Victorian Law Reform Commission: The Law of Abortion

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Discussion Questions

What ethical and legal principles should inform the law of abortion in Victoria?

Safe legal abortion is essential.

Parliament should not legislate on issues of private morality. It is for women to make their personal decisions according to their conscience.

Autonomy: Currently pregnancy is a rare situation in which independent adults have the right to control their own bodies removed.

Laws should be updated to be equitable and non-discriminatory – current laws disadvantage some groups:

Rural and poor women

Many women are denied timely prenatal testing and abortion if fetal abnormality is diagnosed, because unclear laws cause doctors to fear personal and professional damage.

It should be clear when abortion is lawful so that doctors need no longer fear that they will unexpectedly be subject to investigations, adverse press and possible criminal charges.

Uncertain laws should be removed to enable agreed standards of best practice to develop in managing women who may request pregnancy termination.

Laws should make it clear that access to prenatal testing and termination of pregnancy should not depend on where a woman receives care, the values and attitudes of her doctor, institution or a committee, or her personal resources.

There should be consistent approaches to fetal moral status in obstetrics and paediatrics: abortions should not be forbidden in situations in which newborn infants would be allowed to die.

We need a more consistent approach to early human life. Women wanting to have a baby deserve just laws that are clear.

Where medical professionals conscientiously object to provide abortion information or services, they must ensure appropriate and timely referrals are made to health professionals or providers who do not object.

2 What should be the policy objectives of any law of abortion? Are these currently met in Victoria?

Two major policy objectives should be to offer women lawful access to abortion; and for legal clarity so that it always is clear to both Victorian women and their doctors when abortion is lawful.

Pregnant women, like other Australians, should have the right to bodily integrity. Politicians cannot better decide who should have access to abortion; this would suggest that women cannot make their own decisions appropriately, that politicians have greater wisdom.

It is not for politicians to limit abortions later in pregnancy. Politicians seem to infer that women frivolously choose abortion late in pregnancy. Thirty years in prenatal testing has shown one of us the folly of such presumption – nothing could be further from the truth. Women decide early in pregnancy whether they wish to have a baby. Having decided that they wish to do so, they are reluctant to consider abortion even following the diagnosis of a severe abnormality; if they do request abortion they do so with the greatest of reluctance and after deep consideration of the issues.

Access to the full range of reproductive health services, including abortion, must be available for women regardless of where they live[1].

Victoria should comply with Amnesty International's call for abortion to be decriminalized globally. In addition, the World Medical Association Declaration on the Rights of the Patient[2] states: 'The patient has the right to self determination, to make free decisions regarding himself /herself. The physician will inform the patient of the consequences of his /her decision'.

Policies should be geared to achieving positive health outcomes for women, and to meeting the particular needs of groups such as poor women, adolescents, rape survivors and HIV-infected women [3].

Victoria's antiquated, unclear and conflicting laws do not currently met these policy objectives.

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

• Consent of the pregnant woman?

She should *request* abortion – 'consent' implies that she agrees to a proposal promoted by another person; perhaps even reluctantly agrees. She should be informed that abortion is

an option in situations that it is lawful; but it is for her to either request abortion or to decide to continue the pregnancy.

Women who do not want to be mothers should not be mothers. Being a parent is too difficult and important a task to be left up to individuals who are not committed. It would be wrong to bring a child into the world with no one ready, willing or able to assume responsibility for it. Society should provide care for such children, but until it does, termination at any stage of pregnancy should not be refused.

• Threat to the life of the pregnant woman?

This is too strict a criterion.

• Her physical and mental health?

This is too subjective; it relies on the variable and subjective interpretation of 'risk' by the doctor whom the patient happens to consult.

As discussed below, following the diagnosis of fetal abnormality women have unpredictable, unreasonably limited, and often much delayed access to abortion. Studies show high rates of depression and mental health risks of caring for a disabled child [4]. A recent study found that carers who look after relatives, such as the disabled, suffer "extraordinary" rates of depression with 40 per cent of the carers "severely" or "extremely severely" depressed. They have the lowest level of wellbeing of any group in society. Their dissatisfaction with all aspects of life is more pronounced than other marginalized groups surveyed. Abortion is lawful when there is serious danger to mental health; it is unreasonable that access to later abortion following the diagnosis of fetal abnormality is limited. The physical and mental health criteria are failing women.

The only plausible criterion for abortion is on maternal interests, broadly construed. And women are generally best placed to judge what is in their interests [5].

• Social and economic factors when considering the physical and mental health of the woman?

This is also too subjective; it relies on the variable and subjective interpretation of social and economic factors by different doctors. Again, women are generally best placed to judge what is in their interests

• Other factors?

The solution is the ACT model - no abortion laws within the Crimes Act. It should be on request: women should be able to choose not to be a parent. Law should respect a woman's right to control her body. Pregnancy should not be a condition in which women lose the right to control their own body.

4 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?

Response

The fetus being at risk of 'serious handicap' should not be the legal grounds for termination:

'Serious handicap' is a subjective and indefinable term.

'Serious handicap' being the legal grounds for termination is arguably a eugenic law that is offensive to some people. Either the fetus has a right to life – in which case all abortions are murder – or it does not, in which case it is discriminatory to limit abortion to fetuses with medical abnormalities[5].

Discussion

Current practice of late termination of pregnancy is discriminatory: it institutionalizes killing of fetuses with abnormalities perceived to be severe, but not of fetuses with perceived minor abnormalities. (See further discussion by Savulescu [5)]. This is discrimination against fetuses with disability. It is also a form of eugenics. "Eugenics" means "well born" and is tied to the notion of selective breeding. It is generally

understood to be the intentional attempt to bring about a healthier or better population, especially by coercion or limiting options available, especially when there is state involvement.

When a pervasive professional practice or law only allows termination of pregnancy when there is fetal abnormality, this discriminates against abnormal fetuses. While pregnancy termination may not be compulsory, its effect is eugenic. In a similar way to that in which active and passive euthanasia are distinguished, active eugenics can be defined as offering the option of an intervention which directly promotes some eugenic outcome, for example offering financial inducements to the "fit" to reproduce. Passive eugenics is the closing off of options with the result that a eugenic outcome is more likely, for example not offering child support to people who choose to have a disabled child. Allowing late termination of pregnancy for serious abnormality but disallowing it for minor or no abnormality is passive eugenics.

Many would object that current practice is not eugenic because the intention is to offer choice regarding continuing a pregnancy with a major abnormality, and not to promote a healthier population. It is true that practice may not be driven by primary eugenic intention, but the effect is the same. And the effect is foreseeable. We do not see any moral distinction between the intended effects of an action, and the foreseeable but unintended effects of that action. Not allowing women to terminate normal pregnancies has the same foreseeable effect as requiring the termination of abnormal pregnancies, at least in a culture where prenatal diagnosis is promoted and disability is viewed negatively. However, there is reasonable disagreement over whether there is a moral distinction between acts and omissions, and between intended and foreseen consequences.

Late termination of pregnancy should be allowed for fetal abnormality but also some normal pregnancies. It assumes that the fetus does not have a moral status until birth or afterwards. It is the least discriminatory and eugenic option.

A law that assumes that the fetus does not have moral status should be supported. This allows late abortion for abnormality but also for some normal pregnancies. This view thus escapes the criticism that can be leveled if late termination is lawful for fetal

abnormality that there is discrimination against fetuses with disability. (Such discrimination in according a right to life depending on the severity of disability would not be considered acceptable after birth.)

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

Drawing a 'line in the sand'

Any line drawn should not be arbitrary. Arbitrary gestation limits inevitably harm women who fall the wrong side of the line. Take the example of monochorionic (identical) twins: if a twin dies its co twin will likely also die or have severe brain damage. Hence if one twin is moribund, ligating its cord can save the life of the co twin. Such a procedure should be lawful at any gestation when it is medically indicated– it is potentially life saving.

Alternatively, a monochorionic twin pregnancy may present with one twin already dead and the live twin having such profound brain damage due to the death of its co twin that if born then parents would have the option of non treatment. Limiting late-abortion suggests that the fetus *inside* a woman's body has a higher moral status than newborn infant of the same gestation *outside* the body. This is inconsistent and indefensible.

Availability of late-abortion can "save" some fetuses — some women whose fetuses have anomalies of uncertain significance continue their pregnancies, allowing further monitoring, if they know that late-abortion is available. A woman whose fetus has an uncertain diagnosis of an anomaly, such as possible hydrocephaly, may currently need to

make a decision about abortion when the diagnosis remains uncertain instead of waiting some weeks when it may become clear that there is unlikely to be serious disability.

Limiting late-abortion means that many women are forced to have compromised prenatal testing too early. For example, an overweight or increased risk woman may have a more informative scan by delaying it until 20, 22 or even 24 weeks. She is likely to have a limited examination at 18 weeks if later abortion is unlawful or if, as now, laws are unclear.

Laws are not required to prevent an avalanche of women requesting abortion late in pregnancy. Only an unexpected disaster may prompt a woman to rethink her position after the first trimester. Pregnant women, their doctors and hospitals are all reluctant to consider abortion late in pregnancy. There is no rush to late-abortion in countries where some access is openly available, such as England or France; there is no rush to late-abortion in ACT.

Potential gestation limits

20 weeks:

20 weeks is the politician's cut-off: it is easy to remember and they cannot be accused of being for late-abortion. It compromises standard prenatal testing.

No significant fetal event occurs at 20 weeks. It is difficult to identify any logical ethical justification for defining the cut-off for 'late-abortion' as 20 weeks. It harms women in the same ways as 'viability' (see below), but more severely since 20 or 22 weeks is the optimal timing for the main fetal anatomical check – the mid-trimester scan.

Around 23 – 24 weeks (sometimes called 'viability'):

Some people see potential fetal 'viability', commonly considered as the time when a healthy structurally normal newborn can survive, as a critical moment in the abortion

debate. Viability may be difficult to determine – is it when 10% survive, 50%, or maybe 90%? In addition, viability varies according to fetal health, including whether or not a fetal abnormality is present. Although a healthy, normally structured fetus may be considered 'viable' at 23 to 24 weeks, this is not the case for a fetus with a major anomaly such as a hypoplastic left heart (underdeveloped major pumping chamber of the heart).

Indeed few pregnancy terminations when the fetus has an abnormality would be viable at 24 weeks. To advocate viability as conferring fetal status requires individualizing. For example, a fetus with a hypoplastic left heart may have little chance of survival until as late as, say, 36 weeks; if 'viability' is supported then termination should be permitted until this time.

As with a 20 week cut-off, "viability" also compromises standard prenatal testing.

It is hard to see the ethical significance of viability.
1. Viability is not independent viability but the capacity to survive with support, often massive support.

2. Whether one has a right to life is determined by intrinsic properties of being, particularly mental properties unique to persons. We do not say that a person loses the right to life if suffering from an incurable disease. Rights are determined by a person's nature, not by whether we happen to have the technology to maintain life.

3. Moreover, if ectogenesis (artificial wombs) were ever developed, this would imply every embryo would be viable and have a right to life.

4. Fetuses terminated at 10-16 weeks are not viable, but of course would be viable in 3 months time. We would not think that it reasonable to remove an unconscious person from life support just because it would take 3 months for that person to recover. The fact

that recovery would occur is grounds to continue to treat. The reason that we do not think this about fetuses is that they do have the same right to life as an unconscious person.

Abortion law consistent with neonatal practice:

Unlike both 20 weeks and so called 'viability', basing laws on neonatal practice offers some logic as a line in the sand. Since pregnancy termination is the equivalent of turning off treatment for a newborn baby, termination laws should be no more restrictive than neonatal nursery practice[6, 7]. Indeed termination laws should be more liberal than practiced in the nursery since restricting termination of pregnancy limits a women's autonomy.

There is currently an unreasonable contrast between obstetric and neonatal management after 20 weeks[8]. Paediatricians may decide not to treat a baby even if there is some chance of survival. Yet at the same gestation, with the same prognosis, late-abortion is likely to be refused. Apparently, the fetus *inside* a woman's body has a higher moral status than newborn infant of the same gestation *outside* the body. This is inconsistent and indefensible.

Making termination laws no more restrictive than neonatal practice is therefore a minimum reasonable position.

The Australian perinatal care consensus statement[6] states that: 'In an otherwise normal infant born between 23.0 and 25.6 weeks' gestation, there is an increasing obligation to treat. However, it is acceptable medical practice not to initiate intensive care if parents so wish, following appropriate counselling'.

Applying their consensus statement to the fetus [6]: when other serious fetal conditions exist, the option of termination should be available beyond 26 weeks.

The uterus is indeed the best intensive care unit – fetuses with the most terrible abnormalities usually do not die before birth. And denying abortion may only delay the inevitable and extend the suffering of the family.

Future technological developments will impact on any line in the sand; regular review of any such laws would be necessary. Termination laws should, however, not be more restrictive than parental options following delivery.

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

There are no good ethical arguments for a staged approach[5]. Cutoff points inevitably harm some women and families.

Abortion late in pregnancy is uncommon. It is the last resort of women in a desperate situation; it is never requested lightly or frivolously.

If a staged approach is required it should be late in pregnancy with women retaining options so that harms result for a minimum number of women.

A staged approach should be opposed; but if it is introduced, any line drawn should not be arbitrary. Termination should be lawful until at least 26 weeks so that laws are no more restrictive than parental options following delivery. For the same reason, when other serious fetal conditions exist women should be able to have termination beyond 26 weeks.

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

At the end of ethical dialogue, if a patient requests an abortion, and she is legally entitled to it, she should receive it. If it is unlawful, it should not be offered.

• Should these decisions be made by one or more practitioners?

It is a decision between a woman and her doctor. Other doctors or committees should be only at the request of the woman. It is clear that there would not be practical benefits in involving a second doctor – particularly as most women already attend a doctor who then refers them to a second doctor for the procedure. Adding a second doctor would only add an extra administrative task.

• What sort of practitioners? GPs? Obstetricians and gynaecologists?

As is commonly the case, an area of competent medical practice often does not reside in a single specialty group. The practitioner should be a doctor (unspecified).

• Should the practitioner be required to notify the health department or similar body that the procedure has taken place?

The privacy of the patient is a fundamental right, especially in the provision of reproductive services. If privacy is protected, a method of collecting statistics on abortion should be supported.

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

The woman should decide. She is the one who must bear the child and the majority of the burden and largely suffer the consequences of the decision.
Cases in which there is conflict between the woman and her partner raise difficult ethical issues that require sensitive resolution by the doctor, group of doctors in consultation with ethics committees, ethicists or lawyers.
It is clear that a partner has a legitimate stake in a pregnancy but while the fetus is inside the woman's body, she retains a higher stake in decisions about pregnancy.

Committees should not be decision makers, but rather provide advice at the request of doctors and their patients. They are an external group which can intrude into the doctor–patient relationship. These have become established widely in hospitals and elsewhere,

such as the Royal Womens Hospital committee that decides who is permitted to have an abortion from 23 weeks, and often earlier[9].

Current committees may decide on whether a woman can have an abortion without meeting her. The expertise that committee members have in deciding how others should live their lives is often unclear, as is their expertise in ethics [10]. Abortion is one of the few medical interventions in which the doctor–patient relationship is regularly overridden by uninvolved third parties with dubious moral authority. The identity of the hospital committee members is usually anonymous. It includes health administrators, but there is often no lawyer or ethicist. Members may have clinical, nursing or other expertise; these committees are often not legally qualified to interpret the law.

Clinical ethics committees should advise on ethics, not dictate treatment.

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

Counselling should be available – but not compulsory. Forced counselling can sometimes have the goal of discouraging abortion rather than helping a woman or couples come to a difficult decision. It can be an obstacle to timely quality medical care. Most women have their own support group of friends, family and professionals.

10. 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?

An RCOG ethics paper states that the doctor has a duty to inform patients of all appropriate forms of treatment[11]. The patient can then choose and should be able, where appropriate, to seek transfer to where that treatment is available.

A potential clash may occur between the individual autonomy of patient and doctor when the patient requests an abortion and the doctor has a moral objection.

The doctor has a statutory duty in English law to refer the woman to another practitioner.

Conscience can be an excuse to avoid doing one's duty. Treatments should be according to law & just distribution of finite resources [12].
A doctor's conscience should not be allowed to interfere with medical care. One of us (JS) has argued at length elsewhere that the state must ensure that its public hospitals provide a reasonable service of medical interventions which are beneficial to the patient, desired by the patient, cost-effective and legal. If some individuals or institutions have moral objections to beneficial, desired, legal and just medical interventions, then those objections cannot compromise patient care. But that is what is happening now.
This argument is expanded in Savulescu's paper[12].

A study looked at abortion for failed contraception, terminal sedation and contraception to adolescents [13]. It found that 14% of doctors would not inform patients of all legal available medical options - that equates to potentially 40 million Americans. 29% would not refer patients on to a doctor who would provide this service – that means potentially 100 million Americans not referred. It did not examine prenatal screening and testing, late-abortion or other controversial practices.

What treatment you receive depends on the moral and religious values of your doctor. This is unfair.

What would we think of a Jehovah's Witness doctor who has a religious objection to blood transfusion refusing to inform his anaemic patient of blood transfusions, or refusing to refer the anemic patient to another doctor who did not object to blood? We are all in favour of respecting individual's right to refuse treatment for themselves on religious or any grounds; but not for individuals, including doctors, refusing it on behalf of others.

Values are important parts of our lives. But values and conscience play different roles in public and private life. They should influence discussion on what kind of health system to deliver. But they should not influence the care an institution or individual doctor offers

to his or her patient. The door to "value-driven medicine" is a door to a Pandora 's Box of idiosyncratic, bigoted, discriminatory medicine. Public servants must act in the public interest, not their own.

If people are not prepared to offer legally permitted, efficient and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.

Surveys show that access to termination of pregnancy after the diagnosis of fetal abnormality depends on the variable and subjective assessment of the doctor who the woman happens to see[5, 14]. It is reasonable to assume that at least part of the reason is doctor's fear of unclear laws. The law should not entrench such subjective judgments; doctors should not act as gatekeepers to pregnancy termination.

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

Response

The law of Child Destruction should be removed as an abortion law. The Law of Child Destruction represents a second conflicting abortion law. Currently two differing laws can apply in a particular case.

This Victorian law is directly contrary to the explicit goals of the Lords who draw up the legislation [15].

As in UK in 1928, a The Law of Child Destruction may be needed to cover the time between abortion and infanticide, i.e. after delivery prior to cutting the cord.

Discussion

House of Lords debate on the Preservation of Infant Life Bill in 1928 and 1929 (see debate in attachment):

This was very much a gap bill, to fill the unlegislated period between abortion & murder/ infanticide i.e. onset of labour to cutting of cord. It was drawn up to stop women killing their newborn with impunity. It was 'not dealing with the case of taking the life of a child before it was born, but only the taking of the life while it was being born'. The Lords went to great lengths to protect doctors from this law. A proposed amendment was put to state clearly that it only applied to a mother charged with killing her child. This was to ensure that a doctor or midwife could not be charged. It was defeated because of concern that debate had raised awareness of this gap - abortionists might therefore have become aware of the gap. Instead of carrying out an illegal abortion they might now know that they could postpone the procedure and instead kill the newborn before the cutting of the cord so commit no chargeable offence.

Most of the Infant Life Preservation Act from England was incorporated into Victoria's criminal law in 1949 and is now S10 (2) of the Crimes Act 1958. The defense available in the English act if it was done in good faith for the purpose only of preserving the life of the mother was not included in the Victorian statute. Somehow the law was expanded to do the very thing the Lords tried to guard against – the law being used against doctors; but in Victoria not only at delivery but during pregnancy as well.

All of the concerns of Lord Hailsham and the other Lords that this could be used against doctors have eventuated in the current Victorian legislation.

12. Having considered the questions above, what are the key elements you would like to see in any new law of abortion in Victoria?

1 Abortion performed by a medical practitioner should be removed from the

Crimes Act.

2 The Law of Child Destruction should be removed from the Crimes Act.

3 Law should specifically state that other medical procedures causing fetal or embryo death, including feticide, fetal reduction, cord ligation and embryo aspiration, are legally considered as abortion.

4 Bubble Legislation: A buffer-zone should be created around abortion and other sites to stop protestors harassing and intimidating women, those accompanying them and staff.

13. Is there anything else you would like to tell us?

Debate on abortion law reform focuses on early abortion but it is couples with planned pregnancies undergoing prenatal testing who suffer most because of Australia's unclear and outdated abortion laws [8]. Most women diagnosed as having a fetus with a serious abnormality later in pregnancy seek abortion, but do so reluctantly. In their attempts to draw a gestational line in the sand, politicians harm already traumatized couples - some of our most vulnerable people.

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Attached

Savulescu J. Is current practice around late termination of pregnancy eugenic and discriminatory? Maternal interests and abortion. J Med Ethics 2001; 27:165- 171

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House of Lords debate