SECOND READING SPEECH

Reproductive Health (Access to Terminations) Bill 2013

Mr Speaker,

I move the Bill be read a second time.

I am pleased to bring before the House the *Reproductive Health (Access to Terminations) Bill.*

This Bill acknowledges that access to pregnancy termination services is first and foremost a health matter, and not a matter for regulation under criminal laws.

This Bill affirms women as competent and conscientious decision-makers.

This Bill respects that there are many views on terminations and does not impose one view or belief on all Tasmanian women.

In bringing this Bill to the House, I would like to offer my sincere appreciation to the many women and men who have acted and advocated for laws and services that do the same – both today and in decades past.

Such efforts recognise that without the provision of a full range of safe, legal and accessible reproductive services, women experience poorer health outcomes. History clearly demonstrates this, both in Australia and overseas.

In these efforts, I include the collaboration of the Tasmanian women of the 2001 Parliament, including former members of this House; Judy Jackson, Sue Napier and Peg Putt - who came together, across political persuasions, to amend the *Criminal Code* and introduce a legal exception to the 'crime' of terminating a pregnancy when women and doctors meet specific criteria.

At the time, this was a significant step forward, in urgent and extenuating circumstances and I commend these exceptional and compassionate women for their cooperation and commitment to improving Tasmania's termination laws.

Despite these efforts, the passage of time has shown that the criminal law continues to be a restrictive and inappropriate vehicle by which to regulate access to terminations.

Such laws act as a deterrent to the provision of safe and legal services, in the absence of which women seeking a termination are forced to: continue a pregnancy against their will; travel to another jurisdiction for services; or seek unsafe and unregulated services – all at an increased risk to their health and wellbeing.

Research shows that restrictive laws do not reduce the incidence of terminations, but instead negatively impact on the health and wellbeing outcomes of women.

The Bill recognises and seeks to address these issues.

Importantly, the Bill will decriminalise terminations so that Tasmanian women need never again fear criminal or other legal sanctions for accessing one.

It pays to recall that laws criminalising terminations in Tasmania are based on British laws of the 1800's.

This was a different era - women were subject to religious and social mores that denied them many fundamental freedoms and equalities.

The medical world too was vastly different: pre-electricity, pre-antibiotics, and pre-anaesthetic.

Both attitudes towards women and medical practices have come far since then.

And it is time our laws recognised this.

I have heard from many Tasmanian individuals and organisations who agree and who believe our laws should support women in making decisions about whether and when to become a parent or extend existing parental responsibilities.

I acknowledge that not everyone shares this view.

We can be in no doubt of that given the recent actions of vocal and well organised lobby groups.

It is the very existence of these many and varied views about terminations that provides the rationale for a framework that respects choice.

The Bill will not force any woman to have a termination if she does not choose it.

Nor does it impose the threat of criminal sanctions or excessive legal barriers to access for those who do.

It is a reasoned and practical approach.

It recognises that when faced with an unplanned pregnancy, women make deeply considered decisions based on multiple and contingent factors. Whether the woman ultimately chooses to continue or end the pregnancy, she is considering factors such as -

- her age;
- her physical and mental health;
- her cultural background, personal beliefs and values;

- the circumstances of conception, which may have been traumatic and a result of abuse and assault;
- the extent to which she is in a supportive relationship;
- the stability of her living circumstances;
- whether she has sufficient financial and other resources to feed, clothe, educate and provide shelter for a child; and
- whether she continue to meet her existing obligations to herself, her partner, existing children, her parents and her community.

Women's accounts of this decision making reveals the complex personal and social contexts within which reproductive events must be understood.

If, at the end of the decision-making process, a woman seeks a termination in Tasmania, she and her doctor must meet specific criteria in the Criminal Code before a termination is, what the Code terms, 'legally justified'.

The Bill will remove this framework from the Criminal Code, and transfer the criteria to a new health based Act.

In doing so, some changes will be made to the criteria.

The current criteria provide that a doctor may perform a medical or surgical termination – at any gestation – if two doctors agree that the woman's physical or mental health is at greater risk of injury from continuing the pregnancy than terminating it. One of the medical practitioners must be a specialist in obstetrics or gynaecology.

The Bill applies this same criteria to terminations after a particular gestational period – being 16 weeks.

In assessing the risk of harm, a doctor can currently have regard to <u>any matter</u> he or she considers relevant.

The Bill provides greater certainty than this and sets out the relevant considerations.

The doctor is to have regard to the woman's current and future physical, psychological, economic and social circumstances when assessing the impact of a pregnancy and a termination on a woman's physical or mental health.

Every one of these criteria is either named up in legislation in Victoria or has been decided by a court and forms part of case law in NSW.

During the consultation process some people took issue with including references to social and economic factors as matters to which doctors can have regard to.

On this I will make two points.

Firstly – let's be clear – these are already matters that can be taken into account under the current laws.

Secondly – social and economic factors are absolutely relevant and capable of significantly impacting on a person's physical and mental health.

Indeed, the then Acting Chief Justice Kirby in a NSW case noted that the impact of social or economic grounds on psychological health may arise not only at the time of consultation with the medical practitioner but may more likely result in a threat to a woman's health after the birth when those circumstances might be expected to take their toll.

I have no doubt all Members appreciate this. Contributions over the years from all sides in this House have recognised that laws and policies on all variety of issues affect the social and economic lives of individuals. These social and economic pressures naturally have flow-on effects for an individual's physical and mental health and wellbeing.

For some context, I will remind Members that social and economic factors cover circumstances where, for example, a woman is homeless, or living in poverty.

It includes where a woman is unable to feed or care for herself adequately due to a lack of income, or where she is unable to feed or care for her existing children adequately.

It includes where a woman is in an abusive relationship.

So I urge Members - do not misinterpret the words social or economic in relation to this Bill. These words are often misused and abused in this issue – to the point of suggesting women make the decision to terminate a pregnancy in a trivial or frivolous matter, as a matter of convenience or a form of contraception – and I find that to be demeaning and without foundation.

Mr Speaker,

The Bill does not transfer to the new Act the existing requirement that a woman be referred to counselling on 'other matters' relating to continuing or terminating a pregnancy. Such a provision is fraught with problems.

Firstly – it is unclear what 'other matters' means. A doctor is always obliged to inform a patient of the risks, benefits and alternatives of any medical procedure. What 'other matters' means we can only wonder at.

Secondly – the Victorian Law Reform Commission, in its 2008 report on law reform in this area, recommended against mandatory counselling and mandatory referrals.

The Commission did not find any evidence that forcing women into counselling is necessary or advisable.

It noted that counselling is a clinical, service delivery issue rather than one to be directed by law and compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm.

The decision to attend counselling sits best with the woman. For those who do seek it, it is important that counselling is available, accessible, non-judgemental and impartial.

Mr Speaker,

The Bill provides that before the legislated gestational period, a doctor may perform a termination on a woman with her consent and will not be required by legislation to perform a 'risk of harm' test.

I'll pause a moment here, Mr Speaker, to remark on comments I have heard in relation to this consent based framework.

Some opposed to access to terminations use the language 'abortion on demand'.

It has been a deliberate decision of mine not to use the word 'abortion'. It is the name given to a crime in our current laws. It has been used by certain groups throughout history in a derogatory manner, to demean and stigmatise women for making their own decisions about their own reproductive health.

Attaching the word to 'on demand' is another example of that.

A woman can no more demand a termination than any man or woman can demand any medical procedure.

The framework in the Bill before the specific gestational period is based on consent – which is the same legal framework that regulates all other medical procedures.

Consent of the patient is the legal authority for the doctor to act.

Consent takes its usual meaning within the medical context; that is, voluntary consent by a patient, after receiving proper and adequate information about the proposed treatment, including potential risks and benefits and alternative options.

These requirements exist for all medical procedures and are imposed by professional medical standards.

I have also heard these same people assert that removing restrictive termination laws will increase the incidence of terminations.

This is simply incorrect. Research conducted by the Guttmacher Institute and the World Health Organisation demonstrates this.

Mr Speaker,

I do accept that including alternative frameworks before and after a particular gestational period is not a model that is strongly advocated for, by, in particular, women's health organisations.

Naming up gestational periods are often criticised as being:

- arbitrary and lacking in flexibility to deal with exceptional cases;
- a reversal of the assumption that women are competent and conscientious decision makers; and
- in need of constant review.

Rather, there is a preference for a consent model at all gestations, as is the case in the ACT and some jurisdictions overseas, on the basis that it is appropriate to leave the regulation of all terminations, including those at a later term, entirely to the medical profession instead of to the Parliament.

Only a very small number of terminations occur after 20 weeks – the Australian Institute of Health and Welfare estimates only 0.7% - and the majority of these occur in extenuating circumstances.

Providers of this service have rigorous internal processes in place before a termination at this gestation occurs as well as being guided by medical ethics and practice standards issued by professional medical bodies.

The other view is that specific gestational periods are not inappropriate as they recognise that terminations at advancing gestational age, involving fetal or maternal illness are more complex procedures and doctors often, as a matter of good clinical practice, seek the opinion of a colleague.

In considering all of these points, I accepted that a gestational period was appropriate at 24 weeks – as was adopted in Victoria - and that was the period consulted on in the draft Bill.

I am still comfortable with the 24 week period, however, I recognise that there are others who are not – and I have responded to their comments on this.

Mr Speaker,

By repealing the existing crimes in relation to terminations and establishing a new, health based Act, the Bill removes the threat of criminal sanctions for doctors performing a termination.

A doctor failing to comply with the framework in the new Act will risk facing professional sanctions. That is, it is the intention that the Bill will operate to set a standard for the medical profession relating to the conduct of terminations after the specific gestational period, which the Medical Board can have regard to if a complaint is made about a practitioners conduct.

The only time a doctor will face criminal sanctions is if he or she fails to comply with the law relating to consent – in which case, the risk of criminal sanctions will be the same as that for all other medical procedures.

The Bill also includes a consequential amendment to the *Guardianship and Administration Act* so it is clear that the existing provisions in that Act for substituted consent will not be altered by the Bill.

Mr Speaker,

Consistent with current laws, the Bill will continue to recognise a health practitioner's right, except in an emergency, to refuse to treat on the basis of a conscientious objection.

The Bill will also introduce a corresponding responsibility.

Except in an emergency, a doctor who holds a conscientious objection to terminations is to refer a woman seeking a termination or pregnancy options advice to another doctor who does not hold such an objection.

This obligation to refer balances the right of doctors to operate within their own personal values, with the equally important ethical obligation to act in the best interests of the patient and to not deny or impede access to medical care and treatments that are legal.

These responsibilities are contained in the professional code of conduct for doctors issued by the Medical Board of Australia and professional sanctions will apply.

The Bill also extends the referral obligation to counsellors, so that it applies equally to all persons providing a service that includes counselling in relation to pregnancy options.

It won't, of course, capture circumstances where a woman seeks, for example, advice from her best friend or a parent.

But it will capture all counselling services, whether or not they charge a fee.

The referral obligation will not prevent a doctor or counsellor with a conscientious objection to terminations from treating or assisting when a woman comes to them already having decided to continue her pregnancy and seeks advice or information in relation to supports and services to assist her in doing so.

However, I accept that where a doctor or counsellor holds a strong and firm objection to terminations and he or she is asked to terminate a pregnancy or provide pregnancy options advice, it is not appropriate – from the perspective of the doctor, counsellor or patient – for that to occur.

Except, of course, if it is an emergency and the woman's life is at risk.

Otherwise, allowing the patient-practitioner relationship to continue would be to place the doctor or counsellor in a difficult situation because the doctor must either go against his or her beliefs and provide a termination or information about a termination directly to the woman, or omit providing her with the full range of legal and available options.

The referral obligation ensures doctors and counsellors can adhere to their personal beliefs whilst not imposing them on patients. Women can seek pregnancy options advice without fear of being denied knowledge of the full range of options available to them and without fear of their doctor or counsellor attempting to dissuade them from a decided view or push them in a certain direction.

I'll pause here a moment, Mr Speaker, to make the point that this is an important issue. No woman who has made the decision to either continue or to terminate her pregnancy should face criticism, disapproval or attempts to dissuade her – especially not by her doctor, or her counsellor if she has chosen to see one.

Yet this does occur in Tasmania. I have heard from women who have experienced this when seeking a termination from their doctor.

I have heard similar experiences of women attending counselling services that purport to be impartial and unbiased pregnancy counselling services, only to find that in fact they are not.

I am confident the referral obligation in the Bill is a reasonable balance of rights.

The Bill does not legislate the manner of referral and does not demand, for example, a written letter detailing the patient's medical history as one might do with a referral to a specialist.

Instead, the doctor or counsellor will fulfil the duty if he or she provides the woman with the name and contact details of an alternative service provider who does not hold a conscientious objection.

Again, this requirement is intended to set a standard for the medical profession whereby failure to comply so may result in professional sanctions for medical practitioners, while counsellors face a maximum fine of 250 penalty units.

The different consequences for non-compliance reflect that, unlike doctors, counsellors are not regulated by professional boards established under national laws for regulating health practitioners.

And without consequences for non-compliance there is, of course, no enforceable obligation.

Presently in Australia, no formal qualifications or registration is required if one is to assume the title of "counsellor" and the large number of practitioners who use the title are not regulated as a group in the same way as psychiatrists or psychologists are, by the Australian Health Practitioner Regulation Agency (AHPRA).

Individuals are faced with a difficult task of evaluating the qualifications of various counsellors when they seek a pregnancy counselling service. Whilst some who advertise such services, such as counselling psychologists, may be appropriately qualified and therefore regulated through APHRA others may not.

In the absence of current national professional standards for counsellors as a collective group, such as those for medical practitioners, the Bill enables a fine to be applied where a counsellor fails to refer a patient because of their conscientious objection.

During the consultation process many individuals who expressed a personal objection to terminations also objected to referral obligations, seeing it as discriminating against doctors on the basis of their beliefs and infringing upon their right to freedom of conscience.

The Anti-Discrimination Commissioner, however, supports a referral obligation and notes that it has been held by the European Court of Human Rights not to infringe the right to freedom of conscience in Article 18 of the *International Covenant on Civil and Political Rights*.

In addition, it recognises and supports Article 12 of the *International Covenant on Economic, Social and Cultural Rights* which commits parties to protect, promote and fulfil the right of everyone to the enjoyment of the highest attainable standards of physical and mental health. This includes the right to appropriate health care, including reproductive health services.

Mr Speaker,

In relation to the Criminal Code, there will remain two crimes specific to terminations.

It will still be a crime for a person to terminate a pregnancy without a woman's consent - for example, as a result of an assault on a woman.

It will still be a crime for a person other than a doctor to terminate a pregnancy.

Any person who supplies any medication or item knowing it will be used in a termination is not, by reason of that supply, taken to terminate a pregnancy and as such that action alone is not a crime under the Bill.

Such a person may, however, be guilty of an offence under other legislation – for example it is an offence for a person to supply medication without being lawfully permitted to do so under the *Poisons Act*.

Mr Speaker,

I turn finally to access zones.

The Bill establishes 150 metre access zones around premises at which termination services are provided.

It will be an offence for a person to engage in 'prohibited behaviour' in an access zone. 'Prohibited behaviour' is defined in the Bill and includes harassing, intimidating or interfering with a person.

It includes recording a person accessing premises where terminations are provided without that person's consent. And it will be an offence for a person to distribute or publish any such recordings.

The latter is a new offence from the consultation version of the Bill and has been added as it is a natural extension of the ban on making the recording in the first place. Similar offences exist already in the *Police Offences Act* in relation to other types of recordings.

A police officer will have the power to search a person and seize a recording and any equipment used to produce, distribute or publish it.

A police officer who reasonably believes a person is committing an offence may require a person provide their name and address. The police officer may arrest a person who refuses to comply or who provides details that are false.

These powers are standard enforcement provisions to ensure police have the appropriate authority to act when an offence has been committed. They are not 'special' police powers – they exist already for other offences and have been brought across from the *Police Offences Act*.

A person engaging in prohibited behaviour or distributing or publishing a recording faces a maximum fine of 500 penalty units and/or a maximum 12 month prison term.

This recognises the seriousness of the offence and the impact it has on women.

A recent study by Masters candidate, Alexandra Humphries, in relation to Melbourne's Fertility Control Clinic indicated that patients experience considerable distress, shame and anxiety in response to protestors - 77.8 percent of the patients interviewed felt stigmatised by the protests, even where they had received significant support from family, friends and partners in respect of their decision to terminate a pregnancy.

Mr Speaker, the other type of prohibited behaviour in an access zone is protesting in relation to terminations.

This has drawn some attention and I would like to provide some examples of the types of behaviour this will and won't capture.

It will not stop a religious sermon against terminations, in churches that fall within an access zone. Unless of course they broadcast it over a loud speaker in a public manner.

It will not stop an exchange of personal views between mates at a restaurant or pub that falls within an access zone – unless of course they do the same thing.

It will however stop a person from standing in an access zone holding up a placard or handing out pamphlets denouncing terminations.

It will stop a person from engaging in a vocal anti-choice protest.

And it will stop the silent protests outside termination clinics that purport to be a vigil of sorts or a peaceful protest but which, by their very location, are undoubtedly an expression of disapproval.

As one submitter to the consultation framed it – there is nothing peaceful about shaming complete strangers about private decisions made about their bodies.

I respect that each of us are entitled to our views.

What I do not respect is the manner in which some people choose to express them.

And standing on the street outside a medical facility with the express purpose of dissuading or delaying a woman from accessing a legitimate reproductive health service is, to my mind, quite unacceptable.

A democracy has many different freedoms, some of which conflict with each other. And the right to protest, if exercised without restraint, can interfere with other people's rights of privacy and freedom from abuse.

Earlier this year the High Court of Australia, in considering a by-law prohibiting 'preaching, canvassing or haranguing' without a permit, found that while the by-law restricted <u>where</u> the preachers could express their views, it did not infringe their right to express those views.

This appears to reaffirm the right of free speech, but not without restrictions where it is necessary to protect the freedoms of others.

I believe access zones provide the appropriate balance between the right to protest and protecting women from being exposed to those who seek to shame and stigmatise them.

Women are entitled to access termination services in a confidential manner without the threat of harassment.

Mr Speaker,

Research shows that removing restrictive termination laws does not increase the incidence of terminations.

What we do hope to achieve, however, is an increase in the number of Tasmanian women who are able to access services in their home state, rather than being forced to travel to other jurisdictions.

By removing the threat of criminal sanctions for women and for doctors I hope to reduce the legal barriers to service delivery.

I do recognise that improved services won't happen overnight, and there will be many conversations to come as we consider the best way forward.

The Bill is the first step in that process.

Improving access to terminations for women in Tasmania is part of a broader strategy to improve the sexual and reproductive health of all Tasmanians, especially vulnerable populations.

Government and the community sector are currently working together to develop a Tasmanian Sexual and Reproductive Health Strategic Framework.

This includes improved sexual health education and increased access to contraception.

Even with these in place, women will still experience unplanned pregnancies.

Studies suggest that at any one time over half of all Australian women have had an unplanned pregnancy.

One study showed 60 percent of these women were using contraception – with many of them also using more than one form. Others did not – some by choice, some not by choice, and some on the belief they or their partner were sterile.

So it is important to recognise the need for a full range of reproductive health services that have a capacity for timely access in Tasmania.

So that women are supported in their decision making process when faced with a pregnancy that is not planned - and can freely make the decision about whether and when to become a parent without interference from the law.

And so that women who choose to continue a pregnancy but are later faced with a distressing diagnosis are free to make the best choice for them in their circumstances without excessive legal hurdles.

It is important that laws governing women's options during this time support positive sexual and reproductive health outcomes for Tasmanian women.

As stated in the Beijing Declaration Platform for Action - good health is essential to leading a productive and fulfilling life, and the right of women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.

Today Members are, quite simply, being asked to vote for or against women's autonomy.

To vote for or against a Bill that respects all views on terminations.

To vote for or against a Bill that acknowledges women as competent and conscientious decision makers and recognises that a woman is in the best position to make decisions affecting her future and her health.

I vote for this.

And I commend the Bill to the House.