

# Abortion: time to clarify Australia's confusing laws

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## Case summary

In 2000 a general practitioner referred a woman to an Australian teaching hospital at 31 weeks' gestation because the patient requested pregnancy termination. Her fetus had been diagnosed with skeletal dysplasia, most likely achondroplasia. Staff who interviewed her — a geneticist, genetic counsellor, obstetrician, ultrasonologist and psychiatrist — agreed that she was acutely suicidal. Recently, the hospital's lawyer noted that "rarely, if ever, had a woman in such a desperate state been encountered — she would kill herself or do anything not to have the baby she was carrying". The patient rejected all other management options, including adoption. Support for abortion was obtained from the appropriate hospital medical administrator. Fetal intracardiac potassium chloride was administered, as recommended by the UK Royal College of Obstetricians and Gynaecologists (RCOG),<sup>1</sup> with rapid cessation of fetal heart movements and labour induced. The patient refused fetal autopsy, but a photograph of the fetus showed features of achondroplasia.

## ABSTRACT

- Australian criminal law is a matter for states and territories. In relation to abortion, many laws are unclear and outdated, and are inconsistent between states and territories.
- Doctors practise under time constraints and on a case-by-case basis. Most current laws have grey areas that leave doctors vulnerable to accusations, negative publicity and career damage, especially in the case of late abortions.
- All jurisdictions should follow the Australian Capital Territory's lead in allowing women to access abortion without fear of criminal prosecution.
- Federal, state and territory governments should introduce a single clear national law on abortion, both in early and late pregnancy.

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Several months after the event described in the case summary, practitioners involved in the case took part in a hospital meeting that was open to all members of the hospital. About 200 people attended. The Medical Director gave approval for the case to be discussed. The purpose of the discussion was to identify and address ethical issues raised by this kind of case. Shortly after this meeting, one staff member was dismissed (the person was subsequently reinstated but suspended the following day), and an attempt was made to suspend several others without discussion about the facts of the case. A couple of the threatened suspensions had to be withdrawn, as the staff were not employed by the hospital, and the others were withdrawn several days later. The senior medical administrator involved in the decision stood voluntarily down.

An interim internal hospital inquiry panel concluded, among other things, that "the clinicians acted in good faith and ... the management followed was determined by those involved to be the most appropriate" (quoted from an unpublished report). The hospital's Chief Executive Officer reported the case to the state coroner. Both the Chief Executive Officer and the Medical Director of the hospital informed the media that they had reported the case to the medical board. But it was a federal politician who did this. Eighteen months later, the coroner announced a lack of jurisdiction to investigate, because the baby was stillborn. A comprehensive police investigation concluded that the actions of the medical staff involved were lawful in the circumstances.

Several years later, the hospital has still not completed its inquiry and the medical board has not resolved whether to hold an inquiry.

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## A harmful uncertainty

The termination of a 32-week pregnancy on the grounds of probable dwarfism in the fetus raises profound and divisive ethical issues. We do not address the ethics of abortion here, but, rather, focus on the harm that was done in this case by the decision to expose the events to legal and media scrutiny:

- Harm to the patient and her family, whose private medical procedure became headline news;
- Harm to the staff involved, whose careers were damaged and whose personal lives were stressed by the events;
- Harm to the hospital, which has lost many of its senior staff, the administrators' response to the case epitomising their uncaring attitude. There remain many unresolved issues and much bitterness;
- Harm to other institutions, with a call for the medical board to be sacked and criticism of the state coroner's handing over of the patient's private medical records to a politician;
- Potential harm to future patients, as doctors, fearful of being exposed, may take a more conservative approach to offering abortion;
- Harm to Australian society generally, as vaguely defined and inconsistent laws create uncertainty and conflict.

This case also highlights the potentially disastrous outcomes to doctors and patients who have to make difficult decisions in an uncertain legal environment, their situation exacerbated by public controversy fuelled by the media.

We believe that this regrettable sequence of events occurred because of unclear and complex state abortion laws. For example, in Victoria, the meaning of "unlawfully" attempting to induce miscarriage under the *Crimes Act 1958* (Vic), s 65, was determined in 1969 by a Victorian Supreme Court judge. The "Menhennitt ruling" stipulates that an abortion is not "unlawful" if a doctor believes that the abortion is necessary to preserve the woman's life or her physical or mental health. The upper limit of gestation is undefined. The other aspect of Victoria's abortion law, stated in s 10 of the Act, relates to "child destruction" (an unlawful inten-

tional act causing the death of a child capable of being born alive) and is based on the Infant Life (Preservation) Act 1929 (UK). This law states that a child is presumed to be capable of being born alive at 28 weeks. But it is unclear whether the law applies now from 22–24 weeks, when some premature neonates can now be kept alive. Most significantly, there have been no judgments on what “unlawfully” means in this section.

This recent case mirrors other incidents around Australia leading to changes in abortion laws. Each change has been a painful process following a crisis or a prolonged campaign. The Western Australian parliament liberalised abortion laws in 1998, but only after two doctors had been charged with unlawful abortion. In Tasmania, in 2001, after a medical student complained that doctors agreed to abortions simply because women did not wish to have a child, doctors withdrew abortion services. Legislation was eventually passed along the lines of the Menhennitt ruling in Victoria. In 2002, the Australian Capital Territory became the first Australian jurisdiction to remove abortion from criminal statutes, after a 10-year campaign by a parliamentarian (Box).

### Society's view of abortion

About 100 000 abortions are performed each year in Australia — more than one for every three livebirths. Less than 2% of these abortions are for fetal abnormality,<sup>4</sup> the others being for social or economic reasons. And Australians support access to abortion — for two decades, opinion polls have consistently shown that the majority of Australians support women's right to choose<sup>5,6</sup> and believe that forcing a woman to have an unwanted child is worse than allowing abortion.<sup>5</sup> Prenatal screening is virtually universal. If a problem that is likely to lead to serious handicap is detected, most Australian women will seek an abortion, and the community overwhelmingly supports such decisions.<sup>5</sup>

However, many Australian abortions, including many of those for severe fetal abnormality, occur without legal clarity. In Victoria and New South Wales, for example, even a “lethal” fetal abnormality is not sufficient grounds for abortion. To be lawful, the abortion must be necessary to preserve the woman from serious danger to her life or physical or mental health.

Late abortion is a more controversial, but nevertheless accepted, part of medical practice. A survey of Australian clinical geneticists and obstetricians specialising in ultrasound showed that about 75% believed that termination for fetal dwarfism should be available as a clinical option at 24 weeks.<sup>7</sup> In 1998, the RCOG reported a termination of pregnancy for dwarfism diagnosed at 28 weeks in a pregnant woman who was a dwarf herself. The termination was prompted by “the mother's compelling description of her own life and suffering and her genuine repeated request”.<sup>1</sup> The RCOG has also reported terminations for Down syndrome and for spina bifida at 34 weeks. The RCOG Ethics Committee documented over 100 terminations of pregnancy performed after 24 weeks in England in 1996. It stated in 1998 that late termination has become “a standard management option in tertiary referral centres for serious abnormalities diagnosed after 24 weeks”.

The late abortion case alluded to above appears to be ethical<sup>7,8</sup> and consistent with relevant publications from both the RCOG<sup>1,7</sup> and a 1998 Medical Practitioners Board of Victoria report.<sup>9</sup>

### Abortion law in different Australian states and territories<sup>2,3</sup>

**New South Wales, Queensland, Victoria:** Judicial interpretations of what is “unlawful” under the Crimes Act permit abortion on maternal health grounds only.

**Tasmania:** Legislation is along the lines of Victoria's judicial interpretation of “unlawful”.

**Western Australia:** Legislative changes have made abortion legal until 20 weeks' gestation.

**South Australia:** Grounds for lawful abortion include a maternal health ground and a fetal disability ground.

**Northern Territory:** Has similar provisions to those of South Australia up to 14 weeks' gestation.

**Australian Capital Territory:** Abortion has been removed from criminal statutes.

### The need for clear and consistent abortion laws

Many Australian laws relating to abortion are unclear. Laws in four jurisdictions are still based on an 1861 English law, the Offences Against the Person Act. These laws may suggest that the role of the law is to place obstacles in the way of a woman seeking an abortion, making doctors the gatekeepers. This exposes Australian women and their doctors to unacceptable legal risks and doctors to unacceptable professional risks. Despite these risks, Justice Michael Kirby noted, in a NSW Court of Appeal case, that it was common knowledge that in NSW abortion was available, in effect, on demand.<sup>10</sup>

The UK Abortion Act 1967 repealed and replaced its antiquated legal statutes on which much of Australian abortion law is based.<sup>11</sup> An amendment, the Human Fertilisation and Embryology Act 1990, defined grounds for abortion after 24 weeks, including the risk of “grave permanent injury” to the physical or mental health of the pregnant woman, or the presence of a fetal abnormality. The UK Department of Health recognises that the Act has worked well and continues to do so, but also recognises the importance of ensuring that the Act remains effective in the 21st century.<sup>12</sup> In contrast to Australia, the United Kingdom continues to ensure that its Abortion Act remains relevant.

It is unreasonable that Australian women's access to abortion depends on where they live, unless they have the resources to travel. Why should an ACT woman carrying a fetus with a major abnormality at 20 weeks be entitled to a legal abortion, yet if she lived in Western Australia she would need to win approval from a government committee, while in NSW her access to abortion would be uncertain?

Legal uncertainty about abortion is further increased by the crime of child destruction (this crime applies only to abortions performed late in pregnancy). Victoria, Queensland, South Australia and the Northern Territory have child destruction laws. The situations in which the law applies are variable and uncertain. In Victoria, abortion in late pregnancy is said to be lawful if done in good faith, solely to preserve the mother's life.<sup>2</sup> Courts may interpret lawful grounds for termination to include situations in which there is a serious risk to the pregnant woman's life or health, but we cannot be certain.<sup>13</sup> This leaves two differing laws on abortion that might apply in a particular case, despite the fact that the House of Lords debate on the Infant Life (Preservation) Act 1929 (which created the new offence of child destruction) made it

clear that it was not introduced as a second, potentially conflicting law of abortion. Its purpose was to cover the time during and immediately after labour until the cutting of the umbilical cord, a previously unlegislated period — too late for the law on abortion, but too early for the law on infanticide.<sup>14</sup>

Confusion is further heightened by committees being established in hospitals and elsewhere that have become yet another external group intruding into the doctor–patient relationship. In Western Australia, abortions after 20 weeks must be approved by a government committee. In response to the case described here, the hospital involved has established a committee that decides who is permitted to have an abortion from 23 weeks. The identity of the hospital committee members is anonymous. It includes health administrators, but there is no lawyer or ethicist. The committee can decide on whether a woman can have an abortion without meeting her.<sup>15</sup> Abortion is one of the few medical interventions in which the doctor–patient relationship is regularly overridden by uninvolved third parties — in this case, an anonymous committee.

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 (Professor Y Ville, Department of Obstetrics and Gynaecology, Université Paris Ouest, France, personal communication). Indeed, 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 (Y Ville, personal communication).

There would, however, be objections and difficulties in clarifying and unifying Australian abortion laws. Although the majority of Australians support women having access to abortion,<sup>5</sup> politicians prefer to “leave it to the doctor”, as public discussion can lead to social disquiet and can influence votes at elections. Unifying laws would require states and territories to work together, presumably with federal government input. The process would not be easy, but could be achieved with sufficient cooperation and determination, as shown by the successful introduction of new laws on gun ownership and embryo experimentation.<sup>16</sup> With the number of women having abortions vastly outnumbering the number of embryos undergoing experimentation, it is time to address the issue of inconsistent and outdated abortion laws. If the United Kingdom can modernise its abortion laws, surely Australia can do the same.

### Competing interests

None identified.

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