THE UNIVERSITY OF WESTERN AUSTRALIA

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Abortion Legislation – Proposal for reform in Western Australia
Public Health Regulation Directorate
Department of Health
PO Box 8172
Perth Business Centre, WA 6849

To the Public Health Regulation Directorate at the Department of Health,

RE: ABORTION LEGISLATION – PROPOSAL FOR REFORM IN WA

Thank you for your work on the proposal for reform and for the opportunity to make a submission in relation to it. I write on the basis of my experience and expertise as a legal academic who researches and teaches about health and medical law, including abortion. I am also a legal member on the Human Research Ethics Committee at the South Metropolitan Area Health Service (Fiona Stanley Hospital). I am very happy for this submission to be quoted or cited in any future report or publication.

My submission discusses the following matters which I hope will be of assistance to the Department:

- The benefits of removing abortion from the *Criminal Code*;
- Difficulties with the statutory drafting of s 334(3)-(4) of the *Health Act (Miscellaneous Provisions) Act 1911* ('the *Health Act*') which sets out when an abortion is justified;
- Substitute decisionmaking and the meaning of informed consent in s 334(3)-(5) of the *Health Act*;
- The use of gendered language in any legislation relating to abortion; and
- Other matters the Department has sought feedback on.

1 The benefits of removing abortion from the *Criminal Code*

In WA the *Criminal Code* remains the 'starting point' when considering the legality of abortion.[1] Full decriminalisation requires a reframing of abortion as a healthcare matter, rather than a criminal offence. As such, it is appropriate to repeal s 199 of the *Criminal Code* and replace it with regulatory provisions in the *Health Act.*

There are many reasons why full decriminalisation is important. In particular, full decriminalisation can help to address stigma which surrounds abortion and improve access to vital healthcare.[2] As noted in a recently published study of Australian people who had accessed abortions:

- Those who accessed an abortion in a criminalised setting exhibited *'significant negative emotional impacts that were directly linked to the law'*;
- Some participants felt they could not be honest with health professionals as the criminalisation of abortion made them fear that they would be denied care; and
- Abortion being dealt with as a 'criminal law issue' contributed to general confusion about the legal status of abortion.[3]

[1] *Criminal Code* (WA) s 199.
[2] See generally, Roosbelinda Cárdenas et al, '"It's Something That Marks You": Abortion Stigma After Decriminalization in Uruguay' (2018) *15 Reproductive Health* 150 < https://doi.org/10.1186/s12978-018-0597-1>.
[3] Kathryn J LaRoche, L L Wynn, Angel M Foster, '"We Have to Make Sure You Meet Certain Criteria": Exploring Patient Experiences of the Criminalisation of Abortion in Australia' (2021) 31(3) *Public Health Research and Practice* <https://doi.org/10.17061/phrp30342011>.

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As put by Rebecca J Cook:

> *'When a state [criminalises abortion], it is constructing its social meaning as inherently wrong and harmful to society. Through criminal prohibition, a state is signaling conditions in which abortion is criminally wrong... In contrast, the legal framing of abortion as a health issue constructs meanings of preservation and promotion of health. A state is signaling that abortion is a public health concern, and should be addressed as a harm reduction initiative.'*[4]

Simply put, the 'legislative framing' of abortion as a public health issue, rather than an issue of criminal law, matters. The *Health Act* should be the only direct source of regulation relating to abortion in WA.

2 Difficulties with the statutory drafting of s 334(3)-(4) of the *Health Act*

Following on from the discussion above, there remains general confusion about the legal status of abortion across the Australian state and territory jurisdictions. In WA, the inclusion of abortion in the *Criminal Code* is only one source of that confusion.

Another source of confusion is the current drafting of s 334 of the *Health Act*, which sets out when abortion up to 20 weeks gestation is justified by law. In particular, subsections (3) and (4) of s 334 are poorly drafted and not easily understandable. Subsection (3) sets out that an abortion is justified if (a) informed consent is given; **or** (b) the person will suffer serious personal/family/social consequences if the abortion is not performed; **or** (c) there is serious danger to the health of the person if the abortion is not performed; **or** (d) the pregnancy is causing serious danger to the person's health. Subsection (4) then instructs that situations (3)(b), (3)(c) or (3)(d) do not justify an abortion unless informed consent is also given; **or**, for situations (3)(c) or (3)(d), it is impracticable for the person to provide informed consent.

There are two key problems with the current drafting:

- Subsection (3) is confusing. By setting the four situations out as alternates (with each separated by 'or'), it gives the impression that any one of those situations alone can justify an abortion.
    - Of course, this is not correct – the only clause which can itself justify an abortion is (3)(a), when informed consent is provided by the person (the other clauses also require informed consent or an emergency-type situation where it is not practicable to obtain consent).
    - In my own teaching of medical law, each year I encounter many bright law students who are confused by this drafting. If those studying law at a tertiary level find this confusing, there is little doubt that many other WA community members also find this difficult to understand.
- Subsection (3)(b) is redundant. This situation can only ever justify an abortion where there is also informed consent (ie, impracticability of obtaining consent cannot justify an abortion in this situation). Informed consent is itself listed as a situation which justifies an abortion on its own. The inclusion of (3)(b) thus achieves nothing and does not extend the eligibility at all – all it does is create confusion.

As a suggestion, it would be clearer to set out any such provision as follows:

> *An abortion up to [XX weeks gestation] can be performed on a person if:*
> *(a) the person has provided their informed consent; or*
> *(b) it is impracticable to obtain the person's informed consent, and one or both of the following situations apply:*
> *(i) there will be serious danger to the person's physical or mental health if the abortion is not performed; or*
> *(ii) the pregnancy is causing serious danger to the person's physical or mental health.*

[4] Rebecca J Cook 'Stigmatized Meanings of Criminal Abortion Law' in Rebecca J Cook , Joanna N Erdman and Bernard M Dickens (eds), *Abortion Law in Transnational Perspective* (University of Pennsylvania Press, 2014) 347.

3 Substitute decisionmaking & the meaning of informed consent in s 334(3)-(5) of the *Health Act*

'Informed consent' in s 334(3)-(5) of the *Health Act* has a precise meaning which I hope to clarify for the Department. The Discussion Paper prepared by the Directorate notes as follows: *'For informed consent to be valid, it must be freely given by the individual* ***or, if the individual does not have the capacity to give consent, an appropriate representative.****'*

Whilst substitute decisionmaking (eg, by a guardian) is commonplace when people lack capacity to make certain healthcare decisions for themselves,[5] the present statutory definition of 'informed consent' in s 334(5) is inconsistent with supported decisionmaking. Under s 334(5), informed consent is defined as *'consent freely given* ***by the woman****…'.* That definition of informed consent is specifically personal in nature – that is, it reads as requiring personal consent from the person themselves (not a substitute decisionmaker).

Whilst s 50 of the *Guardianship and Administration Act 1990* (WA) might here operate to enable a guardian's consent to act in place of the pregnant person's consent (where the pregnant person lacks capacity), this is not sufficiently clear in the *Health Act* itself and might be misunderstood, especially given the significant variations in laws on this point across Australia. For example, there are some jurisdictions where guardians cannot provide substitute consent for an abortion: in Queensland, a termination of pregnancy for a person who is unable to provide consent must be approved by the Queensland Civil and Administrative Tribunal.[6]

If the Department wishes to enable substitute decisionmakers to provide consent for an abortion, it is important that this is accurately reflected in the wording of the abortion provisions themselves. For example, the *Abortion Law Reform Act 2019* (NSW) clearly sets this out in s 5(2):

> *The medical practitioner may perform the termination on the person only if the medical practitioner has obtained informed consent to the termination from—*
>
> *(a) the person, or*
>
> *(b) if the person lacks the capacity to give informed consent to the termination, a person lawfully authorised to give consent on the person's behalf.*

I encourage the Department to consider adopting similar wording to the NSW legislation if it wishes to enable substitute decisionmakers to provide consent in this situation.

4 The use of gendered language in any legislation relating to abortion

The Discussion Paper itself notes that *'abortion care is accessed by a variety of people, including adult women, girls and people who identify as any gender.'* Similarly, the Australian Government's Pregnancy Care Guidelines note that *'individuals have diverse gender identities. Terms such as pregnant person, childbearing people and parent can be used to avoid gendering birth, and those who give birth, as feminine.'*[7]

It is important for governments to acknowledge this, and the Department is to be congratulated for noting this in the Discussion Paper. However, this recognition must extend further into the terminology used in the legislation itself. Using the term 'pregnant person' in place of 'woman' in abortion legislation would not make the legislation less accurate – it would make it more accurate. Abortion legislation which uses the term 'woman' in place of 'pregnant person' fails to recognise the medical, social, and psychological

[5] Though it should be noted that supported decisionmaking methods are preferable where it may be possible for the person without capacity to make their own decisions if supported to do so.
[6] *Guardianship and Administration Act 2000* (Qld) s 71.
[7] See generally, <https://www.health.gov.au/resources/pregnancy-care-guidelines/introduction>.

realities that there is a diversity of sex and gender,[8] and that people who might legally be classed as any gender can become pregnant and should be able to seek an abortion.[9] This may occur for many reasons – for example, many trans people obtain social and/or legal recognition for their affirmed gender whilst retaining their reproductive characteristics. People with non-binary gender identities may also become pregnant. Some intersex people who were assigned male at birth might also become pregnant (depending on the variations of sex characteristics they have).[10] However, the reasons *why* pregnancy occurs across a range of gender identities are not of present importance – what is presently important is that governments accept this reality and ensure that legislation relating to pregnancy and abortion reflects this.

Indeed, this terminology is widely accepted by clinicians and professionals who work in the relevant fields. It has been noted by researchers that the use of non-inclusive language around pregnancy significantly worsens patient outcomes.[11] Further – as noted in a recent article coauthored by an interdisciplinary group of medical doctos, mental health and psychiatric professionals, pediatricians, and social workers – using the more accurate term 'pregnant people' does not devalue, other, or disrespect cisgender women:

> *'Some might object that this nomenclature favours inclusivity over the experiences of the majority of pregnant people who are cisgender women, and that we should instead be centring the experiences of these women. However,* ***the term 'pregnant person' does not discredit cisgender women; rather it opens the umbrella to cover everyone seeking obstetrical care****. Language evolves, and words matter. Providing comprehensive and accessible healthcare to all includes broadening gender-neutral and affirming language...'*[12]

For these reasons, I strongly encourage the Department to adopt the term 'pregnant person' in place of 'pregnant woman' in all legislation relating to abortion.

5 Other matters the Department has sought feedback on

The preceding sections of my submission provide detailed responses relating to several matters the Department has sought feedback on. For the sake of completeness, I have also provided brief responses to the Department's remaining questions:

- (Question 13) I support **option 2**: *'Remove existing legislated provisions requiring mandatory counselling in in order to obtain informed consent. Medical practitioners would continue to be required to obtain informed consent in line with existing standards of care and professional obligations.'*
    - **Reason:** The notion of informed consent alone requires the person to be provided with adequate information. The provisions requiring mandatory counselling are unnecessary and outdated in the context of modern abortion legislation.

- (Question 14) I support **option 2**: *'Amend provisions to allow only one health practitioner to be involved (excludes late abortions).'*

[8] Goran Strkalj, 'Beyond the Sex Binary: Toward the Inclusive Anatomical Sciences Education' (2020) 14(4) *Anatomical Sciences* 513; Janet Hyde et al, 'The Future of Sex and Gender in Psychology: Five Challenges to the Gender Binary' (2019) 74(2) *American Psychologist* 171; Sarah Hunt, 'Embodying Self-Determination: Beyond the Gender Binary' in *Determinants of Indigenous Peoples' Health, Second Edition: Beyond the Social* (2nd ed, 2018); Emmie Matsuho and Stephanie L Budge, 'Non-binary/Genderqueer Identities: a Critical Review of the Literature' (2017) 9(1) *Current Sexual Health Reports* 116; Ada S Chung et al, 'Non-Binary and Binary Gender Identity in Australian Trans and Gender Diverse Individuals' (2020) 49(1) *Archives of Sexual Behaviour* 2673.

[9] This may occur for many reasons – for example, some people obtain legal recognition for their affirmed gender whilst retaining their reproductive characteristics. People with non-binary gender identities, as well as intersex people (who may have any gender identity) and the existence of non-binary gender identities However, the reaons why this occurs are not important – what is important is that governments accept this reality and ensure legislation relating to pregnancy and abortion reflects this.

[10] It should also be noted that an intersex person – like any person – may have any gender identity.

[11] K MacKinnon et al, 'Recognizing and Renaming in Obstetrics' (2021) 14(4) *Obstetric Medicine* 201.

[12] Ibid.

    - **Reason:** Health resources are already stretched across the state (and, indeed, Australia as a whole). This change would appropriately streamline the abortion care process, and make the process comparable to any other medical care/procedure.

- (Question 15) I support **option 2**: *'Provide updated provisions to allow health practitioners to conscientiously object with clear and unambiguous directions to refer the patient to another health practitioner who is willing and able to provide abortion care.'*
    - **Reason:** A duty to refer does not unduly encroach upon the freedoms of the practitioner. It is a proportionate duty in the circumstances.

- (Question 16) I support **option 2**: *'Increase the gestational age at which additional requirements will apply from 20-weeks to 24-weeks gestation.'*
    - **Reason:** This change would move the gestational limit in WA closer to the gestational limits adopted more recently in other Australian jurisdictions.

- (Question 17) I support **option 2**: *'Remove the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e. late abortions) but require an additional medical practitioner to be consulted.'*
    - **Reason:** The level of regulation at present is unnecessary and burdensome. Health practitioners who work in this field are already experts who practice according to strict legal and professional standards – further approval/oversight by a Ministerial Panel is not necessary. Practitioners are themselves capable of exercising judgment and ensuring that statutory conditions are satisfied. Adopting an approach requiring the consultation of an additional practitioner for late abortions is a more proportionate form of regulation.

- (Question 18) I support **option 2**: *'Remove the requirement for Ministerial approval for a health service to perform late abortions.'*
    - **Reason:** Similarly to the reason above, there are already extensive standards which any health service must meet. Further oversight requiring Ministerial approval is unnecessary.

Thank you for considering my submissions. I would be very happy to further discuss any of these matters, and I consent to this submission being quoted or cited in any future report or publication by the Department.

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