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Victorian Law Reform Commission Inquiry Into the Law Governing Termination of Pregnancy

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Liberty Victoria submission
Victorian Law Reform Commission Inquiry
Into the Law Governing Termination of Pregnancy

1. Introduction

1.1 Liberty Victoria - The Victorian Council for Civil Liberties Inc is an independent non-government organisation which traces its history back to the first Australian civil liberties body established in Melbourne in 1936. Liberty is committed to the defence and extension of human rights and civil liberties. It seeks to promote Australia's compliance with the rights and freedoms recognised by international law.

1.2 Liberty Victoria welcomes this opportunity to comment on reform of the laws governing pregnancy terminations in Victoria. Liberty Victoria has participated in earlier inquiries and consultations on this issue the most recent being a submission to the Senate Community Affairs inquiry into the Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005. Liberty strongly supports this inquiry and believes that reform of the law governing abortions is long overdue. This submission will largely follow the structure of the discussion questions set out on page 21 of the VLRC Information Paper.

2. Ethical and legal principles that should inform the law of abortion

2.1 This submission starts with some preliminary comments on Liberty Victoria's position on pregnancy termination and the guiding principles that should govern the law in this area. Most opposition to abortion rests on the premise that the foetus is a human being from the moment of conception.[1] Liberty Victoria starts from the position that abortion is not morally objectionable and that the foetus 'is only a potential person to whom the law offers lesser protection than to an actual person such as the mother'.[2] This does not mean that a foetus is devoid of legal protection. However, such legal protection does not necessarily entail the foetus having legal rights and being able to assert such rights in the way that an independent living person, such as the mother, can assert rights.[3]

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[1] Judith Jarvis Thomson 'A Defense of Abortion', 1 *Philosophy &Public Affairs* 69 (1971), 69.
[2] Margaret A Somerville, 'Reflections on Canadian Abortion Law: Evacuation and Destruction – Two Separate Issues', 31 *University of Toronto Law Journal* 1, (1981), 1.
[3] Ibid 1.

2.2 Liberty Victoria's position on this issue starts from a number of core premises. One, that women have the intellectual and moral capacity to make decisions about their own fertility. Secondly, that the law governing this area should rest upon, and recognise, Australia's obligations under international human rights instruments, specifically the Universal Declaration of Human Rights (UDHR), THE International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

2.3 Many medical practitioners and lawyers who undertake research in this area base their position and arguments on the core principles found in international human rights instruments and the notion that reproductive rights 'express the principle that women, and men as well, are entitled to control their reproductive lives'.[4] For example, Lynn P Freedman J.D., M.P.H. and Stephen L Isaacs, J.D. (Assistant Professor and Professor, Reproductive Rights Project, Development Law and Policy Program, Center for Population and Family Health, and Clinical Public Health, Columbia University), in examining the relationship between human rights and reproductive choice argue that reproductive health strategies must recognise:

> That women as full, thinking, feeling personalities, shaped by the particular social, economic, and cultural conditions in which each of them lives, are central to their own reproduction.[5]

They refer to their approach as one that essentially starts from the fundamental premise of 'trusting women'.[6] They argue that the key to improving reproductive health, which includes education about contraception and ways of avoiding unwanted pregnancies, is women's autonomy; that is:

> Enabling women to take control over their reproductive lives by entrusting to them both the authority to make decisions about reproduction and the ability to make those decisions based on access to adequate information and appropriate services[7]

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[4] Lynn P Freedman and Stephen L Isaacs, 'Human Rights and Reproductive Choice', 24 *Studies in Family Planning* 18 (1993), 19.
[5] Ibid 18.
[6] Ibid 19.
[7] Ibid 19.

They state that such an approach should be at the centre of the laws concerning pregnancy terminations. Indeed, the concept of trust and autonomy is central to international human rights instruments in respect of reproduction and of women's human rights generally.

2.4 Principles recognising respect for individuals' own choices regarding reproduction are found in a number of international human rights instruments. Particularly pertinent to the debate on abortion is Article 16 of the CEDAW. That provision requires all States Parties to take appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations. In particular, it requires that Parties shall ensure, on a basis of equality of men and women:

> the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Article 12 (1) of CEDAW states:

> States Parties shall take all appropriate measures to eliminate all discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health services, including those related to family planning.

Australia is a party to CEDAW and Australian law should be brought into conformity with its international human rights obligations.

2.5 CEDAW is not the only international human rights instrument relevant to this issue. Articles 1, 3, 12, and 23 of the Universal Declaration of Human Rights are also relevant to 'the individual's right to determine the course of their life including childbearing.'[8] Article 1 of the UDHR states that:

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Implicit in Article 1 is that women should exercise their own reason and conscience in relation to issues concerning their rights. As articulated by Justice Wilson of the Supreme Court of Canada in

[8] Beryl Holmes, *Human Rights – Another Look at Abortion*, Children by Choice Association, QLD, (1991), 3, http://www.reproductiverights.org/pub_bo_gaininground.html

Morgenthaler, Smoling and Scott v The Queen, there is a biological distinction between the sexes, only women can bear children, as such women's needs and aspirations cannot be separated from the right to reproduce or not to reproduce. This means that such a right is 'an integral part of a modern woman's struggle to assert *her* dignity and worth as a human being'.[9] In her concurring opinion Justice Wilson also stated that:

> The decision whether to terminate a pregnancy is essentially a moral decision, a matter of conscience. I do not think there is or can be any dispute about that. The question is; whose conscience? Is the conscience of the woman to be paramount or the conscience of the state? I believe, for the reasons I gave in discussing the right to liberty, that in a free and democratic society it must be the conscience of the individual.[10]

Liberty Victoria shares the view of Justice Wilson and believes that denying a woman's right to control her own reproduction is in breach of Article 1.

2.6 Article 3 of the UDHR states that:

> Everyone has the right to life, liberty and security of the person.

In the *Morgenthaler* case the Canadian Supreme Court found that the abortion provisions in the Criminal Code offended a pregnant woman's constitutionally protected right not to be deprived of her 'life, liberty and security of the person'. The criminal provisions relating to abortion were in breach of s 7 of the Canadian Charter of Human Rights which reiterates Article 3 of the UDHR. The equivalent right is found in s 21(1) of the Victorian Charter of Human Rights and Responsibilities Act 2006. The Chief Justice of the Canadian Supreme Court, in finding the abortion laws inoperative, stated in relation to security of the person that:

> State interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitutes a breach of security of the person. …
> Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her

[9] *R v Mortgentaler v The Queen*, [1988] 1 SCR 30
[10] Ibid 6.

> own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person.[11]

2.7 Article 12 of the UDHR states:

> No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence…

The equivalent right to privacy is found in s 13(a) of the Victorian Charter. According to Berta E Hernàndez, Professor of Law, the right to privacy is expressed in general terms that in essence means that human beings have a human right to privacy or private life.[12] This encompasses 'actions within the realm of interpersonal relations and acts of individual autonomy', including decisions in relation to family life, the human right to make reproductive choices and abortion.[13] Hernàndez points to a number of legal cases that supports this interpretation of the right to privacy. For example, in *Eisenstadt v Baird* (405 US 438 (1972)) Justice Brennan explained that if 'the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child'.[14] Indeed, the famous United States case *Roe v Wade* 410 U.S. 113 (1973) that resulted in a landmark decision about abortion was based upon the finding that many US laws that prohibited abortion were in breach of the constitutional right to privacy under the due process clause of the US Constitution.

2.8 Article 25(1) of the UDHR states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services…

There is no equivalent right in the Victorian Charter however Australia is a signatory to the ICESCR which has an equivalent right in Article 12(1) and (2). It is recognised worldwide that the right to physical and mental health includes issues relating to reproductive health care. This

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[11] Ibid 3.
[12] Berta E Hernàndez, 'To Bear or Not to Bear: Reproductive Freedom as an International Human Right', 17 *Brooklyn Journal of International Law,* 309 (1991), 328.
[13] Ibid 328-329.
[14] Quoted in ibid 309-310.

covers a broad range of services from fertility to family planning, safe childbirth and infant mortality to unwanted pregnancy, and safe terminations. Indeed, the World Health Organisation (WHO), has also declared the right to health as a fundamental human right, and endorsed the right to freely determine the composition of one's family as inextricably tied to health.[15] This is particularly so given the amount of deaths that occur through unsafe abortion which are exceedingly high in the developing world. WHO estimates that 99% of the 500,000 annual maternal deaths occur in developing countries.[16] The right to reproductive health has also been recognised at various international conferences. For example, a comprehensive framework for reproductive health was endorsed and legitimised by 184 UN Member States through the 1994 Cairo Program which defined reproductive health as:

> A state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning *of their choice*, …[17]

2.9 The Preamble to South Africa's *Choice on Termination of Pregnancy Act 1997*, also recognises that:

> The decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programs and services.[18]

As demonstrated many international legal instruments and countries recognise that reproductive health is a basic human right which includes comprehensive coverage ranging from matters concerning

[15] WHO quoted in ibid 336.
[16] Ibid 338
[17] Rebecca J Cook and Bernard M Dickens, 'Human Rights Dynamics of Abortion Law Reform', 25 *Human Rights Quarterly* 1 (2003), 12-13.
[18] Ibid 13.

fertility, contraception and termination. The way to lower the termination rate is not to criminalise abortion. It is broad based education on contraceptive measures, the avoidance of unwanted pregnancies. History demonstrates that women will always seek terminations for unwanted pregnancies, whether terminations are legal or illegal, punitive approaches do not lower rates of abortion, all they do is deny women their basic human rights. As Cook and Dickens state, the 'claim that women should be compelled against their will to serve the wants of others is an instrumental denial of their human dignity and an abuse of their reproductive capacities'.[19] Likewise, Holmes argues that:

> Rights are only rights when they can be exercised in an unfettered way. It is therefore dictatorial, degrading and an insult to the intelligence of a woman to have the decision on whether she will become a mother imposed on her by law or by a panel, or a priest, then leave her to carry out the responsibility of that decision… There is no comparable field of human activity where such a decision is made on another's behalf.[20]

2.10 In *Morgenthaler* Justice Wilson said that the real question (in the case before the Court) was 'whether either the right to liberty or the right to security of the person conferred on the pregnant woman the right to decide for herself whether or not to have an abortion'.[21] In contrast to the other Justices, whose decisions focused more on security of the person, Justice Wilson placed greater emphasis on the 'right to liberty and the content of this right in the context of abortion.'[22] Justice Wilson's opinion is quite remarkable as it brings a legal, human rights and woman's perspective to the issue of abortion and is important in relation to the VLRC's inquiry. Therefore we refer to some of her comments in detail below. In addition, the right to liberty in the Canadian Charter of Human Rights is the same as s 21 of the Victorian Charter of Human Rights and Responsibilities making Justice Wilson's interpretation of abortion in the context of a right to liberty even more pertinent to the current inquiry.

2.11 According to Justice Wilson, the word "liberty", 'properly construed, grants an individual a degree of autonomy in making decisions of

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[19] Ibid 17-18.
[20] Beryl Holmes, above n 8, 4.
[21] *Morgenthaler,* Justice Wilson 72 (166)
[22] M L McConnell 'Even by Commonsense Morality': *Morgenthaler, Borowski* and the Constitution of Canada', (1989) 68 *The Canadian Bar Review* 765, 779

fundamental personal importance'.[23] Referring to the framers of the Constitution and an earlier Canadian Supreme Court decision, Justice Wilson said that in guaranteeing:

> "liberty" as a fundamental value in a free and democratic society had in mind the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his character, to make his own choices for good or ill, to be non-conformist, idiosyncratic and even eccentric – to be, in today's parlance, "his own person" and accountable as such.[24]

Justice Wilson went on to say that:

> Liberty in a free and democratic society does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them.[25]

Justice Wilson concluded that the right of a woman to terminate her pregnancy falls within a class of protected decisions (under the Charter of Rights) as the:

> [D]ecision is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way a woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.[26]

2.12 The main objection to abortion comes from a religiously based morality system. Justice Wilson also addresses the issue of freedom of conscience and freedom of religion in her opinion, she states:

> In a free and democratic society 'freedom of science and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality. Indeed, as a matter of statutory

[23] *Morgenthaler,* Justice Wilson 72 (167)
[24] *Morgenthaler,* Justice Wilson 72 (167)
[25] *Morgenthaler,* Justice Wilson 72 (167)
[26] *Morgenthaler,* Justice Wilson 72 (171)

> interpretation, "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning. Accordingly, for the state to take sides on the issue of abortion, as it does in… legislation by making it an offence for the pregnant woman to exercise her options, is not simply to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one conscientiously held belief at the expense of another. It is to deny freedom of conscience to some, to treat them as a means to an end, [and] to deprive them… of their essential humanity.[27]

2.13 Justice Wilson's opinion reflects the human rights perspective on this issue that Liberty Victoria also supports. Liberty Victoria believes that the guiding principles that should underpin reform of the law of abortion should be international human rights principles not the concept of sin or a particular religious belief. People are entitled to freedom of religion and to conduct their life in relation to those beliefs, however, they are not entitled to impose those beliefs on others or to have them implemented through state laws and then forced on others who do not share that belief system. Any laws governing this area of law must recognise women's basic human rights and see women as free and equal human beings, as well as responsible decision makers in respect of their own fertility. Abortion is one area of policy that needs to be addressed with sensitivity in respect of women's rights. In relation to this issue liberty requires the acknowledgement of certain distinctions between men and women. As Weinrib points out:

> Since liberty is guaranteed equally to men and women…, the state cannot fetter the liberty of women in situations in which men are exempt. Men are exempt 'by nature' from gestation and must be constrained to the responsibility of parenthood by law; women, in contrast, must acquire exemption from parenthood through law that permits abortion.[28]

3 Policy objectives of the law

3.1 Abortion should not be seen as a stand alone procedure but rather as part of a comprehensive program on sexual and reproductive health which in itself is embedded in an overall human rights approach to reproductive health issues. Abortion should not be singled out as a

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[27] *Morgenthaler,* Justice Wilson 72 (179)

[28] Lorraine Eisenstat Weinrib, 'The *Morgentaler* Judgement: Constitutional Rights, Legislative Intention, and Institutional Design', (1992) 42 *University of Toronto Law Journal* 22,

specific area of legislation but rather subsumed under healthcare and medical legislation.

3.2 The primary policy objective of reproductive health measures is safe and reliable fertility control for women and men. If the desire is to become pregnant, then programs should assist the woman to do so and offer medical care and support throughout the pregnancy. The primary public health objective in relation to unwanted pregnancy is prevention. This requires improved access to sexual health and contraceptive information and educational programs. To meet this objective educational programs should begin during secondary education. Unwanted pregnancy is a reality of life, no contraceptive measure is foolproof, should a woman desire a termination then the policy objective is to provide access to that service in a timely and safe fashion. The overall objective of reproductive health programs is reproductive self-determination for women and men.

3.3 A further policy objective should be clarity of law. As the law stands at present it opens up the risk of prosecution for both women and medical practitioners. The law is unclear and confused. Abortion is unlawful under the statute and only rendered lawful due to common law exceptions. However this creates great uncertainty as it can change subject to judicial interpretation. The law needs to be clear and consistent as well as recognise the right of women to bodily integrity.

4 What factors should be taken into account in deciding if a termination is lawful?

4.1 The discussion paper lists a number of factors such as consent of the pregnant woman, threat to life, physical and mental health, and social and economic factors. These are primarily factors that have developed as common law exceptions to the statute law. Threat to the life of a pregnant woman is too limited. A person's human rights extend well beyond a right to survival. This factor and most of the other factors are also determined by parties other than the pregnant woman. Who determines whether there is a risk to the woman's physical and or mental health, and what level of risk is to be required of a woman seeking an abortion? What is the position of the woman's medical practitioner is he or she an opponent of abortion because of religious or other belief? How does, and how should, such opposition impact on the determination? Likewise, who interprets whether economic and social factors are relevant to a decision to terminate a pregnancy? Such determinations are highly subjective and open to interpretation

and should not be relevant in determining whether a woman is entitled to an abortion. The only relevant issue is consent. As such women should be able to access all relevant medical information and counselling services should they wish to consult such services.

5 South Australian legislation includes specific grounds for termination if the foetus is at risk of 'serious handicap'. How should this issue be considered in Victoria

5.1 Serious handicap should not be considered for Victoria. Including such a ground for termination is highly discriminatory and has unwholesome parallels with regimes that consider people with a disability as second-class citizens. Should a couple or woman decide to terminate on the basis of handicap of the foetus and inability to look after a disabled child then that is their/her individual decision and should be respected as such however it should not be established in law.

6 In some jurisdictions, legislation contains different conditions for lawful termination, depending on the stage of pregnancy. What are the advantages and disadvantages of this approach? Should Victoria take this approach?

6.1 The law surrounding abortion differs widely in many regions of the world. According to the Center for Reproductive Rights, 61% of the world's people live in countries where abortion is permitted either for a wide range of reasons or without restrictions as to reasons.[29] Western countries that allow abortion without reason include Canada, Denmark, France, Germany, Greece, the Netherlands, Norway, Portugal, Sweden, Switzerland and some parts of the US. Those that allow abortion on socioeconomic as well as mental and physical grounds include Australia, Barbados, Finland, Great Britain, Iceland, Japan, Luxembourg and Taiwan.[30]

6.2 Indeed many non-western countries also have liberal abortion laws. For example, after years of very restrictive abortion, in 2002 Nepal amended its criminal laws to allow abortion on request in the first 12 weeks of pregnancy the only condition being voluntary consent, a pregnancy resulting from rape can be terminated up to 18 weeks, and

[29] Center for Reproductive Rights, *The World's Abortion Laws*, (2007), http://www.reproductiverights.org/pub_fac_abortion_laws.html
[30] Ibid.

at any time during the pregnancy of the woman's life or physical or mental health are in danger, or there is a risk of foetal impairment.[31] The Bill of Rights of the 1996 Constitution of South Africa, s 12 provides citizens with 'the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and the right to security and control over their body.[32] This is reflected in abortion laws which allow abortion on request in the first 12 weeks of pregnancy, up to 20 weeks if a doctor believes that the pregnancy poses a risk to the woman's physical or mental impairment, or the pregnancy resulted from rape or incest. If the pregnancy would result in foetal impairment or is a threat to the woman's life, abortion can be performed at anytime during the pregnancy.[33] The Ethiopian *Technical and Procedural Guidelines for Safe Abortion Services,* defines woman-centered abortion care as:

> A comprehensive approach to providing abortion services that takes into account the various factors that influence a woman's individual mental and physical health needs, her personal circumstances, and her ability to access services.[34]

In addition, the Ethiopian laws stipulate that abortions should be provided within three days of a woman's request.[35]

6.3 The point of this tour of overseas jurisdictions is to illustrate that there is nothing particularly radical about the Bill that was proposed by Ms Candy Broad MP or about the proposal to reform Victoria's abortion laws. Our laws reflect a conservative agenda rather than any acknowledgement of women's human and reproductive rights. Indeed many non-western countries around the world have more progressive laws pertaining to abortion and women's rights. Further, within some of these countries access to abortion is unrestricted.

6.4 Different conditions relating to different stages in the pregnancy are generally related to concerns about late-term abortions. There is a lot of controversy over late-term abortions, partially due to the use or misuse of the non-medical term 'partial-birth' abortion, and the focus given to such terminations by fundamentalist religious groups. However, this concern is somewhat a diversion, as despite the

[31] Center for Reproductive Rights, *Gaining Ground,* (2006) Chapter IV, 47, http://www.reproductiverights.org/pub_bo_gainingground.html#pdf
[32] Ibid 48.
[33] Ibid 48.
[34] Ibid 49.
[35] Ibid 49.

contentions of opponents, such terminations are rare. According to Dickinson, who reviewed the outcomes for abortion beyond 20 weeks gestation within the environment of legislated notifiable pregnancy termination (Western Australia), between the years May 1998 to 31 December 2002, only 219 women presented for late terminations.[36] Dickinson states that all pregnancy terminations in this latter cohort were for foetal abnormality and those requesting such terminations were statistically older.[37] Likewise, Associate Dean and Professor of Obstetrics and Gynaecology at ANU Medical School, David Ellwood, estimated that across Australia, late term abortions are somewhere between 0.1% to 0.6% of all births each year.[38] He states that nearly all are less than 28 weeks gestation, with the majority less than 24 weeks, and the reason is for severe foetal abnormality that is likely to result in major handicap or perinatal death.[39]

6.5 A review of the evidence on late-term abortion in the United Kingdom conducted by Pro-Choice Forum found similar results.[40] Abortion at 20 weeks or more remained at between 1 and 1.6% of the total number of births.[41] In addition they found that there were 4 main reasons for women having late abortions. First, failure to recognise the pregnancy earlier this was particularly so if the woman was on the pill and had irregular periods, often these women were also very young.[42] Secondly, those who delay seeking abortion due to indecision generally connected with fear or lack of emotional support from family, partner, friends, etc.[43] Thirdly, those for whom the foetus is found to be seriously abnormal. Part of the problem here relates to the available technology. The optimal age to screen for some abnormalities appears to be around 20 weeks and some may take longer for confirmation of abnormality.[44] According to the report, 'rates of abortion for fetal abnormality … reflect the severity of the condition, with most women choosing abortion for lethal conditions, and far fewer where the condition may be treatable.'[45] Finally,

[36] Jan E Dickinson, 'Late Pregnancy termination within a legislated medical environment', (2004) 44 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 337, 337
[37] Ibid 338
[38] David Ellwood, 'Late terminations of pregnancy – an obstetrician's perspective', (2005) 29 *Australian Health Review* 139, 141.
[39] Ibid 141
[40] Pro-Choice Forum, *Late Abortion: a Review of the Evidence,* (2004) http://www.prochoiceforum.org.uk/pdf/PCF_late_abortion08.pdf
[41] Ibid 3
[42] Ibid 13
[43] Ibid 13
[44] Ibid 4 and 13.
[45] Ibid 5.

difficulty in accessing abortion because the GP is unwilling to refer, there is no service nearby, which is often a problem for rural women.[46] As with the other examinations they conclude that late abortions are relatively rare.

6.6 A second issue that is illustrated in research on late-term abortions is their particularity which in turn points to arbitrariness of establishing a cut-off point. As late-term abortions are extremely rare and highly dependent on the circumstances of a particular case, establishing a specific threshold time may result in an injustice. If a severe abnormality cannot be determined early in a pregnancy because the technology is not available, or a threatening condition does not materialise until late in the pregnancy, a woman should not be forced to carry the foetus through to birth against her wishes, or the wishes of both parents. There is an individualising nature about late-term abortions that needs to be acknowledged. There will always be extreme cases where abortions will need to be performed beyond the first trimester and well into the second trimester. The law needs to recognise that this is the case.

6.7 Liberty Victoria consists mostly of lawyers and is not therefore familiar with the intricacies of late-term abortions. This is an area where the VLRC could benefit from the advice of medical practitioners. However, Liberty does recognise from the available evidence that setting an arbitrary cut-off point could result in an injustice and perhaps more suffering in some circumstances thus we believe that legislation should not connect abortion with the stages of pregnancy.

7 If a staged approach is taken, on what basis do you determine a point in time in the pregnancy?

7.1 As the evidence in 6 above suggests; the best option for reducing late terminations in contrast to imposing gestational limits in legislation that would result in women and doctors being prosecuted, is better, more affordable and accessible services to early terminations. If some threshold needs to be established, the best approach would be to establish **guidelines not law** for medical practitioners and hospitals in relation to different gestation periods, and to provide better and safer services to women. Victoria should not set a staged approach in legislation.

[46] Ibid 13.

8 What should be the role of the medical practitioner in deciding whether a termination is lawful and should proceed?

8.1 The role of the medical practitioner should be to support his/her patient. The woman's GP is closest to her and familiar with her history, any decision concerning abortion should be made between the woman and her doctor, or if she is partnered, the couple and their doctor. The important point however is that the decision to allow a woman to have a termination rests with her. It should not be made by a panel of one or more medical practitioners, obstetricians or gynaecologists, who have no relationship with the woman. Nor should a panel be able to make that decision for her, this is a breach of the woman's right to security and liberty of the person. In addition, in rural areas where services are poor terminations, ie., using RU468, will need to be done under the supervision of the local GP, making such decisions dependent on a board of doctors will delay the procedure causing more stress, and possibly a later term-abortion as identified above. The final decision must rest with the woman.

8.2 If the Health Department is to be notified of the procedure occurring this needs to be done in a way that respects the privacy of the woman. In fact the woman should not be identified. This is particularly important given the appalling behaviour by Australian Government Senator and anti-abortion lobbyist, Julian McGauran. McGauran obtained the medical records of a woman who obtained a late-term abortion when an ultrasound confirmed a diagnosis of skeletal dysplasia (dwarfism). The Coroner gave the medical records to Senator McGauran who then used that material as part of his campaign providing the woman's name to the media despite a suppression order made by Master Wheeler of the Victorian Supreme Court. According to de Crespigny and Savulescu, this affair caused severe harm to the patient, her family whose private medical records became headline news; harm to the staff involved; harm to the hospital involved; harm to other institutions such as the medical board and the state coroner for mishandling the medical records; potential harm to future patients; and harm to Australian society generally, as vague and inconsistent laws create uncertainty and conflict for medical practitioners.[47] The right to privacy for the patient must be strictly protected.

[47] Lachlan J de Crespigny and Julian Savulescu, 'Abortion; time to clarify Australia's confusing laws', (2004) 181 *Medical Journal of Australia* 201, 201.

9 Who should have the final say in deciding if a termination will take place?

9.1 For the reasons outlined in section 1 of this submission, (human rights of the woman, specifically security, liberty and dignity of the person), Liberty Victoria believes that it is the pregnant woman who should have the final say over a termination.

10 Should access to lawful termination be conditional upon attendance at counselling and information sessions? If so, what sort of counselling and information?

10.1 Liberty Victoria believes that counselling prior to terminations should not be mandatory nor should waiting periods be imposed. Counselling should be available for women desiring such a service, women have a right to neutral counselling services prior to terminations should they feel the need. Mandatory counselling and waiting periods assume that all women are unable to reasonably determine what is best for them and are unable to rationally reflect on their decision prior to having the medical procedure. This assumption is demeaning to women and undermines their autonomy. It also feeds into the deliberate misinformation about abortions pedalled by the fundamentalist religious right. Further this counselling exercise being mandatory in these circumstances would come to be a burden which women, - who may already be going through a tense and emotionally strained period, - are forced to go through. Compulsion would achieve little, other than become a focus of anger and a cause of distress.

10.2 Abortion providers and hospitals already offer counselling services to women seeking terminations. The push to make counselling services mandatory and to impose waiting periods comes from the fundamentalist religious right. In addition, they also push the idea that women should be advised of the physical and psychological damage that could result from abortion and be advised about post-abortion syndrome. The problem here is that there is no such syndrome, it is a made-up condition by the religious right and is not accepted by the medical or psychiatric professions. This same medical misinformation or propaganda was promoted by the religious right during the Senate Community Affairs Committee Inquiry into the Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005. We repeat below the medical evidence that we submitted to that inquiry regarding the physical and

psychological after effects of abortion, or the so-called 'post-abortion syndrome'.

10.3 Many of the studies supported by opponents have under critical examination been shown to be grossly exaggerated or the material has been used selectively. For example, a recent study by David Fergusson linked abortion to mental health problems. This research was promoted vigorously by anti-choice religious groups. However, it failed to take into account other studies using a much larger sample base that initially found a similar association until partner violence and other variables were factored in, at which point termination of pregnancy did not rate as a contributor to mental health problems.[48] Indeed numerous studies over a 20 year period have found that there is no basis for supporting the argument that abortion causes severe physical or mental health threats (see Adler, et al 1990, 1992; AMA Council on Scientific Affairs 1992; Denious & Russo 2000; National Academy of sciences, 1975; Russo 1992 & Schwartz 1886).[49] This was also confirmed in a two-year study by Major, et al, concerning the psychological effects of abortion that found that the majority of women do not experience any mental health problems or regrets two years after abortion.[50] Another study by Daggundertaken in 1991, found that up to 98% of women who had abortions had no regrets and would choose the same course of action again.[51] The American Psychiatric Association, despite the repeated assertions of anti-choice proponents, does not recognize the so-called 'post abortion syndrome', and found that all the studies that purport to prove its existence contained methodological flaws that rendered the

[48] Russo, Nancy Felipe & Jean E. Denious. (2001). "Violence in the Lives of Women Having Abortions: Implications for Practice and Public Policy." Professional Psychology: Research and Practice, 32(2), 142-150; see also Planned Parenthood (2001), *The Emotional Effects of Induced Abortion,* http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-010600-emoteff.xml;

[49] American Medical Association, Council on Scientific Affairs. (1992). Induced termination of pregnancy before and after *Roe v. Wade*: Trends in the mortality and morbidity of women. *Journal of the American Medical Association*, ***268***, 3231–3239; Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, ***248***, 41–44; Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1992). Psychological factors in abortion: A review. *American Psychologist*, ***47***, 1194–1204; Denious, J. E., & Russo, N. F. (2000). The socio-political context of abortion and its relationship to women's mental health. In J. Ussher (Ed.), *Women's Health: Contemporary International Perspectives* (pp. 431–439). London: British Psychological Society; National Academy of Sciences. (1975). *Legalized abortion and the public health*. Washington, DC: National Academy Press; Russo, N. F. (1992). Psychological aspects of unwanted pregnancy and its resolution. In J. D. Butler & D. F. Walbert (Eds.), *Abortion, medicine, and the law* (4th ed., pp. 593–626). New York: Facts on File; Schwartz, R. A. (1986). Abortion on request: The psychiatric implications. In J. D. Butler & D. F. Walbert (Eds.), *Abortion, medicine, and the law* (3rd ed., pp. 323–340). New York: Facts on File.

[50] Major, Brenda, et al. (2000). "Psychological Responses of Women after First-Trimester Abortion." Archives of General Psychiatry, 57(8), 777-784.

[51] Dagg, Paul K. B. (1991). "The Psychological Sequelae of Therapeutic Abortion — Denied and Completed." American Journal of Psychiatry, 148(5), 578-585.

conclusions non-applicable beyond specific subjects, that is that they cannot be generalised or applied to all women.[52]

10.4 Where emotional problems did occur it was in a small minority of women which studies have found were related to unstable living conditions (conflict with parents), unstable and/or violent relationship with partners, partner abuse, and unsupportive environment, those with positive relationships and partners and parents who supported their position experience far less distress and do not suffer regret over their decision.[53] These studies recognise that terminations can cause mental anguish and distress to some women. However, the percentage is statistically negligible when compared with other factors. For example, Adler, et al, found that there can be immediate mild but transient postoperative depressive symptoms in less than 20% of women after terminations,[54] however, *similar symptoms occur in up to 70% of women immediately following childbirth.*[55] Cases where women exhibit real mental distress and psychological responses are those involving adoption not termination. One study found that 95% of birth mothers who have consented to adoption experience grief, loss and ongoing mental distress, while women who had undergone first-trimester abortions had assimilated the termination experience within a short timeframe without any ongoing distress.[56]

10.5 Similar research has also been undertaken in Australia by Melbourne Psychologist, Dr Susie Allanson which further challenges the claims made by David Fergusson and fundamentalist Christians. The research undertaken by Dr Allanson, includes both international and Australian studies into the relationship between terminations and mental health.

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[52] American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (DSM-IVÃ¤), 4th ed. Washington, DC: American Psychiatric Association.

[53] Russo, Nancy Felipe & Jean E. Denious. (2001). "Violence in the Lives of Women Having Abortions: Implications for Practice and Public Policy." Professional Psychology: Research and Practice, 32(2), 142-150; Russo, Nancy Felipe & Amy J. Dabul. (1997). "The Relationship of Abortion to Well-Being: Do Race and Religion Make a Difference-" Professional Psychology: Research and Practice, 28(1), 23-31; Petersen, P. (1981). "Psychological Alterations Following Induced Abortion." Munchener Medizinische Wochenschrift, 43(20), 1105-1108; David, Henry P., et al. (1985). "Postpartum and Postabortion Psychiatric Reactions." In Paul Sachder, ed., Perspectives on Abortion (pp. 107-116). Metuchen, N. J.: Scarecrow Press; Zeanah, Charles H., et al. (1993). "Do Women Grieve After Terminating Pregnancies Because of Fetal Anomalies- A Controlled Investigation." Obstetrics and Gynecology, 82(2), 270-275.

[54] Adler, Nancy E., et al. (1990). "Psychological Responses after Abortion." Science, 248(4951), 41-44.

[55] Ziporyn, Terra. (1984). "'Rip van Winkle Period' Ends for Puerperal Psychiatric Problems." Journal of the American Medical Association, 251(16), 2061-2063 & 2067

[56] Sachdev, Paul. (1989). Unlocking the Adoption Files. Lexington, MA: Lexington Books; and Sachdev, Paul. (1993). Sex, Abortion and Unmarried Women. Westport, CT: Greenwood Press.

Allanson's paper examines the "growing evidence of the adverse impact of intimate partner violence, childhood violence and other violence on women's mental and reproductive health, and considers what this may mean in the particular context of women presenting for an abortion".[57] As with international research Allanson found that a variety of factors contribute to negative mental health problems post-termination, violence being a significant factor. According to Allanson:

> Post-abortion mental health appears to be worse where there is a history of violence, when there is conflict about the abortion within usually supportive relationships or with the partner in the pregnancy, when the abortion is kept secret from others, and/or when the woman has low self-efficacy about her post-abortion coping and experiences decision ambivalence, [by contrast] mental health appears to be enhanced where there is no violence history, relationships are supportive of the abortion decision, the woman can disclose her abortion experience, and/or she has high self-efficacy.[58]

To support her position Allanson uses research and reports from a variety of organisations including the World Health Organisation as well as the Australian Longitudinal Study on Women's Health.

10.6 Any information given to women on abortion must come from a rational and proven basis. The exploitation of women during a period of reflection, vulnerability and decision-making by the religious right is unethical. Counselling services for women must be available, affordable, and accessible. In addition and most importantly, counselling services must be professional, unbiased and voluntary. Those offering counselling services that have a particular religious view should be required to state publicly that they come from a particular perspective. Pretending to offer a neutral full range of services to women when clearly not, is tricky and unconscionable. All counselling services must be required to comply with the false, misleading and deceptive conduct provisions in the *Fair Trading Act* 1999. In summary, counselling should be available to women who require the service but should not be compulsory for all women. Nor

[57] Dr Susie Allanson, *Violence, Mental Health and Abortion,* unpublished manuscript on file with Liberty Victoria. The manuscript can be obtained from Susie Allanson, Clinical Psychologist, The Fertility Control Clinic, East Melbourne, Victoria.
[58] Ibid.

should women be required to undergo a waiting or cooling-off period, or forced to look at ultra-sound pictures. Liberty Victoria believes that women are quite capable of making their own decisions in relation to fertility and reproduction and counselling should only be an option for those women seeking it.

11 Should the law state that a medical practitioner has no duty to perform or assist a termination unless a woman's life is at risk?

11.1 Liberty Victoria does not believe that people should be forced to do things that they morally object to. If medical practitioners object to abortion on religious or ethical grounds then they should inform their patients of their objections. Medical practitioners should not be forced to undertake procedures they object to. However, neither should they misinform or mislead patients in order to influence their decision. The easiest way to notify patients is to have a notice in the surgery stating that the doctor objects to abortion on religious grounds. Notification will ensure that patients go elsewhere for information on terminations.

11.2 Liberty Victoria does not believe that subjective moral or ethical objections should be explicitly protected in legislation. Indeed, if medical practitioners' moral or ethical objections are to be legally sanctioned by inserting them in legislation then the requirement of a statutory duty to refer that patient to another practitioner who will perform the requested procedure also needs to be inserted into legislation. If doctors are going to be legally protected and in a sense 'let off the hook' from performing a medical procedure, essentially because of non medical "issues" the doctor may have, then the law needs to protect patients who find themselves dealing with such doctors.

11.3 This becomes more pertinent where a woman's life is in serious danger and she presents at a public hospital for treatment that may require termination of a foetus. Under such circumstances refusal to treat the woman is highly questionable, if not objectionable. Doctors working in public hospitals are to some degree the medical equivalent of a public servant and refusing treatment that could result in the death of a woman on the basis of subjective religious beliefs is problematic and should not be protected in legislation.

12 Does the offence of child destruction need to be changed in any way? If so, how?

12.1 Repeal of s 65 of the *Crimes Act 1958* will necessitate changes to the child destruction provisions as ss 10(3) and 10(4) make references to s 65.[59] As the discussion paper makes clear this provision was drawn from an English statute enacted in 1929 and has been rectified by legislative amendment in England in 1991. Further, that its original intention was in relation to a foetus killed during the process of delivery and not abortion. As such this law is confusing and can be interpreted in a number of ways. Liberty Victoria is of the view that s 10 of the Crimes Act should also be repealed.

12.2 If the child destruction section is not repealed then it needs to be clarified to distinguish it from abortion. It needs to be made clear that these provisions are not related to abortion as the original purpose of the provisions relate to death during the process of delivery not to abortion.

13 What the law should say

13.1 First, the law should be created within the framework of the human rights principles outlined in section 2 of this submission. It must start from the position of respecting women's full human rights, including liberty and security of the person, and the right to determine when and if they have children. It must also acknowledge that women are rational human beings capable of making their own decisions regarding fertility. Abortion law reform must also be backed up by a comprehensive sexual and reproductive health program which provides high quality, professional and unbiased information on family planning, pregnancy and terminations, in a timely, affordable and accessible manner. This means that services should be localised, rural women need women's medical centres in regional cities. In addition:

- Counselling should be provided in centres for women who require counselling ***but under no circumstances should it be compulsory.***
- No cooling-off periods should be implemented in legislation, this does not prevent abortion but may increase late-term abortions nor does it recognise that women are capable of making rational decisions. It also assumes that approaches to doctors on this topic are made glibly. It is absurd to think that a

[59] Peter Hanks QC and Melanie Young, above n 36.

person will consider issues that she has not before seeing a doctor, and that she will think "more deeply" about the procedure because of the burden of a delay in completing a very stressful process.

- Only accurate proven medical information should be given to women, women should not be frightened by inaccurate and deceptive information such as linking abortion with breast cancer, or told about post-abortion syndrome. These are not recognised medical conditions but made-up conditions by the religious right. It is appropriate that the material that can be provided is limited to matters dealt with in a legislative framework, to prevent this inaccurate or deceptive information being given.

13.2 Liberty Victoria believes that the ACT *Crimes (Abolition of Offence of Abortion) Act 2002* is the best approach to legislative change. Liberty Victoria issued a press release supporting Candy Broad's Bill decriminalising abortion stating that the regulation of abortion should be like the regulation of any other medical procedure. Liberty Victoria did not see any reason for the implementation of any new laws. In our view Candy Broad's Bill was minimal and straightforward, similar to the ACT Act. It simply removed ss 65 and 66 from the Crimes Act, abolished the common law offences of unlawful abortion and created a new criminal offence for any person carrying out an abortion unless they are a medical practitioner or supervised by a medical practitioner.

13.3 Around the same time that Candy Broad released her Bill another Bill, titled the Health (Amendment) Bill 2007 ("Health Bill") also surfaced. The author of the Bill was not identified however it was presented as an alternative (by the ALP) to the Broad Bill. While presented as a better option than the Broad Bill, in Liberty Victoria's view, the Health Bill was highly problematic and should not be accepted as a legislative option for the decriminalisation of abortion. The Health Bill did not decriminalise abortion nor did it recognise women's right to control decisions about their sexual and reproductive health. Indeed, legal advice on the Health Bill by barristers, Peter Hanks QC and Melanie Young, states that the Bill:

> … not only substantially preserves the current Victorian Law which makes abortion a criminal offence but would also

increase the exposure of health practitioners and others to criminal offences.[60]

13.4 Essentially what the Health Bill did was take abortion out of the *Crimes Act 1958* and re-inserted it as a crime into the *Health Act 1958,* along with the common law exceptions of the Menhennitt ruling, and on top of that, created a new layer of medical bureaucracy to oversee abortion. This is not decriminalisation. This re-criminalises abortion, makes the law more complicated and increases the legal uncertainty for medical practitioners. According to the Advice, the Health Bill, 'confirms and codifies the criminal liability of health care practitioners currently based on ss 65 and 66 of the Crimes Act and Menhennit line of authority'.[61] They further argue that there is considerable scope for legal controversy in the elements of unlawful abortion found in the Bill: unlawfulness is not defined leaving it open to interpretation, the legal burden of proof in relation to requisite belief is placed on the accused rather than the prosecution, and the criminal exposure of persons other than doctors, ie, nurses and members of allied health professions is expanded.[62] The Advice states that these changes come close to treating abortion as an absolute or strict liability offence.[63] Further, the introduction of an "overseeing committee" undermines the absolute need for privacy in this situation. Indeed this makes the situation in Victoria in regards to abortion law worse that the current situation, hence, Liberty Victoria's support for a straightforward decriminalisation approach such as that found in the ACT *Crimes (Abolition of Offence of Abortion) Act 2002.*

14 Conclusion

14.1 In summary, Liberty Victoria believes that the best model is the ACT *Crimes (Abolition of Offence of Abortion) Act 2002*. It is time that the state respect women's rights and refrained from acting as a watchdog over women's reproductive choices. The Bill should simply repeal ss 65 and 66 of the *Crimes Act 1958* and not seek to re-regulate or re-insert the current law into the *Health Act 1958.* In addition, s 10 on child destruction should also be repealed from the *Crimes Act 1958.*

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[60] Peter Hanks QC and Melanie Young, *Amendment of Victorian Abortion Law: Memorandum of Advice re Health Amendment Bill,* Advice for ALRA (3 August 2007)
[61] Ibid
[62] Ibid
[63] Ibid