ABORTION LAW, ABORTION REALITIES

Caroline de Costa[1]

Delivered at the James Cook University
Townsville Campus
3 September 2008

I am honoured to have been asked to give this year's Mayo lecture, although I must also admit to being a little intimidated, as a mere member of the medical profession, by the number of illustrious legal predecessors in this role. On the credit side I can report having given birth, as it has turned out, to two lawyers, with a third child also making plans for law school.

I am also grateful for the invitation in that it has given me the opportunity to learn something of Marylyn Mayo's life — and what an extraordinarily rich life it was. She qualified in law in Auckland at a time when very few women did so, and I'm sure she found very few other women lawyers in North Queensland, but she was active throughout her working life in the law and in teaching the law, involved in many community organisations, very interested in art and in the support of artists, and totally committed to the establishment of many of the institutions now firmly in place in JCU. I have the feeling that she very much enjoyed what she did: I'm also sure that she acted as a role model for a large number of women students at this university, and I am delighted to be speaking in her memory.

My own work has for many years been in women's reproductive health, and this evening I am going to look at how the law has impacted on this area of health. Since ancient times, women's sexuality and hence their reproductive health have been subject to regulations, restrictions, religious canons, rituals and remonstrance. Here we can see, in the very beginning, Adam and Eve slinking from the Garden of Eden, in a fresco by Masaccio. Adam is downcast but Eve quite clearly is the guilty

---

[1] Caroline de Costa BA, MBBS, FRCOG, FRANZCOG, FRCS, MPH is a Professor of Obstetrics and Gynaecology and Head of the Clinical School at James Cook University School of Medicine.

party, responsible as her punishment for women suffering the pangs of childbirth forever more. This is a woman who must be *controlled*, and for centuries laws regarding women's reproductive abilities did just that, controlled women, restricting their ability to make decisions about what they themselves wanted for their own bodies, in particular whether, when and where to bear children, and with whom. For much of this time laws were intimately bound up with adherence to organised religion and with the moral values of the particular society, and until very recently the control exerted over women came largely from men.

Often laws about reproductive health were made nominally to protect women's health, and sometimes they have done so. However often the effect was not what was intended, often the effect was the direct opposite.

My intention is to look at abortion law and its evolution over the past two centuries in Australia, and in the United Kingdom and the United States, since we have taken much of our law from the former, and take much of our culture from the latter. I am also going to look at the actual practice of abortion at various times in those 200 years, practice which has usually differed greatly from what the law allowed, and at why this was so. A large part of my talk will focus on current abortion law in Australia and overseas, the reality of abortion as a political issue, and the changes I believe we need to make in Australian law better to serve the interests of Australian women.

Abortion figures in the Hippocratic Oath, which includes the undertaking 'not to give women an abortive remedy' and medical practitioners took this oath at the time of graduation up until at least the mid-20th century — some still do. However Hippocrates did not have the benefit of modern ultrasound, pregnancy was not diagnosed until quite late, and so his view of what constituted abortion was different from that of 21st century medicine. Indeed, up until the early nineteenth century, the legal attitude toward abortion, in Australia and the United States as in the United Kingdom, was that of English common law: quickening or the first sensation of movement in the womb, which occurs in the fourth or fifth month, was the accepted sign of the presence of a pregnancy. Prior to quickening, termination of the pregnancy — which was often regarded simply as restoring missed menstruation — was considered not criminal at all. After quickening, abortion was only a misdemeanour, unless the woman died. It was the person who administered a drug or otherwise attempted to bring about an abortion who could be charged,

the woman herself was not liable. Abortion apparently was a widespread practice, and all sorts of herbal remedies such as tansy and pennyroyal, and commercial preparations, were commonly used. They were often effective but frequently damaged or even killed the woman.

In 1803, under Lord Ellenborough, abortion in England became a statutory offence — post-quickening abortion was a capital offence, and pre-quickening abortion was punished by transportation — so among us here may be some whose ancestors arrived in early Queensland convicted of this offence!

Between 1803 and 1861, when the *Offences Against the Person Act* (24 & 25 Vict c 100) put the offence of abortion in England and the colonies, including Australia, into its modern form, the law was gradually extended, largely due to the influence of medical practitioners who were increasingly organising themselves into professional groups. The physicians proclaimed their opposition to abortion as arising solely from concern for women's health, however, it has been suggested by several historians that professional prestige and financial gain may have had equally important roles in the profession's support of the criminalisation of abortion.

By 1861 the offence of abortion applied to the woman as well as to the abortionist. This was because the law now had as its basis the idea that abortion was morally reprehensible and should be punished. The quickening concept disappeared. After 1861 abortion was no longer a capital offence — for one thing, juries had been extremely reluctant to convict — but it did carry heavy prison sentences. Some of the wording of the 1861 Act is still contained in the criminal law covering abortion in Queensland today.

Also at this time the Christian churches, especially the Catholic Church, took an increasing interest in abortion. Initially the Church had held what is called the perversity view of abortion, that is, since sex was only permitted within marriage and for the purpose of having children, a woman seeking an abortion must be doing so because she had engaged in forbidden sexual activity, therefore abortion was wrong. But by the end of the 19th century the ontological view — ontology meaning the essence of things — prevailed. The ontological view argues that the fetus is a person from the moment of conception, and it is this view which is still taken by some orthodox Catholics today.

But neither the 1861 Act nor the disapproval of the Church made any difference to the actual practice of abortion in the United Kingdom — it was common, and it remained just as common for women to die from abortion. In 1899 the medical journal *The Lancet* ran a series of articles investigating the commercial suppliers of abortifacient drugs, warning of the dangers and of the uselessness of many preparations. However, *The Lancet's* own advertising pages continued to carry advertisements for 'trustworthy' preparations from medical men, so it would seem that it was the competition rather than the drugs themselves that was the concern.

Laws similar to those of the United Kingdom were made in the United States at various times during the 19th century, but despite these laws, abortion was common in America, becoming a booming free market enterprise with practitioners advertising their services discreetly but widely in the lay press.

A further purely American development was the use of anti-obscenity laws, originally intended to reduce the circulation of pornography through the mail, to prevent the dissemination of information to women about abortion, and indeed about the primitive forms of contraception then available. These laws are associated with the name of Anthony Comstock, head of the New York Society for the Suppression of Vice, who aggressively pursued and prosecuted suspected abortionists, including Madame Restell, a celebrated figure who built a lucrative abortion and birth control business in New York and elsewhere, but who does seem to have been partly motivated by a desire to help women and a belief in the rights of women to control their own bodies.

Abortion law in colonial Australia was the law of the Motherland, and abortion practice in Australia at this time mirrored that in the United Kingdom. By the mid 1850s the abortion-producing drugs widely used in England were equally widely used in Australia, while chemists were strongly linked to referrals to abortionists. So throughout the English speaking world in the 19th century, while the laws forbidding abortion were strict, abortion was a common practice, huge numbers of women underwent unsafe abortions, and many of them died or were rendered chronically ill as a result.

In all three jurisdictions in the second half of the 19th century there also grew among the medical profession the concept of the *therapeutic*

abortion. It was increasingly accepted that if continuing a pregnancy endangered a woman's life then abortion was justifiable.

In the first decades of the 20th century there developed an active movement for birth control that gradually crystallised into a middle class-led demand for accessible contraceptive information and services, quite separate from abortion services, which received less attention. Women continued however the same pattern of the use of drugs and herbal remedies, and back street abortion by untrained practitioners was common. Private hospitals and clinics run by midwives and doctors of varying competence also provided clandestine abortion services. In the 1930s the medical superintendent at the Royal Women's Hospital in Melbourne noted that at least 40 women died in his hospital each year from the consequences of back street abortion, and many more suffered chronic ill-health. In England at around the same time, birth control pioneer Dr Marie Stopes reported receiving 20,000 requests for abortion in a three month period, and in the United States Margaret Sanger, who as a nurse in New York had seen firsthand the effects of too many pregnancies on women and their families, and the common practice of illegal abortion, was also actively developing birth control information and services. The maternal mortality rate — the death rate among pregnant women — in the United States in the first four decades of the 20th century was the highest in the developed world — thirty times today's figures — and Britain and Australia were not far behind. Complications of unsafe abortion were a major contributor.

It was towards the end of this period, 1938, when a landmark case, *R v Bourne* [1939] 1 KB 687, more clearly defined the circumstances in which doctors could perform therapeutic abortions.

Aleck Bourne was a gynaecologist at St Mary's Hospital in London and, according to his obituary in the British Medical Journal many years later, a man of great compassion and courage. In 1938 a girl of fourteen was referred to his outpatient department; she had been raped by five officers of the Horse Guards at their London barracks. They had enticed her there promising to show her a horse with a green tail — she was clearly an innocent child. Following the rape the girl and her parents had first sought treatment at St Thomas's Hospital; it soon became evident that pregnancy had resulted and abortion was requested. The response of the doctors at St Thomas's was that as the rapists were officers, and therefore apparently gentlemen, 'she might be carrying a future Prime Minister of England' and the request was refused. At St

Mary's, Bourne had no such class illusions. He carefully considered the case and concluded that although a plea of danger to the girl's *life* could not be substantiated, termination of the pregnancy was justified because of the risk to the physical and mental health of the girl. He performed the abortion, then quite deliberately informed the police because he felt the urgent need to test the law in court.

Justice Macnaghten presided over the case at London's Central Criminal Court in July of 1938. Bourne's defence lawyers called a number of his colleagues who testified that there were significant risks of both physical and psychological damage if the pregnancy had continued. Justice Macnaghten took the view that if there was 'unlawful' abortion there should also be situations in which abortion was 'lawful'. He extended the meaning of 'the life of the woman' to include her health and in his directions to the jury said that:

> If the doctor is of the opinion on reasonable grounds that the probable consequences will be to make the woman a physical and mental wreck, the jury are quite entitled to take the view that the doctor…is operating for the purpose of preserving the life of the mother.

Bourne was acquitted, and in the following thirty years the case acted as a definite precedent — in Australia and the United States as well as in the United Kingdom — allowing doctors to undertake therapeutic abortions when they honestly believed the woman's health was at risk. This though did not affect the majority of women who sought abortion for a combination of economic, social and medical reasons. Back street abortion was as common as it had ever been, although those who could afford it could obtain a safer surgical procedure from a discreet private clinic. This was the subject of the 2004 Mike Leigh film 'Vera Drake' in which Vera, an English factory worker who provided abortions at no charge for poor women in their own homes, went to prison, whereas the doctor running a lucrative private abortion practice faced no such penalty.

During the 1960s, with the second wave of feminism, there was increasing pressure from the new women's liberation movement for changes in abortion law in Britain. There was also concern among some politicians about the huge discrepancy between the law and practice of abortion, and this led Liberal MP David Steel to introduce the Bill that decriminalised abortion and resulted in the *Abortion Act 1967* (UK), which, with some modifications since, allows induced abortion where

continuing the pregnancy poses a greater risk to the life or physical or mental health of the woman, or her existing family or children, than if abortion is carried out; this legislation obviously built on the ruling in *R v Bourne*.

In the United States at the same time, there was a similar surge of interest in abortion reform. This coincided with the development of the Pill and the first really effective methods of woman-controlled contraception. One of the most active groups of the time was the Chicago Abortion Counselling Service, known as 'Jane' and started by Heather Booth. 'Jane' began as an underground referral group, all members took the pseudonym Jane, and eventually Jane members learnt to perform the abortions themselves. Jane members later estimated that they performed more than 11,000 abortions. Jane became legendary for the quality of their care and the dedication of their members.

However the landmark in US abortion history was not a change in legislation as in Britain but a court case, *Roe v Wade* 410 US 113 (1973). In that case two women lawyers, Sarah Weddington and Linda Coffee, used the situation of a twenty-three-year-old pregnant woman, 'Roe', to challenge Texas's abortion law, which the Supreme Court ultimately found unconstitutional. The decision, written by Justice Harry A. Blackmun and based on the residual right to privacy, overturned numerous statutes that had been in place for more than one hundred years. Restrictions on abortions during the first trimester of pregnancy, that is the first three months, were lifted and abortions in the second trimester were allowed with few restrictions. States were given the right to intervene during the second and third trimesters to protect the life of the woman and the potential life of the fetus. So in the United States women's right to access abortion depends on a legal interpretation rather than direct political action leading to the passage of legislation. The possibility of losing that right also lies in a change to the composition of the Supreme Court, should that august body come to contain a majority of justices with anti-abortion views, and this has resulted in the creation of an abortion 'litmus test' for Supreme Court nominees, who are considered on the basis of their stand on abortion, regardless of their experience or positions on other issues.

In Australia the first challenge to the illegality of abortion came in Victoria, with *R v Davidson* [1969] VR 667 when Dr Ken Davidson was prosecuted and the case was heard by Justice Menhennitt, who, referring to the ruling in *R v Bourne*, defined the meaning of 'unlawful'

as it appears in s 65 of the Victorian *Crimes Act 1958* by reference to what is 'lawful'. He settled on the principle of 'necessity' which provides that an act which would usually be a crime can be excused if:

- It was done to avoid otherwise inevitable consequences.
- The consequences would have inflicted irreparable evil.

Menhennitt J. in his ruling discusses the *Bourne* case and the different wording of the English statute. He accepts that Justice Macnaghten must have applied the defence of necessity in the *Bourne* case. Menhennitt then says that the elements of a defence of necessity include both *necessity* and *proportion* and that he considered the use of the word 'unlawfully' in s 65 imported the elements of necessity and proportion. He then went on to apply this to the context of abortion and said that abortion would be unlawful if the person performing the abortion did not honestly believe on reasonable grounds that the abortion was *necessary* to preserve the woman from serious danger to her life or her physical or mental health (that danger being beyond the normal dangers of pregnancy or childbirth) or if the person did not honestly believe that in the circumstances the abortion was *in proportion* to the danger to be averted. So the issue is the honest beliefs of the doctor rather than the indications for the abortion itself.

Menhennitt J's directions to the jury were favourable to Dr Davidson, he was acquitted, and so it is the Menhennitt ruling which provides Victorian doctors performing abortions today with a defence should they be charged, since abortion remains a crime in Victoria — although that may soon change.[2] But the Menhennitt ruling did not immediately change the situation in Victoria, as anyone familiar with the history of the struggle of Bert and Jo Wainer will be aware. A complex network of abortion providers and police protectors had been established that the Wainers and others spent years fighting. However, Menhennitt J's ruling did mean there was more open discussion about abortion, and a gradual alteration of the social and political environment so that clinics such as the Wainers' Fertility Control Clinic could be established in Melbourne.

The *Davidson* case served as a precedent for *R v Wald* (1971) 3 NSWDCR 25 in New South Wales in 1971, and *R v Bayliss & Cullen* (1986) 9 Qld Lawyer Reps 8 here in Queensland in 1986, when McGuire DCJ's

---

[2] Editor's note: See now the *Abortion Law Reform Act 2008* (Vic).

directions to the jury were favourable to the two doctors concerned and his ruling referred directly to Menhennitt's.

The Bayliss and Cullen story is one of high drama. Dr Peter Bayliss had established the Greenslopes Fertility Control Clinic in Brisbane in the late 1970s and openly and competently practised abortion there, among other procedures. Dr Cullen was his anaesthetist. In May 1985, after eight years of practice, the clinic was raided by what were described in the media as 'squads of police accompanied by government doctors, gynaecologists, nurses, anaesthetists, pathologists and forensic biologists, scientific, photographic and fingerprint experts'. All in all more than forty people, and they all came along in a bus. Police tape surrounded the clinic, two search warrants were used, and the records of 20,000 patients were seized and taken away by police. The search included the drains of the clinic. Although the raid came as something of a surprise to Dr Bayliss, the media had plenty of notice, and took up their positions for close-up coverage of women being turned out into the street. Dr Bayliss was arrested when he declined to give an undertaking that he would not continue performing abortions. There was a similar, smaller raid on a clinic here in Townsville.

Dr Bayliss's legal advisers immediately made an application to the Supreme Court for the return of all patient records. There was an outpouring of public concern and anger at the seizure of the files, opinion polls showing that around 80 per cent of people deplored the police handling of the records. Subsequently the Full Court ruled that the search warrants used by the police in the raid on the clinic were invalid, and ordered the files to be returned.

However, that was not the end of the matter. The then Director of Public Prosecutions, Mr Des Sturgess, obviously unhappy with the court's judgment, made a public plea for any person dissatisfied with the Greenslopes clinic to come forward. From 20,000 women, only one did so, a woman who later admitted that she had believed she would receive financial reward for her action. She was a 20-year-old mother of three and she made a complaint about a termination of pregnancy performed in January 1985 at the Greenslopes clinic — she had a complication of the procedure that led her to undergo a hysterectomy. As a result, Doctors Bayliss and Cullen were charged with procuring an illegal abortion contrary to s 224 of the *Criminal Code* (Qld), and inflicting grievous bodily harm. The DPP himself prosecuted the case, declaring that the clinical consultation prior to the abortion procedure

was ‘a farce’. However, adequate medical records produced by the clinic, and the woman’s own testimony, showed that Dr Bayliss did have an honest belief that her physical and mental health had been threatened by her continuing a fourth pregnancy immediately after her third. Judge McGuire directed the jury on the basis of the Menhennitt ruling applying in the case, and the doctors were acquitted.

Since that time there have been no further successful prosecutions of doctors for the performance of abortion in Queensland or Victoria, and only one in NSW. This does not, however, mean that the legal status of abortion has been resolved in these states or that abortion law reflects abortion reality.

Abortion law is state law, but there are some aspects of Commonwealth law which have been, and continue to be, very relevant. The most important of these are the result of the political deal done in 1996 by former Senator Brian Harradine with the Howard government. Harradine, an independent senator who was expelled from the Labor Party in 1975, is a Catholic who holds strong anti-abortion views. Between 1996 and 1999 Harradine held a degree of power in the Australian Parliament enormously out of proportion to the number of Australian voters actually responsible for his election. Harradine’s vote, with that of independent Senator Mal Colston, was essential to pass government legislation through the Senate. The Howard government wanted to pass the bill allowing the partial privatisation of Telstra, and this duly happened, the Harradine and Colston votes being crucial. In return Howard gave Harradine what he wanted — a ban on the import and use of mifepristone (RU486) in Australia. In addition, Harradine obtained the scrapping of a $130 million AusAID population program in developing countries, mostly in our immediate region and a ban on aid to any overseas agencies providing family planning who also supplied either abortion services or information about abortion.

The Harradine amendment to the *Therapeutic Goods Act 1989 (Cth)* was passed in 1996 and for ten years not only was RU486 unavailable to Australian women, most women apart from a few in the health professions and some interested politicians were unaware of the existence of medical abortion — that is, safe legal abortion induced by drugs rather than by surgical means — and its increasing use overseas. In that decade however there continued to be action in parliament, in particular from the Democrats but also members of all political parties, women and men. There was also continued lobbying

by reproductive health groups and many others and this grew into the very broad movement in the latter months of 2005 that saw the four women Senators take to the Parliament the private members' bill which in February 2006 overturned the Harradine amendment.

However, the overturning of the amendment has not immediately resulted in RU486 becoming available to Australian women. Part of Harradine's political legacy to Australian women has been a great reluctance, on the part of Australian drug companies, to involve themselves with anything as controversial as RU486, and none has made an application to the TGA, the Therapeutic Goods Administration, to manufacture and/or market the drug in Australia, in the way normally done with drugs developed overseas. It is currently used by me and a colleague in Cairns, and by staff at Westmead, two women's hospitals in Melbourne, and one in Perth, under a special piece of legislation of the TGA, called the Authorised Prescriber legislation that allows — after a very complicated bureaucratic process — individual doctors to prescribe particular drugs within their own practices. This is a piece of general legislation dealing with all kinds of drugs, it is not about abortion, but it does restrict the use of approved drugs to patients with 'life-threatening or otherwise serious conditions'. It also requires ongoing oversight by the TGA. I would emphasise that there is no opposition to the drug within the TGA — what they need is an application to market the drug nationally, and I am hopeful that this will happen soon.

One of the paradoxes of the Harradine amendment of 1996 was the fact that Harradine, and his medical advisers if he had any, were apparently unaware that at least three other drugs capable of bringing about medical abortion were already available legally in Australia. These are the drugs methotrexate, misoprostol and gemeprost. The first two when used for early abortion are used what is called 'off-label' — that is, not for the purpose registered with the TGA but nevertheless with the view of peers that the use is medically appropriate — this is a common practice in Australia as overseas. It comes about when new drugs are introduced, which are subsequently found to have multiple uses — drug companies do not want to go to the trouble and expense of a second TGA application.

With the RU486 controversy, Australian women have increasingly become aware of the existence of medical abortion and have been actively seeking it out. In the absence of RU486 a number of Australian practitioners are now using methotrexate/misoprostol combinations

since both these drugs are available in Australia. Methotrexate was used widely in the United States prior to the introduction there of RU486, it has been well researched and is safe and effective but not as effective as RU486 and has more potential side effects. Gemeprost is used in Australian hospitals to bring about late medical abortion — meaning after 16 weeks of pregnancy, and usually for severe fetal abnormality, but overseas studies have shown RU486 plus misoprostol to be more effective for this purpose. So women having these drugs are not having the best evidence-based medical treatment.

Another large part of Harradine's meddling still remains in Australian policy and that is the bans in the AusAID Family Planning Guidelines that inform AusAID's reproductive health programs already mentioned, measures which detract greatly from the value of aid programs for family planning. My personal view is that it is high time that we rid ourselves completely of Brian Harradine's legacy to women in Australia and the wider Asia-Pacific region.

We turn now to state abortion law. In all states and territories apart from the Australian Capital Territory abortion remains a crime, even in Western Australia where there has been recent extensive liberalisation of the law. In Queensland abortion is covered by the *Criminal Code* of 1899, in ss 224-226 — a doctor who performs an abortion commits a crime, the woman commits a crime, and anyone providing any substance or thing to aid the abortion commits a crime. There is a defence for the person charged with one or more of these crimes in s 282 — which allows a 'surgical operation' for the preservation of the mother's life if the performance of the operation is reasonable, and this was broadly interpreted in the case of Dr Bayliss in 1986. The fact that abortion remains a crime has the effect of keeping abortion in a very grey area both in the public mind and in that of the medical profession, right across Australia. Although most general practitioners would take the ethical view that safe legal abortion should be accessible to their patients, and want to be able to refer women requesting abortion to safe and legal services, not many doctors perform abortions. Not many doctors know much about abortion. Not many politicians want to instigate changes because they fear repercussions that may impact on their political careers.

This is changing. We now have the Report of the Victorian Law Reform Commission on the Law of Abortion tabled in the Victorian parliament, with three options for parliamentarians to decide upon — all of them

addressing the stated aim of the Premier to remove abortion from the Victorian *Crimes Act* and give legal certainty to women and doctors. And we have the Bill to adopt option B of this Report having passed its second reading in the Victorian Lower House and awaiting debate on 9th September.

The Report recommends repealing ss 65 and 66 of the *Crimes Act* of Victoria, no matter which option is taken. A medical practitioner who performs an unlawful abortion should be liable to a professional not a criminal sanction. A pregnant woman who undergoes an abortion which is subsequently deemed unlawful should not be liable to any sanction. Option B makes abortion a matter between a woman and her doctor up to 24 weeks gestation and at later gestations abortion would still be lawful if a second doctor agreed.

It is recognised in the Report that abortion is usually a significant moral decision for a woman and that the woman is the person best placed to make that decision. Any counselling should be entirely voluntary on the part of the woman and non-directional. It is also accepted that abortion providers can provide non-directive counselling to women, that abortion providers do not coerce women into abortion. A practitioner who has a conscientious objection to abortion should have no obligation to perform or assist with a procedure, but must inform the woman of the conscientious objection and make an effective referral to another practitioner; this is essential in rural areas with few doctors available.

So underpinning all the recommendations in this Report are the firm beliefs that women are independent individuals who are capable of making up their own minds about abortion, that women should be provided with accurate and non-judgmental information about abortion options (and alternatives if appropriate),and that access to services should be as equitable as possible. The Report is based on strong ethical principles consistent with our current 21st century views on women's rights to access safe and effective reproductive health services, and the outcome of the Bill currently before the Victorian Parliament is eagerly awaited.[3]

What about change elsewhere? In Queensland we are slowly making plans in the same direction. We have some particular problems in

[3] Editor's note: The Bill was subsequently passed as the *Abortion Law Reform Act 2008* (Vic).

Queensland — Far North Queensland alone is as large as the state of Victoria. Ballarat to Melbourne is 200 km and that can be difficult for a woman seeking an abortion in Melbourne, but Thursday Island to Cairns is 1000 km. There is no equity of access to abortion between women in Southeast Queensland and those in the Far North. There is also the matter of the wording of the defence to abortion available to Queensland practitioners — this specifically mentions that a 'surgical operation' may be performed in the interests of the woman's physical or mental health. Whether medical abortion would be covered by this wording is currently unknown.

In April 2006, at the time we received approval in Cairns to import and use RU486, the lawfulness of medical abortion in Queensland was as you might imagine something that greatly exercised the minds of me and my colleague. Independently the Queensland branch of the Australian Medical Association consulted the State's Solicitor-General and subsequently the Premier and the Attorney-General issued a joint statement that took the view that where the TGA had approved a drug, use of that drug would be lawful in Queensland pursuant to the *Health (Drugs and Poisons) Regulation 1996* (Qld), the legislation that enables registered doctors throughout the state to prescribe licensed drugs. We were most grateful for this public support from the Premier, however, it must be noted that the legislation under which we are licensed by the TGA is not the legislation applying generally to other pharmaceutical products, and the Premier's assertion has not been tested in court. We also, in Queensland as in most other states, lack any legislation dealing with the performance of abortion for severe fetal abnormality, which, because such abnormalities cannot in general be detected before 16 weeks gestation, is usually late abortion.

Western Australia does have legislation dealing with late abortion. In Western Australia in 1998, following the attempted prosecution of two doctors and a major public campaign, a new section was inserted into the *Criminal Code*. Western Australia now has a comprehensive statutory system dealing with the performance of abortion that is very liberal with respect to early abortion.

However, abortion in Western Australia after twenty weeks must be agreed to by two doctors from a panel of six appointed by the Minister for Health. Less than 0.5 per cent of abortions in Western Australia are performed after twenty weeks. It is known that some women from

Western Australia and from other states travel to Victoria to access late abortion if they fail to meet criteria in their own state.

So the thoughtful liberalisation of the Western Australian abortion laws has nevertheless resulted in a lack of access for some women and abortion tourism. Also in Western Australia abortions must be performed in approved premises, which affect the practice of early medical abortion, since this can take place in the woman's home. So there is a need for further review, even in Western Australia. There is a similar situation in South Australia, where although the law has been updated and liberalised, abortion is still within criminal legislation, and can only be lawfully performed in licensed premises.

In New South Wales abortion remains in the *Crimes Act 1900*, with similar wording to Queensland's *Criminal Code*. The only defence is the interpretation of what is 'lawful'. Justice Levine in 1971, and Justice Kirby in 1995, expanded the Menhennitt ruling, in an attempt to interpret the law in line with current thinking and practice. Justice Kirby ruled that the mother's physical or mental health, in the future as well as currently, could be taken into account when considering whether there were lawful grounds for abortion in a particular case. This has resulted in possibly the most liberal interpretation of abortion law outside Western Australia; nevertheless abortion remains a crime in New South Wales.

In actual practice, women living in the larger urban areas of Australia today, and who are well informed, can generally access safe *surgical* abortion in early pregnancy, after discussion with a doctor and possibly a counsellor. Where the abortion is provided outside a public hospital, there is a fee over and above the Medicare rebate and in many cases this is substantial. *Rural* women and those living in smaller towns and cities can have great difficulty accessing surgical abortion. Early *medical* abortion is largely unavailable to all Australian women although increasingly doctors are using second-best drugs for this. Late medical abortion, even for severe fetal abnormality, is not easily accessible to some women. Drugs for medical abortion are advertised on the Internet, and there is no doubt that some enter Australia this way — this is a very risky action for a woman to take.

Is abortion an important issue for Australian women? Most certainly. We don't keep national data for abortions, but it has been reliably estimated that there are around 90-100,000 surgical abortions annually

across Australia. This equates to 20 per 1,000 women of reproductive age, and means that there is a 1:3 chance that a woman of reproductive age will have an abortion at some time in her life. By comparison, other countries like Belgium, Holland and Scandinavian countries have much lower rates of 6:1,000 women despite much more liberal abortion policies. These countries also provide much better sex education and contraceptive information and services to their citizens. Because we don't have accurate figures we don't know exactly when in pregnancy abortions are done in Australia, but we are probably similar to New Zealand, with 88 per cent being performed in the first 12 weeks, 11 per cent up to 16 weeks, and only 1 per cent later. I would emphasise that late abortion is *rare* in Australian practice and is usually done for major medical indications in the fetus or the woman. In Australia, most women have only one abortion in their lifetime. And most women, although they understandably may have some regrets about having to make this difficult decision for themselves, experience no long-term physical or psychological sequelae.

The Victorian Law Reform Report analysed all the major surveys conducted into the beliefs of Australians about women's access to abortion in the past six years. The conclusion is that a majority of Australians support a woman's right to choose whether to have an abortion, and that '…though there is less support for abortion amongst people with religious beliefs than among people without religious beliefs, nonetheless even among persons with religious beliefs, supporters of abortion remain in the majority'.

The main opposition to reforming abortion law in Australia comes from some Christian groups who retain the ontological view — that the fetus becomes a person at the moment of conception, and that abortion therefore equates to murder. This is clearly not the view of the majority of Australians.

Many Catholics have in fact rejected the notion that a fetus, especially in the first trimester, is a fully formed person. In its 1974 Declaration on Procured Abortion, the Vatican acknowledged that it does not know when the fetus becomes a person. Liberal Jewish and Muslim theologians concur on this view. The United States Supreme Court explored fetal personhood at some length in its *Roe v Wade* decision and concluded: 'When those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to

speculate as to the answer.' In the United States, Australian and United Kingdom law, the fetus is not a person until fully born alive.

In summary then, we have moved very far from the Eve concept of woman. We now understand women as fully human, able to make conscious choices for themselves about their reproductive health, on the basis of their personal, carefully considered ethical views. While we should strive, through the provision of better and earlier contraceptive information and services, and better sex education programs, to lower abortion rates in Australia, we also need to bring abortion law and practice into line with best practice overseas. Abortion has always been part of every society, and will continue to be so in ours. Attempting to ban abortion results in unsafe abortion and abortion tourism — in Europe, in those countries where abortion is still unavailable, Irish women travel to England, Polish women to Germany, Maltese women to Spain, all seeking safe abortion. In Australia we have an urgent need for uniform laws across the country that are part of health regulations rather than criminal legislation. I believe that equitable access to safe legal abortion services is one of the fundamental reproductive rights still denied to many Australian women, and certainly too many women in the wider Asia-Pacific region for which Australia has responsibility. Change is essential if Australian women are to have true reproductive freedom.

I would like to thank the following who assisted in the preparation of the lecture:

Naomi de Costa, Josie Valese, Javed de Costa,
Viveka de Costa, Brian Bartley, Cait Calcutt and
Judge Jane Patrick of the Victorian County Court.

GUEST ADDRESS