

⁹⁵ *Abortion Law Reform Act 2008* (Vic), s 5(2).

⁹⁶ NSW Health, *Framework for Terminations in New South Wales Public Health Organisations*, http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_022.pdf

⁹⁷ *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 4.

⁹⁸ *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 5.

⁹⁹ *Health Act 1911* (WA), s 334(3).

¹⁰⁰ *Health Act 1911* (WA), s 334(7).

¹⁰¹ *Criminal Law Consolidation Act 1935* (SA), s 82A(1).

¹⁰² *Criminal Law Consolidation Act 1935* (SA), s 82A(7).

5.3.6 Northern Territory

In the Northern Territory different requirements for abortions apply depending on the gestation period. Prior to 15 weeks gestation, an abortion may be performed if:

- a medical practitioner and one other practitioner, one of whom is a gynaecologist or obstetrician, are of the opinion, formed in good faith, that:
 - the continuation of the pregnancy involves greater risk to the woman’s life, or injury to her physical or mental health, than if an abortion were performed, or
 - there is a substantial risk that if an abortion was not performed, the child would be seriously handicapped because of physical or mental abnormalities, or
- a medical practitioner is of the opinion that an abortion is necessary to save the woman’s life.¹⁰³

From 15 to 23 weeks an abortion may be performed if a medical practitioner is of the opinion that an abortion is immediately necessary to prevent serious harm to the woman’s physical or mental health, or to save her life. From 24 weeks an abortion may only be performed for the purpose of saving the woman’s life.¹⁰⁴

5.3.7 International jurisdictions – gestation and decisions about lawful abortion

The law in other western countries varies considerably in the number of week’s gestation and the circumstances in which abortion is lawful. A selection of the gestational limits and circumstances is shown in Table 1.

Table 1. International jurisdictions: Summary of number of week’s gestation and circumstances where abortion is lawful

Canada	Abortion legally unrestricted since 1988; no legally specified gestational limits
United States of America	Constitutional right to abortion up to foetal viability; after viability a state may override the right. Abortion prohibited in 43 states unless necessary to protect woman’s life or health; gestational limit is most often foetal viability, but in some states is 20 or 24 weeks or the third trimester.
England, Wales & Scotland	Up to 25 weeks, abortion available if two doctors consider necessary to prevent greater risk of injury than abortion to woman’s physical or mental health or existing children, or if substantial risk such as physical or mental abnormalities to the child as to be seriously handicapped From 25 weeks, if two doctors consider necessary to prevent grave permanent injury to woman’s physical or mental health; or one doctor considers it immediately necessary to save woman’s life or prevent grave permanent injury
New Zealand	Up to 20 weeks gestation abortion is available if two doctors certify that continuing the pregnancy would result in serious danger to woman’s life or physical or mental health; substantial risk that the child would be so mentally or physically abnormal as to be seriously handicapped; pregnancy results from incest or unlawful sexual intercourse with a young family member, or the mother is severely mentally sub-normal. After 20 weeks, available if two doctors certify it is necessary to save the life of the mother or prevent serious permanent injury to her physical or mental health.
Belgium	Up to 12 weeks gestation, abortion available if the pregnancy causes a state of distress for the woman. From 12 weeks, available if two doctors are of the opinion there is a serious risk to the health of the woman or an extremely serious and incurable disease of the foetus.
Denmark	Up to 12 weeks, abortion is available on request From 12 weeks, available if continuation of pregnancy would risk the mother’s physical or psychological health; the pregnancy resulted from a criminal act; there is a great risk the child will suffer a serious disease caused by genetic predisposition or by harmful effects during pregnancy; the mother cannot provide the child with the required care due to illness or her immaturity; or pregnancy, delivery or care of the child is expected to cause a serious and unavoidable burden on the mother such that it is in her / her family’s interests to terminate

¹⁰³ *Medical Services Act (NT)*, s 11(1), (2)

¹⁰⁴ *Medical Services Act (NT)*, s 11(3), (4).

France	Up to 12 weeks abortion is available if the woman is in a state of distress. From 12 weeks, available with the approval of two doctors and a psychologist/social worker, if continuation of pregnancy poses a serious risk to the woman's health, or if a strong probability the child will suffer from a severe illness recognised as incurable. Woman must be offered counselling; waiting period of one week between consultation and abortion.
Germany	Up to 12 weeks, abortion available after mandatory counselling or if pregnancy resulted from a sexual crime. 13 to 22 weeks, available if medically necessary to prevent danger to the woman's life or grave injury to physical or mental health, and danger cannot be averted in another way from her point of view.

Source: Queensland Parliamentary Library, *Research Brief: Comparative tables of abortion legislation*, available at <http://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/18-HealthAbortion/18-bp-29Nov2016-LibRes.pdf>

5.4 Issues considered during the inquiry

5.4.1 Legislating gestational restrictions

Some submitters questioned the need for legislation to include restrictions on abortion based on gestation, and argued that such limits are arbitrary.¹⁰⁵ As outlined above, legislation in other Australian jurisdictions uses different gestation periods to differentiate the decision making requirements for a lawful abortion.

Submitters suggested that it is the role of medicine to guide pregnancy management, with any gestational limits defined in clinical guidelines to ensure best practice according to clinical management and medical technology.¹⁰⁶ For example Dr David McFarlane stated:

*...no gestational age restrictions [should] be placed on abortion, because the very uncommon later term abortions involve peculiar and rare circumstances that legislation could only complicate and make more traumatic for the families involved in making terribly difficult decisions about these pregnancies.*¹⁰⁷

While concurring that there should be no gestational limits, other submitters supported proposed requirements for abortions after 24 weeks gestation in the interest of addressing community concerns.¹⁰⁸ For example Pro Choice Queensland submitted it 'would ideally like no gestational limits imposed in legislation. However, we understand there is community concern around this issue and we would therefore support this clause'.¹⁰⁹

At a public hearing Ms Frances from the Australian Christian Lobby described the provision of the Bill which imposes different requirements for a lawful abortion after 24 weeks as 'arbitrary'. Ms Francis also suggested that best practice globally should be examined and noted that 12 weeks appears in the law of a number of European countries, such as Belgium, Denmark, France and Germany.¹¹⁰

Other submitters argued that 24 weeks was arbitrary because there 'should be an absolute ban on all late-term abortions'.¹¹¹ Those submitters stated that abortions after 24 weeks gestation should never occur as 'there is no reason why abortion would be required beyond 24 weeks gestation to deal with

¹⁰⁵ See for example submissions 701, 864, 879, 904, 905, 1007 and 1038.

¹⁰⁶ See for example submissions 1014 and 1209.

¹⁰⁷ Submission 809, p 3.

¹⁰⁸ See for example submissions 565, 812, 861, 880, 1004, 1008, 1012, 1021 and 1024.

¹⁰⁹ Submission 874, p 3.

¹¹⁰ Record of proceedings, 27 October 2016, p 35. See Table 1 above for a summary of requirements based on gestation in some European countries. Some provide that abortion is available after 12 weeks if one or two doctors' opinion is that abortion is necessary to avert serious physical or mental health risk to the woman, or if there is an incurable foetal disease

¹¹¹ See for example submissions 5, 8, 836, 859, 867, 869, 872, 884, 889, 890, 1002, 1003, 1006, 1013, 1030 and 1031.

foetal anomaly'.¹¹² Dr van Gend said 'It is equally wrong to have an abortion at eight weeks if it is unnecessary—if it is purely on demand', rather than based on saving a woman's life.¹¹³

Professor Permezel, RANZCOG, confirmed that the seriousness of some foetal abnormalities (which may affect a woman's physical or mental health) may not be apparent until later than 24 weeks gestation.¹¹⁴

5.4.2 Requirements for abortions after 24 weeks gestation

After 24 weeks gestation the Bill enables a doctor to perform an abortion if the doctor forms a reasonable belief that continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the woman than if the pregnancy were terminated. In addition, the treating doctor would be required to consult at least one other doctor who also believes that continuing the pregnancy would involve greater risk of injury to the woman's physical or mental health than an abortion. This requirement was criticised by a number of submitters and witnesses.

Some submitters and witnesses raised concerns about the potential for collusion or conflict of interest, or for the second doctor to 'rubber stamp' a proposed abortion without proper consideration of the circumstances or an examination of the woman. Those submitters argued that proposed section 21 did not provide adequate safeguards for the woman as there is no requirement for the second doctor to be independent or to physically examine the woman.¹¹⁵ For example, the Australian Family Association – Queensland submitted:

*The requirement that abortions after 24 weeks have to be approved by two doctors is just a sham and a façade, as the second doctor is not required to see or speak to the patient, or even look at her file. Also, the second doctor does not have to be independent so it could be that the two doctors at an abortion clinic who would profit from the procedure would approve the late-term abortion.*¹¹⁶

As noted above, late term abortions in Queensland are performed in public hospitals. Licensed private health facilities only perform abortions up to 20 weeks gestation in accordance with the Queensland Health CSCF.¹¹⁷

Dr Ray Campbell, Director, Queensland Bioethics Centre, stated:

*...the second doctor does not even have to examine the patient. It can be a phone call. There is no protocol given as to how that doctor gives their view. It could be two doctors from the same clinic. It just opens itself, in my mind, to subterfuge or just having a nice way out of it. Normally when you seek a second opinion regarding something, you at least see the doctor who is giving the second opinion.*¹¹⁸

The committee explored whether the requirement for consultation with a second doctor should require a face to face consultation with the patient. Some stakeholders argued that a medical consultation should be required; for example Dr Campbell said:

I believe that getting a second opinion is required because it is supposed to be a termination in light of a serious threat to the woman's physical or mental health. I do not think that can be established simply through the sharing of records or one doctor sharing his point of view. I think that it takes a patient-to-doctor examination. That is something we see in various other areas of

¹¹² Ciara Ross, submission 856, p 3.

¹¹³ Record of proceedings, 7 November 2016, p 4

¹¹⁴ Record of proceedings, 27 October 2016, Brisbane, p 27.

¹¹⁵ See for example submissions 8, 20, 122, 811, 834, 836, 841, 867, 870, 872, 884, 889, 890, 1003, 1006, 1015, 1016, 1030, 1031, 1034 and 1038.

¹¹⁶ Submission 1030, p 6.

¹¹⁷ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland*, p 38; Public hearing transcript, Brisbane, 4 August 2016, p 8.

¹¹⁸ Public hearing transcript, Brisbane, 27 October 2016, p 18.

*medicine all the time. If you go for a second opinion it is normal that it involves a face-to-face meeting.*¹¹⁹

Other stakeholders argued that it was unnecessary to legislate a requirement for the treating doctor to consult with at least one other doctor as ‘doctors already are required to prioritise the wellbeing of their patients, and seek appropriate support from colleagues.’¹²⁰ Concern was also raised that the requirement may ‘undermine the doctor-patient relationship, and be offensive to the strict and high standards of professional care Australian doctors must abide by’.¹²¹

Professor Michael Permezel, President of RANZCOG, expressed the view that consultation with another doctor ‘should be discretionary’ but acknowledged that ‘the community feels more comfortable with the second doctor as is currently worded in the provision’.¹²²

Professor Permezel argued that it should not be compulsory for the woman to be examined by the second doctor, and that the circumstances should determine whether an examination was required. A woman is likely to be facing a difficult decision about termination:

...forcing her to a second doctor it is like ... ‘I’m a terrible person and I’ve now come to you to beg for a termination of pregnancy,’ it really puts a woman in an appalling situation. What happens in reality is that if the first doctor is very confident with the decision, then speaks to a colleague who signs off.

*If it is a case note review in a straightforward case ... there is no need to drag the woman in. ... Some of them are just so obvious – you have the genetic report or whatever – that a second doctor can confidently sign off and in other cases it will be necessary to see the woman.*¹²³

In response to committee questions, Dr Alex Markwell from the Australian Medical Association Queensland noted that the issue is addressed by the current clinical guideline:

*As the guideline currently is written, it describes that there are two medical specialists, one of whom must be a specialist obstetrician and, ideally, one of those specialists should be the practitioner performing or overseeing the procedure. The speciality of the second medical practitioner should be relevant to the circumstances of the individual case, so that would encompass the many complexities ... There are also other clinicians who may be involved, depending on the circumstances.*¹²⁴

Some submitters also criticised the Bill because a doctor who failed to comply with the requirement to consult another doctor would not commit an offence, but may be subject to action under the Health Practitioner Regulation National Law or the *Health Ombudsman Act 2013*.¹²⁵ One submitter said that a ‘law without consequences is no law at all.’¹²⁶ Another suggested the absence of a penalty was ‘window-dressing’.¹²⁷

Potential disciplinary actions against a doctor include cancellation or suspension of their registration to practice, the imposition of conditions on their practice, fines, and reprimands.

¹¹⁹ Public hearing transcript, 27 October 2016, p 21 and communication with the Office of the Chief Health Officer, 6 February 2017

¹²⁰ See for example submissions 52 and 701.

¹²¹ Submission 52, p 4.

¹²² Public hearing transcript, Brisbane, 28 October 2016, p 31.

¹²³ Public hearing transcript, Brisbane, 28 October 2016, p 31.

¹²⁴ Public hearing transcript, Brisbane, 28 October 2016, p 44.

¹²⁵ See for example submissions 8, 20, 122, 811, 869, 884, 881, 889, 890, 1006, 1015, 1016, 1028 and 1030.

¹²⁶ Submission 869, p 1

¹²⁷ Submission 1015

5.4.3 Foetal abnormality as a reason for abortion

Some submitters and witnesses raised concerns that the Bill does not adequately address the situation where an abortion may be requested due to a severe foetal abnormality,¹²⁸ and a woman consequently is 'coached' to 'say that she cannot cope or is mentally unstable' to access an abortion.¹²⁹

Dr Joseph Thomas stated:

In a sense, the pathway now is tortuous, because they have to go to an ethics committee at the Royal. They have to pretend to be a little bit unable to cope and have psychiatric grounds on mental health or physical reasons, not based on foetal abnormality. I think that is hiding behind the facts. If there is a foetal abnormality that the parents are needing a termination for, that should be stated as such and not a termination occurring based on a maternal condition.¹³⁰

...we don't have a current law in Queensland that allows termination on foetal abnormalities and I think it is time for us to have that.¹³¹

Similarly Dr Renuka Sekar stated:

...the law should make it clearer for both practitioners and patients who sometimes, due to the baby's abnormalities, request termination of pregnancy. It is not addressed at all. Congenital abnormalities or foetal abnormalities are not in the law at all. It makes it very cloudy for both the patient and the practitioner.¹³²

Professor Permezel, representing RANZCOG, expressed a different view, suggesting that a foetal abnormality should not be the basis for abortion:

We actually do not strongly support that a foetal condition should be grounds for termination. I think the reason for that is that it is offensive. ... I think it is offensive to those children and their parents if the abnormality itself becomes grounds for termination. It is much preferred if it is the impact of that abnormality on the woman and her family that is the grounds, not actually the abnormality itself.

If there is not that negative impact on the woman and/or her family, then I do not think the termination should take place.¹³³

Professor Permezel also confirmed that the seriousness of some foetal conditions, for example cytomegalovirus infection, may not be apparent until later in pregnancy. He said:

At 20 weeks gestation you may know that the foetus has that infection but you will not yet know how seriously it is affected. By 30 weeks, you are getting a very good idea through ultrasound assessment of foetal brain development and whether or not that foetus is seriously affected by that condition. We think it is totally unreasonable for any legal framework to impose the necessity of the woman to be making that decision before she knows what is going to happen.¹³⁴

¹²⁸ See for example submissions 1179 and 1267.

¹²⁹ Dr Joseph Thomas, public hearing transcript, Brisbane, 27 October 2016, p 62.

¹³⁰ Public hearing transcript, Brisbane, 27 October 2016, p 57.

¹³¹ Public hearing transcript, Brisbane, 27 October 2016, p 59.

¹³² Public hearing transcript, Brisbane, 28 October 2016, p 49.

¹³³ Public hearing transcript, Brisbane, 28 October 2016, p 27-28.

¹³⁴ Record of proceedings, 27 October 2016, Brisbane, p 27.

6. No duty to perform or assist in abortion except in emergency – proposed section 22

6.1 Overview of the proposed new section 22

Proposed section 22 of the Bill would provide that no one is under an obligation to perform or assist in performing an abortion unless an abortion is necessary in an emergency to save the woman's life or prevent her from suffering serious physical injury.

In an emergency, a doctor would be obliged to perform an abortion and a registered nurse has an obligation to assist. In all other circumstances a person would retain a right to refuse to assist in performing an abortion. There is no obligation in the Bill for a health practitioner who chooses not to perform abortions to refer a woman to another practitioner.

In effect the proposed sections legislate to enable the exercise of a conscientious objection, which occurs where a health practitioner 'refuses to provide, or participate in, a legally-recognised treatment or procedure because it conflicts with his or her own personal beliefs and values'.¹³⁵

6.2 Conscientious objection - current rules in Queensland

Clinical guidelines and professional codes currently regulate health practitioners' conscientious objection to abortion, in public and private health facilities.

Under the Queensland Health clinical guideline, *Therapeutic termination of pregnancy*, a health practitioner may choose not to provide abortion services on the basis of a conscientious objection, however, the guideline states that health care professionals have a professional responsibility to ensure appropriate transfer of care occurs in a reasonable time frame in the circumstances.¹³⁶

The Medical Board of Australia's *Good Medical Practice: a Code of Conduct for Doctors in Australia* states that doctors may decline to provide or participate in treatments to which they conscientiously object, and that in such circumstances good practice involves the doctor informing the patient of their objection, and not allowing their 'moral or religious views' to deny or impede patients' access to medical care.¹³⁷

The AMA's *Position Statement – Conscientious Objection* acknowledges that doctors 'are entitled to have their own personal beliefs and values' and that in 'exceptional circumstances, and as a last resort, a doctor may refuse to provide, or participate in, certain medical treatments or procedures that conflict with his or her own personal beliefs'.¹³⁸ Where a doctor has a conscientious objection to providing, or participating in, a procedure, the position statement requires the doctor to take the following steps:

- inform the patient of the objection as soon as practicable, and advise them they have a right to see another doctor
- take any necessary steps to ensure access to care is not impeded, ensuring the patient has sufficient information
- continue treating the patient with dignity and respect
- provide the patient with other care if they wish, and
- refrain from expressing personal beliefs to the patient in a way that may cause distress.¹³⁹

¹³⁵ Australian Medical Association, *Position Statement – Conscientious Objection*, 2013, p 1.

¹³⁶ Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8.

¹³⁷ Medical Board of Australia, *Good medical practice: A code of conduct for doctors in Australia*, March 2014, p 7.

¹³⁸ Australian Medical Association, *Position Statement – Conscientious Objection*, 2013, p 1.

¹³⁹ Australian Medical Association, *Position Statement – Conscientious Objection*, 2013, p 1.

The position statement advises doctors to ‘always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with the doctor’s personal beliefs and values’.¹⁴⁰

The *Code of Ethics for Nurses in Australia* and Royal College of Nursing Australia’s *Conscientious Objection: Position Statement* include similar guidelines for nurses and midwives to those outlined above for doctors.

Conscientious objection as it relates to abortion services is also addressed in a RANZCOG position statement; it states that no health practitioner is expected to perform abortion services contrary to their personal convictions, however they have a ‘professional responsibility to inform patients where and how such services can be obtained’.¹⁴¹

6.3 Regulation in other jurisdictions – conscientious objection

6.3.1 Australia

Victoria, South Australia, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory have legislated that no person is under a duty to perform or assist in performing an abortion.¹⁴² However, in an emergency where an abortion is necessary to save the woman’s life or prevent her from suffering serious injury, legislation creates a duty on health practitioners (except in the Australian Capital Territory).¹⁴³

New South Wales does not have legislation regarding conscientious objection, relying instead on policy directives that allow health practitioners to refuse to perform or assist in performing abortion services because of a conscientious objection.¹⁴⁴ Similar to the states that have legislation about conscientious objection, the policy directives in New South Wales require health practitioners to perform, or assist in performing, an abortion in an emergency where it is necessary to save the woman’s life; they cannot refuse on the basis of a conscientious objection.¹⁴⁵

Referral to another health practitioner

Victorian legislation requires health practitioners, who choose not to perform abortions on the basis of a conscientious objection, to refer patients to another health practitioner who does not have a conscientious objection.¹⁴⁶ Tasmanian legislation similarly requires health practitioners who choose not to perform abortions to provide a list of health services that provide information or counselling on the full range of pregnancy options to patients seeking an abortion.¹⁴⁷

The Australian Capital Territory and New South Wales have not legislated a requirement to refer a patient to another health practitioner, however policy directives require health practitioners with a conscientious objection to refer, or take reasonable steps to refer, patients to a practitioner who does not have a conscientious objection.¹⁴⁸

¹⁴⁰ Australian Medical Association, Position Statement – Conscientious Objection, 2013, p 1.

¹⁴¹ RANZCOG, *College Statement: Termination of pregnancy*, C-Gyn 17, July 2016, p 4.

¹⁴² *Criminal Law Consolidation Act 1935* (SA), s 82A(5); *Health Act 1911* (WA), s 334(2); *Health Act 1993* (ACT), s 84; *Medical Services Act* (NT), s 11(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 6.

¹⁴³ *Criminal Law Consolidation Act 1935* (SA), s 82A(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 6; and *Abortion Law Reform Act 2008* (Vic), ss6 – 7.

¹⁴⁴ New South Wales Health, *Pregnancy – Framework for Termination in New South Wales Public Health Organisations*, 2 July 2014, p 7; Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8.

¹⁴⁵ New South Wales Health, *Pregnancy – Framework for Termination in New South Wales Public Health Organisations*, 2 July 2014, p 7.

¹⁴⁶ *Abortion Law Reform Act 2008* (Vic), s 5(2).

¹⁴⁷ *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 7.

¹⁴⁸ ACT Government Health, *Canberra Hospital and Health Services Clinical Guideline – Management of Termination of Pregnancy, Miscarriage or Fetal Death*, Issued 4 August 2016, p. 4; New South Wales Health, *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*, 2 July 2014; Queensland Maternity and Neonatal Clinical Guidelines Program, *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic termination of pregnancy*, Queensland Government, Brisbane, 2013, p 8.

6.3.2 Other countries

A number of other countries, including the Great Britain, New Zealand, United States, the Republic of Ireland, France and Germany have legislated such that no person is under a duty to perform or assist in performing an abortion.

For example, Great Britain has legislated that no person is under an obligation to participate in any legal abortion treatment to which they have a conscientious objection, unless the treatment is necessary to save the woman's life or prevent grave permanent injury to her physical or mental health.¹⁴⁹ New Zealand legislation also provides that no medical practitioner, nurse, or other person is under an obligation to perform, or assist in performing, an abortion if they object on grounds of conscience.¹⁵⁰

6.4 Issues considered during the inquiry

6.4.1 Introduction

Enabling health practitioners to refuse to provide abortion services based on conscientious objection may be perceived as a human right; the right to freedom of religion, conscience and thought. Conscientious objection may also be conceptualised as preserving the practitioner's oath 'to do no harm and to respect life'. However, it may be argued that conscientious objection is not solely an issue of health practitioners' rights, but also an issue for women's' rights as it may have 'very real consequences' for women's reproductive health and reproductive rights.¹⁵¹

In policies where conscientious objection is accepted as part of the framework for medical care, the extent to which conscientious objection should apply is usually considered. Also, the procedures and obligations that apply to health practitioners who have a conscientious objection must be considered. These issues are examined below.

6.4.2 Legislating a right of conscientious objection

There appeared to be broad consensus among submitters and witnesses to the inquiry that health practitioners should have a right to conscientious objection, allowing them to choose not to perform, or assist in performing, abortions and that this right should be enshrined in legislation.¹⁵²

For example, Cherish Life Queensland stated:

*The current wording of this clause in the Bill ... protects the freedom of Queensland health professionals to exercise their right to conscientious objection.*¹⁵³

Similarly the Human Rights Law Centre stated:

*We welcome the inclusion of conscientious objection provisions in the Bill. The Bill entitles medical practitioners to refuse to assist in performing abortions, except in emergency situations where it is necessary to save the life of, or prevent a serious physical injury to, the woman.*¹⁵⁴

However, not all submitters supported legislating conscientious objection, for example Ms Pamela Doherty stated:

*I do not support this clause. All medical practitioners should prioritise the needs of their patients and not their own moral conscience on health matters. They should not be able to legitimately impose their own views on women who wish to terminate their pregnancies.*¹⁵⁵

¹⁴⁹ *Abortion Act 1967* (UK), s 4.

¹⁵⁰ *Contraception, Sterilisation and Abortion Act 1977* (NZ), s 46.

¹⁵¹ Anna Heino et al, 'Conscientious objection and induced abortion in Europe', *European Journal of Contraception and Reproductive Health Care*, 2013, 18(4), pp 231-232.

¹⁵² See for example submissions 539, 565, 811, 812, 863, 876, 1013, 1021, 1040 and 1042.

¹⁵³ Submission 1040, p 9.

¹⁵⁴ Submission 894, p 2.

¹⁵⁵ Submission 879, p 2.

Other submitters questioned the need to legislate conscientious objection, suggesting that professional codes and standards adequately deal with the matter.¹⁵⁶ On this issue, Dr Ray Campbell, Director, Queensland Bioethics Centre, stated:

*I am left with the query: why are we legislating in this area of conscientious objection when for years the professional associations have handled it?*¹⁵⁷

6.4.3 Imposing a duty in emergency situations

While many submitters and witnesses appeared to support conscientious objection, views were divided regarding whether health practitioners should be obligated to perform or assist in performing an abortion in an emergency where it is necessary to save the woman's life or to prevent her serious physical injury.

Some submitters supported the proposed section 22, excluding the right to conscientious objection in an emergency and imposing a duty to provide urgent procedures that are life-saving measures.¹⁵⁸

Other submitters suggested the right to conscientious objection should be absolute and a duty to perform an abortion should not apply even in an emergency,¹⁵⁹ as such a duty would 'force medical practitioners, be it doctors or nurses to act against their religious and/or spiritual convictions'.¹⁶⁰ Concerns were also raised about a perceived ambiguity in what would constitute an emergency 'necessary to save the life of, or to prevent a serious physical injury to, the woman', and the possibility that proposed section 22 'is open to interpretation, and ... liable to being progressively broadened over time'.¹⁶¹

Some submitters also expressed the view that a legislated duty to perform, or assist in performing, an abortion in an emergency was unnecessary because there is no such thing as emergency abortion.¹⁶²

6.4.4 Referral to another practitioner and notice of objection

The absence of a requirement in proposed section 22 for health practitioners with a conscientious objection to refer patients to another practitioner, who does not have such an objection, was also an issue of debate among stakeholders. Some supported the absence of a requirement to refer, while others suggested an amendment was needed to include such a requirement.

A number of submitters argued that health practitioners who have a conscientious objection should not be required to refer patients, as a referral implies 'the doctor considers the treatment necessary and in the best interests of the patient', which in the case of abortion is contrary to the practitioner's beliefs.¹⁶³

For example The Australian Family Association stated that:

*Thankfully, unlike draconian conscientious objection provisions in Victoria and Tasmania, it [the Bill] does not require doctors to be complicit by forcing them to refer their patient to an abortionist. If a GP doesn't believe abortion is in the best interests of the patient, he or she should actually not refer as a matter of medical ethics.*¹⁶⁴

¹⁵⁶ See for example submissions 45, 874 and 905.

¹⁵⁷ Public hearing transcript, Brisbane, 27 October 2016, p 18.

¹⁵⁸ See for example submission 701 and 871.

¹⁵⁹ See for example submissions 863, 870 and 898.

¹⁶⁰ Catholic Women's League State of Queensland Inc, submission 872, p 5.

¹⁶¹ Dr Hayley Thomas, submission 863, p 1.

¹⁶² See for example submissions 898, 905, 1002, 1006, 1030 and 1147.

¹⁶³ Donna Purcell, submission 811, p 3. See also submissions 539, 863, 1030, 1040 and 1013.

¹⁶⁴ Submission 1030, p 8. Note: the Victorian legislation does not require referral to 'an abortionist' but to 'refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion (s. 8(1)(b), *Abortion Law Reform Act 2008* (Vic)).

Cherish Life Queensland stated:

*For conscientious objection to be honoured fully, the law could not compel doctors to refer their patients to another doctor who would provide abortion, as that would make the referring doctor complicit in the abortion.*¹⁶⁵

Other submitters argued that as health practitioners are ‘in a position of power and authority when women seek their assistance’¹⁶⁶ a requirement to refer would ensure women receive the advice they need, have access to the treatment they need, and that their rights are realised in practice.¹⁶⁷ For example, Reproductive Choice Australia submitted:

*Failure to refer to an unbiased medical practitioner, or worse, referral to an anti-choice group, can delay access to abortion as well as add to cost and distress. We recommend the inclusion of a legal requirement for referral in the case of conscientious objection so that the woman can access unbiased, all-options counselling and advice.*¹⁶⁸

In relation to concerns about referrals and doctors’ complicity in abortion, Professor Permezel stated:

*It is my view that you would never refer for a termination if you have a conscientious objection... I do not think you need to; you refer for further counselling so that when the patient goes to another provider, abortion is one of the options including continuing with the pregnancy. Certainly I refer to doctors with whom there is a range of options, including termination. They are not going to do a procedure; they are going to have further counselling, but this time the counselling can include termination of pregnancy. I think a doctor with conscience can refer providing the option of continuing with the pregnancy remains on the table. You are not referring for a service; you are referring for broader counselling than you as a conscientious objector are able to provide.*¹⁶⁹

6.4.5 Notice of conscientious objection

Some submitters and witnesses also suggested an additional requirement for a public notice or register identifying health practitioners who have a conscientious objection. For example, Dr MacFarlane suggested that the ‘legislation could also mandate that ‘pro-life’ practitioners clearly identify themselves’.¹⁷⁰ In a similar vein, Dr Carole Ford OAM submitted:

*In the case of conscientious objectors it would also be ethical if their position was clearly indicated to prospective patients in the waiting room or on a medical register.*¹⁷¹

Another option to inform pregnant women that was canvassed during the inquiry was to include those doctors who do provide abortion services on an accessible list.

The submission from Pro Choice Queensland supported a publicly available register of conscientious objectors.¹⁷² In response to questions at a public hearing, Pro Choice said the other option is:

*...where doctors who will perform abortions could potentially be on a list somewhere. At the moment Children by Choice, ... has a list of abortion providers in Queensland and nationally. Not all doctors choose to be publicly published on that list.*¹⁷³

Ms Bradley of Pro Choice also noted that in some circumstances doctors who perform abortions may not wish to be included in a public register.¹⁷⁴

¹⁶⁵ Submission 1040, p 43.

¹⁶⁶ Human Rights Law Centre, submission 894, p 2.

¹⁶⁷ See for example submissions 52, 565, 701, 809, 861, 877, 894, 904, 908, 1008, 1014, 1021, 1029, 1039, 1042, 1179, 1183 and 1209.

¹⁶⁸ Submission 1209, p 3.

¹⁶⁹ Public hearing transcript, Brisbane, 28 October 2016, p 31.

¹⁷⁰ Submission 809, p 5.

¹⁷¹ Submission 1005, p 4.

¹⁷² Submission 874, p 3.

¹⁷³ Public hearing transcript, Brisbane, 28 October 2016, p 23.

¹⁷⁴ Public hearing transcript, Brisbane 28 October 2016, p 25.

7. Patient protection or ‘safe access zones’ – proposed sections 23 to 25

7.1 Overview of the proposed new sections

Proposed section 23 of the Bill provides that the Minister must, by written notice, declare a protected area around an abortion facility. An area to be declared a protected area must be:

- at least 50 metres at any point from the facility, and
- sufficient, to ensure the privacy of, and unimpeded access for, anyone entering, trying to enter or leave the facility, and
- no bigger than necessary to ensure privacy and unimpeded access.

The Minister may also declare a time period during which the area is protected; if no declaration is made, proposed section 24 provides that the area is a protected area between 7am and 6pm each day the facility is open.

Ministerial declarations for protected areas and protected periods must be in writing and must be published on the Department of Health’s website. While a Ministerial declaration is not subordinate legislation, it is subject to disallowance by the Parliament.¹⁷⁵

In a protected area, a person must not engage in prohibited behaviour, which is defined as:

- harassing, hindering, intimidating, interfering with, threatening or obstructing a person including by capturing or attempting to capture their image with the intention of stopping them from entering the facility or having or performing an abortion in the facility
- an act that can be seen or heard during the protected period, done with the intention of stopping a person from entering the facility or having or performing an abortion in the facility, and
- a protest by any means relating to the performance of abortions during the protected period.

Any person who engages in prohibited behaviour in a protected area commits an offence and is liable for a maximum penalty of 25 penalty units (\$3,047).¹⁷⁶

Proposed section 25 provides that a person will also commit an offence if they publish an image of someone entering or leaving, or trying to enter or leave, a facility with the intention of stopping them from having or performing an abortion there and where they do not have the person’s consent for their image to be published. A person who publishes such an image is liable for a maximum penalty of 50 penalty units (\$6,095) or six months imprisonment.¹⁷⁷

7.2 Current rules in Queensland

Queensland currently has no laws specifically providing for protection or safe access zones around abortion facilities. However, legislation with general application such as offences for public nuisance may afford some protection; these provisions are discussed in more detail below at 7.4.5.

7.3 Regulation of safe access zones in other jurisdictions

7.3.1 Victoria

Since 2015 Victorian legislation has prescribed a safe access zone as an area within a radius of 150 metres of an abortion facility.¹⁷⁸ The legislation was introduced after a long period of demonstrations outside clinics, the murder of a security guard at a Melbourne clinic in 2001, and the Victorian Law

¹⁷⁵ Proposed section 23(4) applies sections 49 to 51 of the *Statutory Instruments Act 1992* to a declaration notice, as if it were subordinate legislation.

¹⁷⁶ The value of a penalty unit is \$121.90: Penalties and Sentences Regulation 2015, s 3.

¹⁷⁷ The value of a penalty unit is \$121.90: Penalties and Sentences Regulation 2015, s 3.

¹⁷⁸ *Public Health and Wellbeing Act 2008* (Vic), s 185B(1).

Reform Commission's 2008 recommendation that the government consider a legislative response to the issue.¹⁷⁹

Within a safe access zone it is an offence for a person to:

- beset, harass, intimidate, interfere with, threaten, hinder, obstruct or impede a person accessing, attempting to access, or leaving a facility
- communicate by any means in relation to abortions in a manner that can be seen or heard by a person accessing, attempting to access, or leaving a facility and that is reasonably likely to cause distress or anxiety
- impede or interfere with a footpath, road or vehicle regarding a facility without reasonable excuse
- intentionally record a person accessing, attempting to access, or leaving a facility without their consent.¹⁸⁰

Engaging in prohibited behaviour in a safe access zone is an offence, and a person is liable for a penalty of 120 penalty units (\$18,655.20) or imprisonment for a term not exceeding 12 months.¹⁸¹

7.3.2 Tasmania

Tasmanian legislation prescribes a safe access zone as an area within a radius of 150 metres of an abortion facility. Within a safe access zone it is an offence for a person to:

- threaten or harass a person
- interfere with a footpath
- protest, and
- record persons entering an abortion facility.¹⁸²

Engaging in prohibited behaviour in a safe access zone is an offence, and a person is liable for a penalty of 75 penalty units (\$11,775) or imprisonment for a term not exceeding 12 months, or both.¹⁸³

7.3.3 Australian Capital Territory

Australian Capital Territory legislation prescribes a safe access zone as a declared area of at least 50 metres from an abortion facility that is sufficient to ensure privacy and unimpeded access for anyone accessing, attempting to access, or leaving a facility.¹⁸⁴ Safe access zones apply between 7am and 6pm each day a facility is open.¹⁸⁵ Within a safe access zone it is an offence for a person to:

- harass, hinder, intimidate, interfere with, threaten, obstruct or record a person with the intention of stopping them from entering a facility or having an abortion
- perform an act that can be seen or heard by anyone in the safe access zone, that is intended to stop a person from entering a facility or having an abortion, and
- protest in relation to the provision of abortions.¹⁸⁶

Engaging in prohibited behaviour within a safe access zone and publishing recorded information both are offences, and a person is respectively liable for a penalty of 25 penalty units (\$3,750), and 50 penalty units (\$7,500) or imprisonment for 12 months, or both.¹⁸⁷

¹⁷⁹ Victorian Law Reform Commission, *Abortion law*, 2008, p 140

¹⁸⁰ *Public Health and Wellbeing Act 2008* (Vic), ss 185D and 185B(1).

¹⁸¹ *Public Health and Wellbeing Act 2008* (Vic), s 185B(1). The value of a penalty unit is \$155.46: *Sentencing Act 1991* (Vic), s 110; *Monetary Units Act 2004* (Vic), s 5; Victorian Government Gazette GG15, 14 April 2016, p 639.

¹⁸² *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 9.

¹⁸³ *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 9. The value of a penalty unit is \$157: *Penalty Units and Other Penalties Act 1987* (Tas) s 4A; Tasmanian Government Gazette GG21, 1 June 2016, p 892.

¹⁸⁴ *Health Act 1993* (ACT), s 86.

¹⁸⁵ *Health Act 1993* (ACT), s 85.

¹⁸⁶ *Health Act 1993* (ACT), ss 85 and 87.

¹⁸⁷ *Health Act 1993* (ACT), s 85. The value of a penalty unit is \$150: *Legislation Act 1987* (ACT) s 133(2).

7.3.4 Other countries

The province of British Columbia, Canada, has created safe access zones around abortion facilities, residences and offices of doctors who provide abortion services, and residences of other employees of abortion facilities. Within a safe access zone, it is an offence for a person to engage in footpath interference, protest, beset, intimidate, or attempt to intimidate, physically interfere with, or record patients or employees.¹⁸⁸

The United Kingdom (including Northern Ireland) does not have legislation prescribing safe access zones, however other mechanisms such as harassment laws are commonly used to deter protestors.

7.4 Issues considered during the inquiry

7.4.1 Introduction

Abortion is a value driven, complex and emotive issue, and there are strongly held beliefs within the Queensland community about the availability of, and access to, abortion services. Those who oppose abortion sometimes demonstrate, pray or provide ‘footpath counselling’ outside abortion facilities in accordance with their beliefs and values. Those who support access to abortion argue that those activities impinge on privacy and have a detrimental effect on women attending health facilities where abortions are provided.

Safe access zones would prohibit demonstrations and ‘footpath counselling’ within the declared zone around the facilities, with the intent to protect the safety, and respect the privacy, of people accessing abortion services and employees who work at the facilities. Regulation of activity in safe access zones raises issues about reasonable constraints on freedom of speech, whether constraints are constitutional, and whether regulation is necessary given existing laws. These issues are examined below.

7.4.2 Legislating for patient protection

Views were divided among submitters and witnesses about whether safe access zones should be introduced around abortion facilities in Queensland.

Some submitters and witnesses expressed the view that demonstrations and ‘footpath counselling’ outside abortion facilities are necessary to support women. For example Dr Timothy Coyle stated:

*...approaching mothers outside abortion clinics provides the valuable service of helping those mothers who are ambivalent about abortion ... counselling outside abortion clinics must continue to prevent tragedies...*¹⁸⁹

Similarly Angela Duff, of The Australian Family Association, stated:

*...the bill would establish so-called protected areas near abortion facilities in order to criminalise peaceful protesters who are praying and footpath counsellors who are standing to help vulnerable women who may request assistance or an alternative. ... These so-called protected areas would protect only profit-making abortion businesses, certainly not women and their unborn babies.*¹⁹⁰

Other submitters and witnesses considered safe access zones to be necessary to protect women,¹⁹¹ signified by one woman’s account of her personal experience:

¹⁸⁸ Access to Abortion Services Act 1995 (BC) s 2.

¹⁸⁹ Submission 8, pp 1-2.

¹⁹⁰ Public hearing transcript, Brisbane, 27 October 2016, p 28.

¹⁹¹ See for example submissions 112, 702, 812, 1014, 1032 and 1267.

*As a Queensland woman I have had to endure navigating protesters on both occasions that I accessed an abortion ... which added to the burden of stress and stigma, and remains with me to this day as one of the most stressful aspects of my experience on the day of my procedures.*¹⁹²

Also supporting the need for safe access zones, Ms Melissa Fox of Health Consumers Queensland stated:

*It would be our provision that women in these challenging circumstances, who are making one of the hardest decisions of their lives, do not have to see these signs or see these people at all. I think it is an underestimation of women's intelligence and the choices they are weighing up to think they need to be faced with these messages and that that will in fact change their minds.*¹⁹³

Some submitters who supported the concept of safe access zones expressed concerns about the specific operation of proposed sections 23 to 25 in relation to the size and method of enacting a safe access zone, and potential ambiguity in what constitutes prohibited behaviour. These submitters suggested the size of safe access zones should be increased to 150 metres and should apply automatically rather than by a declaration of the Minister, consistent with legislation in Tasmania and Victoria.¹⁹⁴

In addition, Children by Choice and Reproductive Choice Australia raised the following concerns about prohibited behaviour:

*...the list of prohibited behaviours within the proposed exclusion zones may be ambiguous enough to allow some actions which, while not providing a direct impediment to staff and patients seeking to access a service, may still be emotionally distressing...*¹⁹⁵

*The intention requirement creates an unnecessary extra element of the offence and a barrier to enforcement... Canadian courts considering access zones in British Columbia explained that a broad "white line prophylactic rule" that simply prohibits behaviours without needing to prove intention or an impact on the victim is necessary...*¹⁹⁶

7.4.3 Freedom of speech

The provision of safe access zones around abortion facilities raises the issue of whether demonstrations outside health facilities are protected as a form of freedom of speech. While the Australian Constitution does not explicitly protect a right to freedom of speech, the High Court has held that an implied right to freedom of political communication exists as a necessary part of Australia's system of representative and responsible government. This right operates as a right to freedom from government restraint about political matters, rather than as a personal right to freedom of speech.¹⁹⁷

Therefore, legislation may place restrictions on speech provided that any such restrictions do not impinge on the system of representative government. Whether legislation imposing restrictions on speech is constitutionally valid will be established by examining whether it burdens political communication, has a legitimate purpose compatible with the maintenance of representative and responsible government, and is reasonably appropriate and adapted.¹⁹⁸

A number of submitters and witnesses raised concerns about the impact safe access zones would have on freedom of speech outside abortion facilities.¹⁹⁹ For example Cherish Life Queensland stated:

Abortion remains a contentious political and moral issue and as such, those who passionately believe in the right to life of the unborn, the health and wellbeing of women and the cultural

¹⁹² Elizabeth Price, submission 812, p 2.

¹⁹³ Public hearing transcript, Brisbane, 28 October 2016, p 33.

¹⁹⁴ See for example submissions 45, 52, 565, 687, 701, 874, 894, 904, 1005, 1029, 1039 and 1209.

¹⁹⁵ Submission 565, p 7.

¹⁹⁶ Submission 894, p 3.

¹⁹⁷ *Lang v Australian Broadcasting Corporation* (1997) 189 CLR 520, p 560.

¹⁹⁸ *McCloy v New South Wales* (2015) 325 ALR 15.

¹⁹⁹ See for example submissions 19, 23, 51, 539, 705, 836, 883, 901, 1003, 1020, 1031 and 1040.

*fabric of our state must have their political communication protected... Criminalising freedom of speech is a totalitarian imposition of one belief system on all Queenslanders and should be rejected.*²⁰⁰

Professor Michael Quinlan stated:

*The views of people who, for reasons of conscience or religion, seek to peacefully pray or peacefully protest ought not to lead to them being treated as criminals and is unlikely to lead to them changing their convictions.*²⁰¹

Conversely, a number of submissions and witnesses suggested that safe access zones appropriately balanced the right to freedom of speech with the rights of patients and health facility employees to privacy, safety and self-determination. For example, Dr Renuka Sekar stated:

*Stressed and emotionally vulnerable patients do not need to be confronted by protesters when attending facilities offering family planning advice and termination. Similarly, health care workers have a right to safe access to and from work and to work safely free from threat and intimidation. The law should seek to balance the right of peaceful protest with the safety of patients and health care workers and prohibit anti-abortion protest within a certain distance of relevant facilities.*²⁰²

Consistent with this view, Dr Caroline de Costa stated:

*These are very personal, intimate matters, and it is often very difficult for a woman to make this decision and to go through the process. She should not be confronted by the kind of thing that does happen outside clinics. At the same time, I appreciate that people have a right to freedom of speech, but there are plenty of other places where they can make their views known and they should not be interfering with access to clinics.*²⁰³

7.4.4 Constitutional considerations

Professor Nicholas Aroney, Professor of Constitutional Law, specifically addressed the constitutionality of safe access zones in his submission and as a witness to the inquiry. In Professor Aroney's view proposed section 24(2)(a) and (b) would be constitutionally valid. Proposed section 24(2)(a) and (b) would prohibit harassing, hindering, intimidating, interfering with, threatening or obstructing a person, or doing an act that can be seen or heard by a person, with the intention of stopping them from entering the facility or having or performing an abortion in the facility.

*While it is strongly arguable that they both [the provisions of the Bill] place burdens on the freedom, it is also arguable that they pursue objectives that are compatible with the constitutionally prescribed system of representative government, namely to enable persons to have access to abortion facilities and to protect their privacy.*²⁰⁴

However, in Professor Aroney's opinion, proposed section 24(2)(c), which would prohibit 'a protest' relating to the performance of abortions, would be unconstitutional:

*In terms of compatibility, in my opinion, paragraph (c) [prohibiting protests] is not compatible with the Constitution. This is because ... it is directed at protests per se whether or not such protests are intended to stop a person from entering an abortion facility or from having an abortion. The prohibition on protesting per se is not a purpose which is compatible with the Constitution.*²⁰⁵

²⁰⁰ Submission 1040, p 10.

²⁰¹ Submission 883, p 5.

²⁰² Submission 112, p 6.

²⁰³ Public hearing transcript, Brisbane, 28 October 2016, p 24.

²⁰⁴ Submission 1020, p 5.

²⁰⁵ Public hearing transcript, Brisbane, 28 October 2016, p 51.

Professor Willmott also addressed the constitutionality of safe access zones:

*...what the committee, the parliament and the drafters would have to grapple with is balancing the genuine constitutional right to protest and to make their political views known with the right of a woman to be able to obtain health care in circumstances where she is not harassed or intimidated. It is a balancing of that right. There might be constitutional issues to make sure that balance is correct, but there are legislative models.*²⁰⁶

Ultimately, only the High Court can determine the constitutional legitimacy of safe access zones around abortion facilities, and it is difficult to predict how the High Court may construe the legitimacy of safe access zones. There is currently no clear judicial conception of ‘political debate’, and the High Court has been divided on whether the right to freedom of political communication includes offensive or hurtful communication.²⁰⁷

There have been no challenges to the High Court regarding the constitutionality of safe access zone legislation in Australia to date, however it is known that one person convicted under safe access zone legislation is challenging the Tasmanian law. Mr John Graham Preston, who was found guilty of breaching the Tasmanian safe access zone laws after unsuccessfully arguing in the Magistrates Court that the safe access zone legislation was unconstitutional, is appealing his conviction in the Tasmanian Supreme Court.²⁰⁸ There is potential for the matter to be appealed to the High Court at a later date.

7.4.5 Activities regulated by other legislation

A number of submitters suggested that it was not necessary to legislate safe access zones outside abortion facilities as protections are currently provided under provisions regarding public nuisance, unlawful assembly, unlawful gathering and threatening violence.²⁰⁹

The extent to which provisions in the *Summary Offences Act 2005* would apply will be determined by the exact nature and behavior of the people demonstrating outside the facility.

Public nuisance provisions may afford some protection to women and employees entering or leaving abortion facilities. Under these provisions it is an offence for a person to behave in a disorderly, offensive, threatening or violent way where the behavior interferes, or is likely to interfere, with another person’s peaceful passage through, or enjoyment of, a public place.²¹⁰ The provisions would restrict language or behaviour that impede access to an abortion facility but would likely have limited application where a group’s prayer, silent protest or mere presence caused distress.

The unlawful assembly provisions would only apply if there was a reasonable threat of violence. Protection is only afforded under these provisions where the conduct of a group of three or more causes another to reasonably fear that unlawful violence will be used against a person or property.²¹¹ The provisions would not apply if a person felt harassed or distressed by a group’s conduct but did not fear that the group would become violent.

Protection under legislation about unlawful gathering is dependent on the group not having a lawful reason to enter or remain in a building, public or place used for a business purpose, or on land used in connection to the building.²¹² Therefore, legislation about unlawful gathering would likely not apply where the group is on public land outside an abortion facility as it is improbable their presence in itself would be unlawful. Similarly, protections under the Criminal Code in relation to threatening violence would only apply if a person threatened to enter or damage the abortion facility.²¹³

²⁰⁶ Public hearing transcript, Brisbane, 28 October 2016, p 72.

²⁰⁷ Eleanor Jones, ‘Implementing Protest-free Zones around Abortion Clinics in Australia’, 2014, 36 Sydney Law Review, p170-174 citing Monis (2013) 87 ALJR 340.

²⁰⁸ Graham Preston, submission 705; Tasmania Office of the Solicitor-General, Annual Report for 2015-16, 2016, p 9.

²⁰⁹ See for example submissions 42, 110, 705, 811, 872, 841, 881 and 883.

²¹⁰ *Summary Offences Act 2005*, s 6.

²¹¹ *Summary Offences Act 2005*, s 10A.

²¹² *Summary Offences Act 2005*, s 12.

²¹³ *Criminal Code*, s 75.

8. Fundamental legislative principles and explanatory notes

8.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (Legislative Standards Act) states that the fundamental legislative principles (FLPs) are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to the rights and liberties of individuals, and the institution of Parliament.

The committee has examined the application of the FLPs to the Bill and brings the following potential issues to the attention of the Legislative Assembly.

8.1.1 Rights and liberties of individuals

Protected areas - proposed sections 23 to 25

The Bill proposes to introduce protected areas, or safe access zones, around abortion facilities, and to prohibit certain behaviour within these areas during the protected period (refer to chapter 7). Prohibited behaviour includes a protest by any means relating to the performance of abortions, and any act that can be seen or heard, done with the intention of stopping a person from entering the facility or having or performing an abortion in the facility.

The prohibition on certain types of behaviour, such as protests, raises potential concerns about whether the provisions have sufficient regard to FLPs in relation to individual rights and liberties.

International human rights law

The Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR) recognise the rights to freedom of opinion and expression, freedom of association, freedom of peaceful assembly and freedom of thought, conscience and religion.²¹⁴

The right to these freedoms may be interpreted as a right to assemble, demonstrate and distribute materials outside abortion clinics, and the proposal to introduce protected areas prohibiting certain behaviours within these areas may be interpreted as impinging on these freedoms. However, these rights are not inviolable. The instruments recognising the rights also recognise that laws may place restrictions on them being exercised where it is in the interests of public safety, order, health or morals, or the protection of the rights and freedoms of others.²¹⁵

Therefore, the proposal to restrict a person’s right to assemble, demonstrate or distribute materials outside an abortion clinic would be consistent with international human rights principles, if the restriction is in the interests public safety, order, health or morals, or for the purpose of protecting the rights and freedoms of others.

It is also important to note that while the Commonwealth Government has ratified the UDHR and the ICCPR, this does not automatically create rights and duties enforceable by individuals in Australia. The rights and duties contained in these instruments only have force in Australia if they are incorporated into Australian legislation.²¹⁶ It must also be recognised that Queensland has no authority to enter into international treaties, under the Australian Constitution, international instruments may only be entered into and ratified by the Commonwealth.

²¹⁴ *Universal Declaration of Human Rights*, 10 December 1948, arts 18, 19, 20; *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS (entered into force 23 March 1976) arts 18, 19, 21, 22.

²¹⁵ *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS (entered into force 23 March 1976) arts 18, 19, 21, 22.

²¹⁶ *Teoh* (1995) 183 CLR 273; *Kioa v West* (1985) 159 CLR 550.

Australian law

An implied right to freedom of political communication also exists in Australia, that operates as a right to freedom from government restraint about political matters (refer to Chapter 7).²¹⁷ The proposal to introduce protected areas around abortion facilities raises the issue of whether demonstrations outside these facilities are protected by this right to freedom of political communication.

Similar to international law, the exercise of this right may be restricted by legislation. Restrictions are permissible if they do not burden political communication, have a legitimate purpose compatible with the maintenance of representative and responsible government, and are reasonably appropriate and adapted.²¹⁸ Whether the restriction on where a person may assemble, demonstrate or distribute materials that would be imposed by the Bill has constitutional legitimacy is ultimately a question for the High Court.

Committee comment

The committee noted the rights enshrined in the UDHR and the ICCPR, and the permissibility of placing restrictions on the exercise of these rights under international law. The committee also noted the right to freedom from government restraint about political matters implied in the Australian Constitution, and that restrictions may also be placed on this right under Australian law.

8.1.2 Penalties

A penalty should be proportionate to the offence and legislation 'should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other'.²¹⁹

Unqualified person performing an abortion

Proposed section 20 imposes a maximum penalty of 10 years imprisonment if a person who is not a qualified health practitioner performs an abortion. This penalty is less than the current maximum penalty for unlawfully procuring an abortion under the Criminal Code, which is 14 years imprisonment.

Other offences in Queensland that carry a 10 year prison sentence include entering a premises with intent to commit an indictable offence,²²⁰ and unlawfully assaulting a person causing bodily harm while armed with a dangerous weapon.²²¹

The penalty proposed under section 20 is consistent with the penalty imposed in Victoria and more than the five year imprisonment term imposed in Western Australian and the Australian Capital Territory.

Engaging in prohibited behaviour in a protected area

Proposed section 24 imposes a maximum penalty of 25 penalty units (\$3,047) for engaging in prohibited behaviour in a protected area.

Other offences in Queensland that incur a maximum penalty of 25 penalty units include being a public nuisance in a licensed premises (alternate penalty of six months imprisonment),²²² and selling, supplying or consuming liquor in a carpark.²²³

The penalty proposed under section 24 is consistent with the penalty imposed in the Australian Capital Territory, 25 penalty units (\$3,750),²²⁴ and is lower than the penalties imposed in Victoria and Tasmania. Victoria imposes a maximum penalty of 120 penalty units (\$18,655) or 12 months

²¹⁷ *Lang v Australian Broadcasting Corporation* (1997) 189 CLR 520, p 560.

²¹⁸ *McCloy v New South Wales* (2015) 325 ALR 15.

²¹⁹ Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook*, page 120.

²²⁰ *Criminal Code*, s 421.

²²¹ *Criminal Code*, s 339(3).

²²² *Summary Offences Act 2005*, s 6.

²²³ *Liquor Act 1992*, s 142ZZE.

²²⁴ *Health Act 1993* (ACT), s 87. The value of a penalty unit is \$150 - *Legislation Act 1987* (ACT) s 133(2).

imprisonment,²²⁵ and Tasmania imposes 75 penalty units (\$11,775) or 12 months imprisonment, or both.²²⁶

Publishing images of a person entering or leaving a facility

Proposed section 25 imposes a maximum penalty of 50 penalty units (\$6,095) or six months imprisonment for publishing an image of someone, without their consent, entering or leaving an abortion facility with the intention of stopping them from having or performing an abortion.

Other offences in Queensland that incur a maximum penalty of 50 penalty units include failing to leave a licensed premises when required to leave after creating a disturbance,²²⁷ and wilfully and unlawfully damaging a device designed to prevent a fire (alternate penalty of 6 months imprisonment).²²⁸

The penalty under proposed section 25 is consistent with the penalty imposed in the Australian Capital Territory - 50 penalty units (\$7,500) or six months imprisonment, or both.²²⁹ The penalty is lower than those in Victoria and Tasmania where the maximum penalties are 120 penalty units (\$18,655) or 12 months imprisonment in Victoria,²³⁰ and 75 penalty units (\$11,775) or 12 months imprisonment, or both, in Tasmania.²³¹

Committee comment

The committee noted that the proposed penalties are largely consistent with similar offences in other jurisdictions, and are broadly proportionate to the penalties for other offences within the Queensland legislative framework.

8.2 Institution of Parliament

The Legislative Standards Act provides that legislation should have sufficient regard to the institution of Parliament. The Bill raises a potential FLP issue in relation to an exercise of delegated legislative power.

Proposed section 23 provides for the Minister to declare a protected area around an abortion facility, and for a time period during which the period is protected. While declarations for protected areas or protected periods are not subordinate legislation, they are subject to the requirements for tabling, disallowance as if they are subordinate legislation.

Committee comment

The committee noted that the proposed declarations for protected areas and protected periods would be subject to tabling and disallowance requirements. The committee considered that because of this safeguard, ensuring declarations come to the attention of the House and are subject to Parliamentary scrutiny, that the legislation had sufficient regard to the institution of Parliament.

8.3 Explanatory notes

Part 4 of the Legislative Standards Act requires that explanatory notes be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information the explanatory notes should contain.

²²⁵ *Public Health and Wellbeing Act 2008* (Vic), ss 185E. The value of a penalty unit is \$155.46 - *Sentencing Act 1991* (Vic), s 110, *Monetary Units Act 2004* (Vic), s 5; *Victorian Government Gazette GG15*, 14 April 2016, p 639.

²²⁶ *Reproductive Health (Access to Terminations) Act 2013* (Tas), section 9. The value of a penalty unit is \$157 - *Penalty Units and Other Penalties Act 1987* (Tas) s 4A; *Tasmanian Government Gazette GG21*, 1 June 2016, p 892.

²²⁷ *Liquor Act 1992*, s 165(2).

²²⁸ *Fire and Emergency Services Act 1990*, section 86F.

²²⁹ *Health Act 1993* (ACT), s 87. The value of a penalty unit is \$150 - *Legislation Act 1987* (ACT) s 133(2).

²³⁰ *Public Health and Wellbeing Act 2008* (Vic), s 185E. The value of a penalty unit is \$155.46 - *Sentencing Act 1991* (Vic), s 110, *Monetary Units Act 2004* (Vic), s 5; *Victorian Government Gazette GG15*, 14 April 2016, p 639.

²³¹ *Reproductive Health (Access to Terminations) Act 2013* (Tas), section 9. The value of a penalty unit is \$157 - *Penalty Units and Other Penalties Act 1987* (Tas) s 4A; *Tasmanian Government Gazette GG21*, 1 June 2016, p 892.

Explanatory notes were tabled with the introduction of the Bill. The committee's comments on the explanatory notes are similar to those made on the first abortion Bill introduced by Mr Pyne MP.

The committee noted that a Private Member does not have the resources of a department to prepare explanatory notes, but considered that the explanatory notes fell short of the requirements set out in the Legislative Standards Act. The explanatory notes did not contain all of the information required under that Act.

For example, the Legislative Standards Act requires explanatory notes to include, in clear and precise language, 'a brief assessment of the consistency of the Bill with fundamental legislative principles and, if it is inconsistent with fundamental legislative principles, the reasons for the inconsistency'.²³² The explanatory notes tabled with the Bill provide no information about fundamental legislative principles, except to state that the Bill 'is consistent with Fundamental Legal Principles'.

Another requirement of the Legislative Standards Act is a 'simple explanation of the purpose and intended operation of each clause of the Bill'. While the explanatory notes summarise each clause, the committee considers there is insufficient detail about the intended operation of each clause. The explanatory notes could have provided more information to assist the committee and Members to understand how the individual clauses are intended to operate, particularly in relation to other legislation.

²³² *Legislative Standards Act 1992*, section 23

Appendix A – Witnesses at public hearings

Public hearing – Thursday 27 October 2016

Cherish Life Queensland

- Ms Donna Purcell, Vice President
- Ms Kara Thomas, Director of Research, Policy and Advocacy

Women’s Forum Australia

- Ms Rachel Wong, Director of Research Policy and Advocacy

Queensland Bioethics Centre

- Dr Ray Campbell, Director

Australian Family Association

- Ms Angela Duff, Vice President
- Mr Alan Baker, Queensland State Committee Member

Right to Life Australia

- Dr Katrina Haller, Senior Executive Officer

Australian Christian Lobby

- Ms Wendy Francis, Queensland State Director

Private capacity

- Ms Rita Joseph
- Dr Mark Hobart
- Professor Michael Quinlan
- Professor Nicholas Aroney
- Dr Anthony Herbert
- Dr Joseph Thomas
- Mr Duncan Stuart

Public hearing – Friday 28 October 2016

National Alliance of Abortion and Pregnancy Options Counsellors

- Ms Elizabeth Price, Counsellor

Children by Choice

- Mr Kate Marsh, Communications Coordinator
- Ms Siân Tooker, Counsellor

Women’s Legal Service

- Ms Katherine Kerr, Social Worker
- Ms Bronwyn Lloyd, Solicitor

Pro Choice Queensland

- Ms Amanda Bradley
- Dr Caroline de Costa

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

- Professor Michael Permezel, President

Health Consumers Queensland

- Ms Melissa Fox, General Manager

Soroptimists International, South Queensland Branch

- Ms Kylie Hillard
- Ms Fran Cahill

Public hearing – Friday 28 October 2016 (continued)

Australian Medical Association Queensland

- Dr Alex Markwell

True Relationships and Reproductive Health

- Dr Colinette Margerison, Clinician

Queensland Council for Civil Liberties

- Mr Michael Cope, President

Private capacity

- Dr Renuka Sekar
- Professor Lindy Willmott
- Professor Ben White

Public hearing – Monday 7 November 2016

World Federation of Doctors Who Respect Life

- Dr David van Gend
- Dr Di Grocott

Priceless Life

- Ms Catherine Toomey, Managing Director
- Ms Luchi Miranda, Counsellor

Family Planning Alliance Australia

- Dr Deborah Bateson

Private capacity

- Ms Madeleine Wiedemann
- Ms Wendy Downs

Statement of Reservation

STATEMENT OF RESERVATIONS

There are two related Bills before the House:

- (i) Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016;
- (ii) Health (Abortion Law Reform) Amendment Bill 2016

They will proceed by cognate debate with separate votes on each Bill.

The Bills are distinct in form but with the potential for legal issues to arise based on the terms of the Bills and how Members vote. Though Bills that become Acts of Parliament may end before a Court for interpretation a Parliament should not pass legislation that it knows may or will raise questions of interpretation. The role of the Parliament is therefore to strive is to pass cogent legislation that is drafted in clear and unambiguous language and not inconsistent with other legislation.

In this case the vote of the House on the two Bills could result in at least four potential outcomes:

- (a) Both Bills are passed
- (b) Both Bills are rejected
- (c) The Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 passed.
The Health (Abortion Law Reform) Amendment Bill 2016 rejected.
- (d) The Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 rejected
The Health (Abortion Law Reform) Amendment Bill 2016 passed.

At least one of these outcomes raises serious questions of future interpretation and uncertainty, particularly in regards to the criminal code.

The fact that four permeations exist raises concerns, as no member can accurately predict the final outcome. That is an added complexity and worryingly places members in the position that their choices may not result in the outcome they want or worse, put in place laws that are conflicting and uncertain. That outcome is not in the interest of the people of Queensland. It is not in their interests to create uncertainty.

Further, do the Bills deal with all issues that should be dealt with? That is, are there unintended consequences and consequential amendments that will eventually need to be implemented? In short, has there been adequate consideration of all issues?

The process has been lengthy and the issue sensitive but the Bills and the method by which they are to be debated leave much unanswered.

The point is – has the legislation covering this very sensitive and emotional question been drafted in a manner that should be before a Parliament and is the process in which we are about to engage correct? We have a responsibility to pass clear and unambiguous legislation. We do not believe we are at that stage.

As a consequence we cannot recommend the Bill be passed.

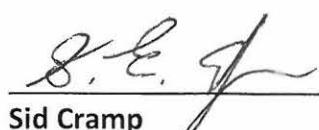


Mark McArdle
State Member
for Caloundra

16/2/17



Mark Robinson
State Member
for Cleveland



Sid Cramp
State Member
for Gaven