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THE LEGAL STATUS OF PRENATAL LIFE IN AUSTRALIA

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A thesis submitted in fulfilment of the requirements for the degree of Master of Laws

Faculty of Law, University of Sydney, 2015
Declaration of originality

I hereby certify that this thesis is entirely my own work and that any material written by others has been acknowledged in the text.

The thesis has not been presented for a degree or for any other purposes at the University of Sydney or at any other university of institution.
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CHAPTER ONE

INTRODUCTION

In Australia, birth is recognised in all jurisdictions as the time when a human being becomes a legal person with legal rights. In the prenatal period, the legal situation is less clear. Lacking a legal personality, the fetus cannot be the victim of a crime, yet its destruction may be recognised as unlawful in certain circumstances, in some jurisdictions. The way in which Australian law punishes or condones destruction of the fetus is the subject of this thesis. The aims of this thesis are to consider how the Australian law characterises the fetus and to ascertain whether there is a consistent position on when it is lawful to destroy a fetus.

Specifically, this thesis reviews destruction of the fetus in four contexts chosen for their contrasting perspectives on the fetus; Firstly, third party assaults against the pregnant woman, where the fetus is a separate entity wanted by its mother and unjustly destroyed; Secondly, maternal duty of care to the unborn child, where the mother’s autonomy to behave as she wishes is in conflict with the well being of the fetus; Thirdly, abortion, where the mother intentionally wishes to destroy the fetus; and Fourthly, conscientious objection by doctors to performing lawful abortion, where the doctor requires the law to acknowledge their belief about the value of the fetus even though it may conflict with how the law values the fetus.

This thesis predominantly presents a doctrinal analysis of the legislation and case law in Australia in these four areas. The central thesis of this work is that ‘The legal status of prenatal life in Australia is relative.’ This thesis will demonstrate that in Australian law, the legal status of the fetus is flexible and subject to change, with the context of fetal destruction as well as factors intrinsic to the fetus, relevant to determining the issue. This thesis demonstrates that there is a disparate approach between the jurisdictions as to what factors are consistently relevant in deciding this issue.

1 Crimes Act 1900 (NSW) s 20; Crimes Act 1900 (ACT) s 10; Criminal Code)1899 (Qld) s 292; Criminal Code Compilation Act 1913 (WA) s 269; Criminal Code Act 1983 (NT) ss 1C sc1(2)(a)-(c); R v Hutty [1953] VLR 338, 339.
It concludes that laws affecting destruction of the fetus in Australia, although valid, are weak because of the law’s inability to commit to a position on what the fetus is and to carry that through in all scenarios that involve its destruction. The destruction of human life is a moral issue as well as a legal issue. As life is a continuum, laws regulating destruction of prenatal life can impact society’s views about human life generally. It is arguable, therefore, that these laws should enunciate clear principles.

The natural law theory argues that we can know objective truths through the use of reason via a set of basic, unchanging practical principles and a set of general moral standards.\(^2\) Accordingly, natural laws should sit neatly together, because the soundness of law is said to derive from unchanging principles.\(^3\)

Positive law would appear to underpin Australian laws on destruction of the fetus. According to Hart, as nobody can know objective truths or morals, so long as the lawmaker has the authority to make the law, the law need not necessarily reflect morality or justice.\(^4\) As a consequence of this position, positive law may be changed without reference to notions of what is right or what is moral.\(^5\)

Accordingly, awkward contradictions that arise from the fetus having a relative status in law do not make the law invalid. However even with positive law, Kelsen notes it must still be able to demonstrate an ethical minimum to achieve a measure of justice as well as respect in the community.\(^6\) Additionally, Fuller notes that ‘good’ law needs to display, amongst other things, consistency and generality in application.\(^7\) By its critique of the legal status of prenatal life in Australia, this thesis will demonstrate that Australian laws affecting the destruction of prenatal life present a confused picture of the value of the fetus and when and why it may be destroyed. This calls into question whether changes should be made to achieve ‘good’ law. Weak laws with unclear principles as to when and why destruction of the fetus is unlawful may have a broader impact on other laws dealing with life and death issues. This is particularly so in quality of life versus sanctity of life arguments that arise in end of life decisions.

\(^3\) Finnis, above n 2, 351.
\(^5\) Ibid.
\(^7\) Lon L. Fuller, *The Morality of Law* (Yale University Press, 1964) 48, 63.
This thesis has several limitations. Firstly, although the term ‘prenatal life’ is used throughout this thesis, it does not address the issue of human embryos created outside the woman’s body through assisted reproductive technologies. Secondly, this thesis deals only with the domestic laws of Australia. Where there is an absence of legislation or case law on point in Australia, this thesis looks to the way in which comparable international jurisdictions such as the United Kingdom, Canada or the United States of America have considered and responded to a particular issue.

Thirdly, this thesis will draw on only a small, but key, portion of the voluminous scholarly writing on abortion and a woman’s bodily autonomy. It is not the intention of this thesis to explore the morality of abortion and human rights law but rather to highlight the main arguments on both sides of the debate and to analyse how they have been applied, if at all, in the legislation and case law of Australia.

The terminology used in debates about the legal status of prenatal life can be divisive and emotive. Criminal legislation in Australia generally uses two terms, *unborn child* and *fetus*. Neither of the terms is defined in the legislation. In this thesis, terms such as *prenatal life*, *unborn child*, *fetus*, *embryo*, *pregnant woman* and *mother*, will be used interchangeably, as determined to be most appropriate to the context or as used in the legislation, articles, commentary and other materials being discussed. It is not intended to give legal content to the word.

A brief outline of the main Chapters now follows.

Chapter Two discusses the ongoing application of the born alive rule in Australia, where the fetus is denied legal personhood. It critiques the Australian law’s current solution of characterising the pregnant woman and the fetus as a single entity, in order to meet the community’s expectations that a third party who destroys a fetus should be guilty of a crime precisely because a fetus was destroyed. It contrasts this with the existence of child destruction offences, which recognise the fetus about to be born or capable of being born alive as a separate entity. The conflict between child

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8 Above, n 1.
9 See Crimes Act 1900 (NSW) ss 4, 42; R v King (2003) 59 NSWLR 472; Crimes Act 1900 (ACT) ss 43, 48A; Criminal Code 1899 (Qld) s 313(1); Crimes Act 1958 (Vic) s 15; Criminal Code 1924 (Tas) s 184A.
10 Criminal Code 1899 (Qld) s 313(1); Criminal Code 1988 (NT) s 170; Criminal Code Compilation Act 1913 (WA) s 290; Crimes Act 1900 (ACT) s 43.
destruction offences and late term abortion is flagged here and discussed further in Chapters Four to Seven, which deal with abortion law.

Chapter Three analyses the conflict between the developing notion of a maternal duty of care to the unborn child and its clash with maternal bodily autonomy. It considers the approaches in literature to perceiving pregnancy in the law and practical examples from overseas cases where the courts have been asked to constrain the actions of the pregnant woman for the benefit of the fetus.

Chapter Four considers the regulation of abortion law in New South Wales and Queensland where a pregnant woman may still be charged with procuring an unlawful abortion. The laws in these States have been interpreted in case law to not expressly reference any characteristics of the fetus as relevant to determining the lawfulness of abortion. Accordingly, late term abortions may well be lawful, however a lawful abortion still requires legal oversight that goes beyond that for a standard medical procedure. This is recognised by the requirement that doctors hold an honest belief that the abortion is a proportionate response to concerns about the pregnant woman’s life or health.

It is not clear whether the doctor may take into account the value of the fetus in assessing the appropriateness of abortion. The focus on maternal health in New South Wales supports the single entity characterisation of the woman and the fetus. This is consistent with its criminal laws. However Queensland’s retention of child destruction laws, with severe penalties for harming the unborn child at any time prenatally, create a potential conflict with late term abortion. With little guidance in the legislation and case law as to what maternal circumstances are serious enough to warrant abortion, consistent and predictable legal outcomes in these States cannot be guaranteed, hence the call for abortion law reform.

11 Crimes Act 1900 (NSW), s 82; Criminal Code 1899 (Qld), s 25.
12 See R v Wald (1971) 3 DCR (NSW) 25 (‘Wald’); R v Bayliss (1986) 9 Qld Lawyer Reps 8 (‘Bayliss’).
13 See Wald (1971) 3 DCR (NSW) 25, 29; Bayliss (1986) 9 Qld Lawyer Reps 8, 45.
Chapter Five considers the relevance of the gestational age of the fetus to abortion law and considers the approach used in the United Kingdom and the United States of America. Unlike New South Wales and Queensland abortion law, in Western Australia, the Northern Territory and South Australia, the fetus is formally recognised, specifically through its gestational age, which is measured and given value in the law.

However in these jurisdictions, there is no agreement as to what gestational age is relevant to when abortion is lawful.\textsuperscript{16} Additionally, serious concerns for maternal health held by medical professionals will override the fetus’ right to protection.\textsuperscript{17} Using fetal characteristics as a basis to consider the lawfulness of abortion may clash with child destruction laws in Western Australia and the Northern Territory, given abortion may be lawful at 20 and 23 weeks respectively, subject to certain conditions.\textsuperscript{18}

Using gestational age as a basis for valuing the fetus creates a sub category between fetuses. Chapter Six considers the inclusion of another fetal characteristic, the presence or risk of serious disability in the fetus as a basis for lawful abortion in Western Australia,\textsuperscript{19} the Northern Territory,\textsuperscript{20} and South Australia.\textsuperscript{21} As a standalone criterion, it takes the emphasis away from abortion being about women and their bodily autonomy and makes a statement about the attribute of disability.

This Chapter considers judicial decisions in other areas of medical law to see whether quality of life, as opposed to sanctity of life, is a standard position in Australian law. As with maternal health concerns, the decision as to whether the fetus’ disability or risk of disability is serious enough to satisfy the legal requirements for its lawful destruction is left to the individual judgment of medical practitioners,

\textsuperscript{16} Health Act 1911 (WA) ss 334(3),(7)(a); Medical Services Act (NT), ss 11(1), 11(3); Criminal Law Consolidation Act 1935 (SA) ss 82A(1)(a)(i), (7), (8).

\textsuperscript{17} Health Act 1911 (WA) s 334(7)(a); Medical Services Act (NT) ss 11(3)(a)(i)(ii), (4)(a); Criminal Law Consolidation Act 1935 (SA), s 82A(7).

\textsuperscript{18} Health Act 1911 (WA) s 334(7); Medical Services Act (NT) s 11(3).

\textsuperscript{19} Health Act 1911 (WA) s 334(7)(a).

\textsuperscript{20} Medical Services Act (NT) s 11(1)(a)(ii).

\textsuperscript{21} Criminal Law Consolidation Act 1935 (SA) s 82A(1)(a)(ii).
subject to further judicial review. Hence, consistent outcomes cannot be guaranteed.

Chapter Seven considers abortion on demand, where any concern for destruction of the fetus is notably absent. The fetus need only be unwanted by the pregnant woman. It reviews the laws in Tasmania and Victoria, where there is abortion on demand up to 16 weeks gestation in Tasmania and 24 weeks gestation in Victoria. It considers the practical effects of this legislation on the emerging and controversial practice of social sex selection abortion, where a woman seeks abortion because she does not wish to give birth to a child of a particular gender.

The maternal health requirements in these States where abortion is requested after the gestational time limit expires, says something about the value of the mature fetus and presents a restraining hand on abortion on demand up to birth. This Chapter also covers the law in the Australian Capital Territory, where doctors are the gate keepers of abortion due to lack of guidance from the lawmaker about when and in what circumstances abortion may be performed.

Chapter Eight discusses the extent of legal recognition of conscientious objection by doctors to performing or participating in abortion in Australia. It considers statutory duties in Victoria, Tasmania and South Australia, where doctors are compelled to perform an abortion in an emergency where it is considered necessary to preserve the life of the mother, or prevent serious physical injury or mental health injury to the mother, regardless of conscientious objection. It also considers the statutory

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22 Health Act 1911 (WA) s 334(5); Criminal Law Consolidation Act 1935 (SA) s 82A(1)(a); Medical Services Act (NT) s 11(2).
23 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 4.
27 Health Act 1993 (ACT) ss 81-83.
28 Abortion Law Reform Act 2008 (Vic) s 8(3).
29 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 6(3).
30 Criminal Law Consolidation Act 1935 (SA) ss 82A(5)-(6).
duty in Victoria and Tasmania on doctors who conscientiously object to abortion to refer the pregnant woman on to another doctor so she may obtain an abortion.\(^{31}\)

The tension between perceiving destruction of the fetus from the perspective of the fetus, and perceiving it as merely a woman’s health issue and nothing more culminates in the recognition of conscientious objection by doctors to participating in abortion. A doctor’s alternative views on abortion and the value of the fetus are relevant to the discussion so long as the State will allow the doctor to act on those views.

As there is no Australian case law that assists with interpreting the practical extent of these provisions, this thesis considers relevant overseas case law involving health care professionals and conscientious objection to abortion. This issue of restricting the application of conscientious objection raises the question of whether these laws, validly made, are unjust (in the broad understanding of that term). This is a highly political area of rights discourse and an emerging area of conflict in the law.\(^{32}\)

As this thesis will demonstrate, recent law reforms have focussed on increasing access to abortion and repealing child destruction laws.\(^{33}\) Continuing agitation for further law reform is made on the basis that nationally consistent abortion laws will provide certainty to the medical profession about when abortion is lawful, characterise abortion as a standard medical procedure, and affirm the primacy of a woman’s bodily autonomy over consideration of the fetus as human life of equal value.\(^{34}\)

\(^{31}\) Abortion Law Reform Act 2008 (Vic) s 8(1); Reproductive Health (Access to Terminations) Act 2013 (Tas) s 7(2).


\(^{33}\) See, eg, Abortion Law Reform Act 2008 (Vic); Criminal Code (Medical Treatment) Amendment Act 2009 (Qld); Reproductive Health (Access to Terminations) Act 2013 (Tas).

\(^{34}\) See, eg, De Costa, Douglas and Black, above n 15, 189; Douglas, above n 14, 86; De Crespigny and Savulescu, above n 15, 203.
This reform agenda may be in conflict with not only doctors who refuse to perform or participate in abortion because of strong, personal or religious beliefs about the fetus, but also with advances in scientific knowledge that may challenge the notion of personhood or viability of the fetus at certain gestational ages. How to balance these conflicting interests and create good law that is consistent, respected by the community and reflective of its ethical minimum is indeed a challenge for the lawmaker. Ultimately, it is a good indicator of whether the lawmaker wishes to accommodate conflicting views on the value of the fetus or whether it will simply impose its view on the community.

Accordingly, research into the legal status of prenatal life remains a topical area. This thesis makes a contribution to existing research into the law by comparing and contrasting Australian laws current as at 2015 from the four conflicting perspectives of third party assaults against the fetus, maternal duty of care to the fetus, abortion and conscientious objection by doctors to performing abortion. The inconsistencies in the law due to the fetus having a relative status, confirms the difficulty in creating a national framework on the legal status of the fetus, without law reform. This thesis concludes with some suggested amendments to create more consistency in the law, but ultimately notes that even with such changes, positive laws affecting the destruction of prenatal life in Australia will remain confusing where there is no agreement on what the fetus is and why it is right or wrong to destroy it.

CHAPTER TWO

THIRD PARTY CRIMES AGAINST PREGNANT WOMEN

2.1 Introduction

In Australia, a person has no legal rights and is not considered to be a legal person until they are born.¹ Years ago, stillbirth and miscarriage were common occurrences and there was an inability to determine conclusively whether an unborn child was alive within the womb and whether it might survive after birth.² With advances in science, this difficulty no longer exists. Technology such as 3D and 4D ultrasound, and investigations such as fetal heart rate monitoring, can confirm the health and viability of the child in the womb and possibly even suggest sentience in the unborn child and its capacity to feel pain.³

Despite this knowledge, in Australia we maintain what is known as the ‘born alive rule’ so that being born alive is the accepted point at which the law considers that a crime may be committed against a person,⁴ with murder only capable of being committed on a person who is in being.⁵ However, the reality that a person exists whilst in the womb, regardless of their legal status, is recognised in all jurisdictions. Within Australia, prenatal life is legislatively referred to in five ways with the terms ‘a child’,⁶ ‘an unborn child’,⁷ ‘a ‘fetus’,⁸ a child capable of being born alive’,⁹ and by a woman being ‘not more than [X] weeks pregnant’.¹⁰ The last two terms differentiate the fetus by its age and as will be seen, is a key factor in a number of offences that involve destruction of the fetus.

¹ Crimes Act 1900 (NSW) s 20; Crimes Act 1900 (ACT) s 10; Criminal Code 1899 (Qld) s 292; Criminal Code Compilation Act 1913 (WA) s 269; Criminal Code Act 1983 (NT) ss 1C scl (2)(a)-(c); R v Hutty [1953] VLR 338, 339.
⁶ Crimes Act 1900 (ACT) s 42; Criminal Law Consolidation Act 1935 (SA) s 82A(7); Criminal Code 1899 (Qld) s 294.
⁷ Health Act 1911 (WA) s 334(7)(a); Criminal Code (Medical Treatment) Amendment Act 2009 (Qld) s 224; Criminal Code 1899 (Qld) ss 282, 313.
⁸ Crimes Act 1900 (NSW) s 4; Crime Act 1958 (Vic) s 15.
⁹ Criminal Law Consolidation Act 1935 (SA) s 82A(8).
¹⁰ Medical Services Act (NT) ss 11(1)(a), 11(3)(a)(i), 11(3)(b); Abortion Law Reform Act 2008 (Vic) ss 4-5; Reproductive Health (Access to Terminations) Act 2013 (Tas), ss 4-5.
Robert notes that the complexity of pregnancy has long presented a challenge to the legal system’s notion of a unitary legal subject that underpins common law tradition.\footnote{Hannah Robert, ‘The Bereavement Gap: Grief, Human Dignity and Legal Personhood in the Debate over Zoe’s Law’ (2014) 22 Journal of Law and Medicine 319, 319.} The three primary schools of thought regarding how the law ought to deal with this unique relationship are that the pregnant woman and the unborn child are the same entity; that they are separate entities; or that the fetus is made up of not just its biological, physical characteristics, but also extrinsic relational factors.\footnote{Robert, above n 11. See also, Isabel Karpin, ‘Legislating the Female Body: Reproductive Technology and the Reconstructed Woman’ (1992) 3(1) Columbia Journal of Gender & Law 325, 329.}

Graycar and Morgan observe that a third party assault on a pregnant woman causes more ethical concern than abortion because it involves the senseless destruction of human life, where its loss is grieved.\footnote{Regina Graycar and Jenny Morgan, The Hidden Gender of Law (Federation Press, 2nd ed, 2002) 243.} This thesis agrees that community expectations demand justice for the destruction of wanted prenatal life, but does this reflect indignation for the lack of maternal consent or concern for the inherent dignity of the fetus? As this Chapter will show, all these schools of thought regarding how to characterise the fetus are displayed in criminal laws dealing with third party actions that destroy the fetus.

The focus of this Chapter is an analysis of laws that criminalise destruction of the fetus by third parties including the born alive rule; child destruction offences; and third party assaults to the fetus leading to harm in the womb that may or may not result in a live birth. It demonstrates an inconsistency in how these laws interact together within a jurisdiction and between the jurisdictions.

This Chapter concludes that the criminal law has resisted the urge to do away with the legal significance of birth and has refused to determine the legal status of prenatal life. Interestingly, the acceptance of new and ongoing scientific discoveries about the fetus has not translated into a change in thinking regarding fetal personhood.\footnote{See, eg, Talat Uppal et al, ‘The Legal Status of the Fetus in New South Wales’ (2012) 20 Journal of Law and Medicine 178, 183; Savell, above n 2.} Rather, the desire to find an acceptable balance between community expectations flowing from destruction of the wanted fetus without the mother’s consent and lawful abortion has resulted in confusing principles as to when and why it is unlawful to destroy a fetus.
2.2 The Born Alive Rule

In this section, this thesis will explore the born alive rule generally and then review how it is applied in legislation and case law throughout Australia on a state-by-state basis. In New South Wales and the Australian Capital Territory, a child is ‘deemed to have been born alive if it has breathed, and has been wholly born into the world whether it has had an independent circulation or not’.\(^{15}\)

Similarly, in Queensland and Western Australia, a child is a human being, and thus capable of being killed, when it has been completely delivered in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel-string is severed or not.\(^{16}\)

In the Northern Territory, a person’s birth occurs at the time the person is fully removed from the mother’s body and has an independent existence from the mother. Factors relevant to determining this fact include whether the baby is breathing; has organs functioning of their own accord; or has an independent circulation of blood.\(^{17}\) South Australia and Victoria rely upon the common law, which is similar to the position in the other states and territories. The decision of Barry J in *Hutty* was that:

> A baby is fully and completely formed when it is completely delivered from the body of its mother and it has a separate and independent existence in the sense that it does not derive its power of living from its mother. It is not material that the child may still be attached to its mother by the umbilical cord… But it is required that the child should have an existence separate from and independent of its mother, and that occurs when the child is fully extruded from the mother’s body and is living by virtue of the functioning of its organs.\(^{18}\)

Once born alive, the child formally acquires legal personhood and with it, the legal rights and protection that all people enjoy. However whilst providing a restraining hand as to what may be done to a baby after birth, the born alive rule does not provide guidance as to how to characterise the fetus in the antenatal period.

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\(^{15}\) *Crimes Act 1900* (NSW) s 20; *Crimes Act 1900* (ACT) s 10.

\(^{16}\) *Criminal Code 1899* (Qld) s 292; *Criminal Code Compilation Act 1913* (WA) s 269.

\(^{17}\) *Criminal Code Act 1983* (NT) ss 1C sc1(2)(a)-(c).

\(^{18}\) [1953] VLR 338 at 339. This position was re-affirmed by the New South Wales Court of Criminal Appeal in *R v Iby* (2005) 63 NSWLR 278.
New South Wales provides the seminal case on the application of the born alive rule in Australia. In the 2005 case of *R v Iby ('Iby')*, the definition for being born alive in New South Wales and the legal consequences that flow from this status were reviewed by the Court of Criminal Appeal. Here, the accused was the driver of a motor vehicle that collided with a car driven by a woman who was 38 weeks pregnant. The accident caused the woman to undergo a caesarean delivery.

The child was born alive, had a heartbeat and respiration, but required immediate assistance with breathing via a mechanical respirator and died two hours later. The accused was charged with dangerous driving causing death and manslaughter. The issue to be decided was what was meant by the words ‘born alive’. The prosecution case was that the child had fully issued from his mother, lived independently albeit on a mechanical respirator for two hours before he died and therefore had been a living person. The defence argued that although the child had a beating heart, he could only breathe with assistance and this was insufficient proof of life for the purpose of proving homicide.

The Court of Appeal noted that the born alive rule was based on antiquated factors, being primitive medical knowledge and previously high rates of stillbirth, and that the legal significance of birth was ‘an artificial and non-scientific concept of when life begins’. Accordingly, the Court acknowledged that there was a strong basis to abandon the born alive rule completely. In considering application of the rule today, the Court held that the rule should ‘be applied consistently with contemporary conditions by affirming that any sign of life after birth is sufficient’. There was held to be no requirement that the child born alive be capable of surviving as a functioning being. On this reasoning, the appeal was dismissed.

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20 Ibid [1].
21 Ibid.
22 Ibid [3].
23 Ibid [4].
24 Ibid [20].
25 Ibid [32].
26 Ibid [78].
27 Ibid [63].
28 Ibid 288.
29 Ibid [54].
30 Ibid [79].
This minimalist interpretation of being born alive was applied in Barrett v Coroner’s Court\(^{31}\) that involved the home birth of a child who was documented as having exhibited pulseless electrical activity of 10 minutes duration. The Supreme Court in South Australia held that this satisfied the criteria for being born alive. There are a number of implications for this minimal interpretation of being alive. Freckelton notes that these include a potential increase in the ambit of coronial inquests for neonatal death following obstetric intervention,\(^{32}\) and the need to ensure that the legal definitions for life and death are coherent.\(^{33}\)

The issue to be decided by the Court in Iby did not extend to how the defendant’s actions against the pregnant woman satisfied the charge of manslaughter against the child when the harm was occasioned in utero. However, the House of Lords decision in Attorney General’s Reference (No 3 of 1994)\(^{34}\) dealt with a similar factual scenario as Iby, although here, the intentional stabbing of the pregnant woman led to early labour and the child lived for 121 days.\(^{35}\) The defendant did not intend to harm the child and initially pleaded guilty to the crime of wounding the woman with intent but when the child died, he was charged with murder.\(^{36}\)

In issue was whether the crimes of murder or manslaughter could be committed where unlawful injury is deliberately inflicted on a pregnant woman, where the child subsequently born alive dies of injuries caused or substantially contributed to by injuries inflicted in utero. Discussed at length was the legal reasoning as to how the accused could have the necessary mens rea for murder of the child when harm was occasioned when the fetus was not a legal person.

\(^{31}\) [2010] SASCFC 70.
\(^{34}\) (1998) AC 245 (HL).
\(^{35}\) Ibid 251 per Lord Mustill.
\(^{36}\) Ibid.
The House of Lords accepted that just because the fetus was not a legal person, it did not follow as a matter of course that the fetus was an adjunct of its mother. Rather, it held that the fetus was a unique organism to which existing principles could not necessarily be applied. Accordingly, it would not be sensible to say that the fetus could never be harmed or nothing could be done to it that was not dangerous. The Court reasoned that the possibility of a dangerous act directed at a pregnant woman causing harm to the child subsequently born existed and the defendant must accept all consequences of his act. As the defendant intended to harm the woman, and although the fetus was not the intended victim of the crime, the mens rea was present for manslaughter, and the actus reus was completed when the child died.

Casey is critical of this reasoning, arguing that if it is true that one cannot be damaged unless they exist, then criminal injury cannot magically spring into being in the absence of an agent. Casey’s comments are persuasive, stemming from a desire that there be fixed legal principles about the fetus, however the hesitation of individual judges to set aside the born alive rule is understandable given the potential ramifications that flow from it. To set aside the born alive rule is to make a pronouncement about the personhood of the fetus, something that may be better suited to the Parliament.

Ultimately, as Savell notes, the continuation of the born alive rule is needed to provide a logical platform for lawful abortion. To abandon the born alive rule and bestow legal personhood on prenatal life would not only cause significant problems with lawful abortion, but transactions that enable people to access assisted reproductive technologies.

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37 Ibid 256 per Lord Mustill.
38 Ibid 271 per Lord Mustill.
39 Ibid 274 per Lord Hope of Craighead.
40 Ibid.
42 See, eg, *Tremblay v Dailge* [1989] 2 SCR 530. The Canadian Supreme Court noted that the task of classifying a fetus is very different when done by the law or done by science, with the court’s task being restricted to regulating rights and duties between people. In *Hamid v Director of Proceedings* [2003] 3 NZLR 289, 313 [117]-[118] per McGrath J, the New Zealand Supreme Court noted that the born alive rule is maintained for convenience today and does not rest on developed medical or moral principle.
43 Savell, above n 2, 631.
The born alive rule is also used in other areas of law. As will be discussed further in Chapter Three, in personal injury law, the law may recognise that a person has been harmed whilst in the womb and thus accrues a legal right, but this right is only actionable when the person is born and therefore capable of suffering a loss.\footnote{Watt v Rama [1972] VR 353; X and Y v Pal (1991) 23 NSWLR 26; Harriton v Stephens [2006] HCA 15.} Similar reasoning exists for personal property laws and succession laws.\footnote{Williams v Ocean Coal Co Ltd [1907] 2KB 422, 429, 431, 432.}

As can be seen, these laws do not disrupt the application of the born alive rule. However, their retrospectivity highlights the contradiction in logic or weakness of the rule - from the perspective of the fetus - that a person exists in law only when they are born yet they can be harmed before the law says they legally exist. The increasing incidence of fetal surgery complicates this differentiation between the fetus and the child born alive.\footnote{Freckelton, above n 32, 18.} If the fetus does not exist as a person and cannot be harmed, who or what is the surgeon operating on?

Accepting the legal rule that the fetus is not a person, even in the seconds prior to birth, in order to accommodate abortion, and then using the rule as a basis to stifle intelligent debate has consequences. As will be discussed in Chapter Eight, conscientious objection by doctors to performing or participating in abortion is based on a belief that the fetus is a human life and that aborting it is morally wrong. Whilst abortion may be seen in some jurisdictions as an actionable right that involves nothing more than a standard medical procedure, it still requires the assistance of a doctor to carry it out. Whilst the status of the fetus is a question that supersedes the law, this sometimes seems to be forgotten.

Legislation in New South Wales, Queensland and the Australian Capital Territory contain provision for offences that cover harm occasioned to a child when they are not yet born, though the offence is only actionable after the child is born. In other words, the legislation retrospectively recognises an assault if the person survives it.\footnote{Crimes Act 1900 (NSW) s 42; Criminal Code 1899 (Qld) s 313(2); Crimes Act 1900 (ACT) s 43.} However some jurisdictions make provision for child destruction offences. Child destruction concerns destruction of a very mature fetus about to be born or capable of being born alive. This offence highlights the artificiality of the born alive rule from...
the perspective of the fetus. It obligates the law to protect and value the fetus and suggests that the maturation of biological traits of the fetus may well determine personhood.\textsuperscript{49}

The ongoing existence of such offences represent a clash with lawful late term abortion, which may place little or no focus on the biological realities of the fetus. The arguments around retaining or repealing the offence of child destruction will now be reviewed.

2.3 \textit{The Offence of Child Destruction}

The offence of child destruction exists in several Australian jurisdictions. Its continued existence has been criticised for causing confusion or conflict with the born alive rule and late term abortion.\textsuperscript{50} The offence derives from the \textit{Infant Life Preservation Act 1929} (UK), which covered a lethal act performed intentionally during childbirth on a child capable of being born alive, but for the act. It was seen as necessary because the born alive rule would deliver an injustice, as destruction of the fetus, the very point of the act, would have prevented the commission of a crime.\textsuperscript{51}

Due to the lack of prosecution for child destruction, there is uncertainty as to whether child destruction covers just the act of childbirth, or destruction of a fetus capable of being born alive.\textsuperscript{52} Rankin argues that in Australia, if being born alive requires only minimal signs of life as per the judgment in \textit{Iby}, then the \textit{capacity} to be born alive likewise only requires the fetus to be capable of minimal signs of life. He suggests that this understanding could decrease the gestational age of a fetus potentially caught by child destruction to include a significant number of lawful medical abortions.\textsuperscript{53}

\textsuperscript{49} Casey, above n 41. Contra Savell, above n 2, 664. Savell argues that such comparisons are crude and lack an understanding of the complexity of personhood.


\textsuperscript{51} Victorian Law Reform Commission, above n 50, 99 [7.15].

\textsuperscript{52} Ibid 102 [7.47].

\textsuperscript{53} Rankin, above n 50, 20.
This is a valid point. Rankin’s solution is to argue for a repeal of child destruction offences in Australian jurisdictions so as to avoid ambiguity and confusion with lawful late term abortion.\(^{54}\) Whilst this would ensure clarity, it does not address the ethical issue of whether the mature fetus should be given greater protection in the law. Certainly the maturation level of the fetus as the basis of a crime is in line with the gradualist approach to lawful abortion, whereby gestational age of the fetus is relied on to signify growing concerns about fetal personhood.

This point was made in the landmark Californian case, *People v Smith*, where the defendant was accused of the homicide of a 12-15 week old fetus.\(^ {55}\) The pregnant woman was beaten by the defendant who used the words ‘bleed baby, bleed’ whilst kicking the pregnant woman in the stomach and back.\(^ {56}\) She suffered a miscarriage some weeks later, whilst in hospital for treatment of her injuries from the beating.\(^ {57}\)

The Court of Appeal held that a viable fetus, with its capacity for independent existence, could be the object of murder whereas a non-viable fetus (defined as having only an expectancy and potentiality for life) could not.\(^ {58}\) As the evidence here did not support viability, the Court dismissed the charge of murder.\(^ {59}\)

Ultimately, the Court created a special legal identity or status for the viable fetus, although the attributes of independent existence were not set out in any detail. It noted that the concept of viability of the fetus arose from the reasoning of the Supreme Court in the seminal decision of *Roe v Wade*, that made abortion lawful where the fetus had only the expectancy and potentiality for human life.\(^ {60}\) The Court noted in *Smith* that where viability is the litmus test for lawful abortion, and where advances in medical science have shortened the period of gestation, logic demands that the fetus at a lower gestational age requires increased legal protection.\(^ {61}\)

\(^{54}\) Ibid 26.
\(^{55}\) (1976) 59 Cal. App. 3de 751.
\(^{56}\) Ibid.
\(^{57}\) Ibid.
\(^{58}\) Ibid 753.
\(^{59}\) Ibid.
\(^{60}\) 410 U.S. 113 (1973) 162.
\(^{61}\) (1976) 59 Cal. App. 3de 752.
The definition of a child capable of being born alive was discussed in the United Kingdom decision of *C v S*. The Court of Appeal affirmed that a fetus of 18-21 weeks gestation although capable of showing signs of life such as a pulsating cord or heart beat but not capable of breathing nor able to survive for more than a short period of time, was not a child capable of being born alive. This is obviously a harsher test than that in *Iby*.

Gestational age limits that prohibit very late term abortion bear witness to the reality of failed late term abortions performed on a fetus capable of being born alive. The multiple guilty verdicts against abortionist Dr Kermit Gosnell in Philadelphia in the United States of America are a case in point. Gosnell, a medical doctor who ran the Women’s Medical Society, regularly performed late term abortions on pregnant women. When the abortions were unsuccessful in destroying the unborn child, he took to finishing the job outside the womb by severing the child’s spinal cord with scissors.

Had the babies been destroyed before birth, Dr Gosnell could have been performing a lawful medical procedure, subject to the laws of his State. As it stood, he was found guilty of three counts of first-degree murder and sentenced to life imprisonment. Cases such as these highlight the conundrum of late term abortion. Where the technique delivers a live child, a strange situation exists where the woman and the doctor are confronted with what the law describes as a person with a right to life, but whom a few seconds beforehand, was not a person in the eyes of the law and was capable of being lawfully destroyed because it was not capable of being harmed.

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63 Ibid 142.
65 Though in this particular case, it is unlawful in Philadelphia to perform an abortion on a woman at 24 weeks gestation unless her life is at stake.
The United States has legislation that reinforces the consequences of the born alive rule specifically in circumstances of failed late term abortion. In the federal *Born-Alive Infants Protection Act 2002*, minimal signs of life, such as a heartbeat, pulsation of the umbilical cord, breath and a voluntary muscle movement, are adequate signs of life to provide the child with legal recognition of personhood and legal rights, including the right to life.

In response, the American Academy of Pediatric Steering Committee concluded that the Act would not alter decisions about withholding or discontinuing medical treatment that are considered to be futile by the medical care providers in conjunction with the parents such that infants deemed not appropriate to resuscitate or to have treatment should be treated with dignity and respect and provided with comfort. 66

The use of gestational age limits for lawful abortion can be found in five Australian jurisdictions, although the lack of consensus regarding the lower limit for abortion is startling. 67 Three jurisdictions do not acknowledge the maturity of the fetus as a relevant consideration for lawful abortion. 68 Herein lies the difficulty in discussing child destruction offences in Australia where there is discordance with the underlying abortion law.

Four jurisdictions maintain child destruction offences and each of them permits lawful late term abortion in certain circumstances, none of which are the same. This thesis now considers these four jurisdictions to ascertain the level of guidance provided in the relevant statutes as to when the offence applies and in analysing these laws, it will consider the underlying abortion laws in order to ascertain any potential conflicts between child destruction and late term abortion.

67 Gestational age is a relevant criterion for abortion in Victoria, Tasmania, South Australia, the Northern Territory and Western Australia. This will be explored in detail in Chapters Five, Six and Seven.
68 Maternal health concerns are the only basis for lawful abortion in New South Wales and Queensland, as discussed in Chapter Four. The Australian Capital Territory has no gestational age criterion for lawful abortion. This will be discussed in Chapter Seven.
2.3 (a) **Queensland, Northern Territory, Western Australia, Australian Capital Territory**

Criminal statutes in Queensland, Northern Territory, Western Australia and the Australian Capital Territory maintain the offence of child destruction. As discussed above, the controversy with maintaining these offences include whether they are restricted in application to the actual time of childbirth, or to a wider set of circumstances that include abortion techniques at any time during the second trimester of pregnancy.

Ellwood notes that the term ‘late term abortion’ is generally understood to mean abortion past 20 weeks gestation. It involves different techniques to abortion performed earlier in time due to the challenges of fetal size, the potential for maternal complications, and the not infrequent need for an intact fetus so that a post mortem may be performed. With a ‘grey zone’ of fetal viability between 23 and 25 weeks gestation, late term abortion on a child capable of being born alive may well be lawful and therefore contradict child destruction laws. As all of these jurisdictions allow for the possibility of a lawful late term abortion, this thesis will consider the possible conflict.

In section 313(1) of the Queensland Criminal Code 1899, it is an offence for any person who ‘when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a crime, and is liable to imprisonment for life.’ The overlap between child destruction and late term abortion is arguably covered by section 282 of the Code which provides a defence for where a surgical operation or medical treatment is performed on a person in good faith for the benefit of the patient or to save the pregnant woman’s life (this will be explored further in Chapter Four).

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69 Criminal Code 1899 (Qld) – ‘Killing unborn child’ s 313(1).
72 Crimes Act 1900 (ACT) s 43. The maximum penalty for this offence is 10 years imprisonment.
74 Ibid 140.
However Douglas argues that as Queensland’s abortion laws are particularly uncertain with no specific gestational age requirement, and with the practice itself being highly political, it is not possible to state for certain that s 313(1) would not apply to late term abortions.\textsuperscript{76} Rankin agrees that despite the lack of Australian case law on point, the possibility of overlap between child destruction and late term abortion exists.\textsuperscript{77}

This thesis concurs. Whilst the lack of prosecution for either child destruction or unlawful late term abortion lends support to the view that a conflict is more theoretical than actual, the fact that Queensland’s abortion provisions make no reference to fetal characteristics is confirmed in the case law interpretation. Decisions such as \textit{R v Bayliss},\textsuperscript{78} discussed in detail in Chapter Four, indicate that whilst serious maternal health concerns will override concern for fetal life, the courts have not reduced abortion to be merely a woman’s health issue.

The lack of certainty regarding what situations satisfy serious maternal health concerns coupled with the possibility of prosecution, underline concerns expressed by abortionists advocating for law reform in Queensland.\textsuperscript{79} However such concerns represent one side of the argument only.

The Australian Capital Territory, maintains the offence of child destruction in section 42 of the \textit{Crimes Act 1900} where it is a crime punishable by up to 10 years imprisonment for a person preventing a child from being born alive either intentionally or recklessly by any act or omission ‘occurring in relation to childbirth and before the child is born alive.’ There is a lack of legal guidelines as to when abortion is lawful other than that it has to be performed by a doctor in a facility approved by the Minister with the requisite consent.\textsuperscript{80} Abortion is a private medical matter between the pregnant woman and the Hospital.

\textsuperscript{77} Rankin, above n 50, 23.
\textsuperscript{78} (1986) 9 Qld Lawyer Reps 8.
\textsuperscript{80} Health Act 1993 (ACT) ss 81-2.
However this thesis notes the concerns raised by the Victorian Law Reform Commission in its Final Report on Abortion. Relying on advice it received from a medical panel, the Commission expressed concern that on rare occasions, a decision must be made during childbirth to kill the child to save the mother. Additionally, parents may request the intact birth of a disabled fetus to assist with their grieving process.\(^{81}\)

Whilst it is possible these scenarios might be caught by the child destruction provisions, repealing the law for these rare occasions has to be balanced against the protection the mature fetus gains from laws that punish an unscrupulous health care practitioner performing indiscriminate late term abortions such as in the Dr Gosnell example referred to above. It becomes a question for the lawmaker. The lack of child destruction prosecutions supports the position that conflict here may be more theoretical than actual.

Similarly worded child destruction laws exist in the Northern Territory and Western Australia but in these jurisdictions, gestational age is used to control abortion. In the Northern Territory, a late term abortion after 23 weeks is lawful where a medical practitioner determines that it is necessary for the sole purpose of saving the mother’s life.\(^{82}\) In Western Australia late term abortion past 20 weeks is lawful where two doctors from a panel of six determine that there is a serious condition in either the mother or the child that in the clinical judgment of those doctors, justifies the abortion.\(^{83}\) The abortion must take place in a facility approved by the Minister.\(^{84}\)

Accordingly, these late term abortions require serious medical reasons to be verified before they will be performed. This thesis argues that the abortions are likely to be lawful and therefore unlikely to be caught by the child destruction offence. Child destruction offences integrate into abortion laws in these jurisdictions because there is already a stated concern for the mature fetus whereby it is more difficult to achieve a lawful abortion the closer it comes to viability. The circumstances where late term

\(^{81}\) Victorian Law Reform Commission, above n 50, 109 [7.84]-[7.85].
\(^{82}\) Medical Services Act (NT) s 11(4)(a).
\(^{83}\) Health Act 1911 (WA) s 334(7)(a).
\(^{84}\) Ibid s 334(7)(b).
abortion may be lawful in these jurisdictions will be discussed further in Chapters Five and Six.

This thesis now reviews the two jurisdictions that have repealed child destruction laws and considers the basis of the repeal, and the ramifications upon related laws affecting the fetus.

2.3 (b) Victoria and Tasmania

As suggested by Rankin, one way to deal with the perceived inconsistency issue between child destruction and lawful late term abortion is to repeal the offence of child destruction altogether. In recognition of this conflict in the law, Victoria abolished the offence of child destruction in 2008, when it introduced the Abortion Law Reform Act 2008 (Vic). The Victorian Law Reform Commission noted that the offence of child destruction had never been used in Victoria for its original purpose, which was stated to be an attempt to avoid the crime of homicide that would apply if death occurred after birth, by destroying the unborn child before or during birth. Rather, it was used to regulate late term abortions and assaults on a pregnant woman causing harm to the fetus but the law failed to do either with clarity.

The old offence of child destruction was considered to be an anachronism developed to cover a potential former offence: the calculated and intentional killing of a child in the process of childbirth to avoid punishment for infanticide or murder, due to a gap between abortion and homicide laws. Today, Victoria has abortion on demand up to 24 weeks gestation, and thereafter where two doctors agree that abortion is appropriate in all the circumstances of the case. Victoria’s repeal of child destruction laws and its liberal abortion laws suggest a clear de-valuing of the fetus and characterisation of abortion as an ordinary matter of women’s health.

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85 Rankin, above n 50, 26.
86 Victorian Law Reform Commission, above n 50, 98 [7.19].
87 Ibid 108 [7.93].
88 Ibid 96 [7.6].
89 Abortion Law Reform Act 2008 (Vic) s 4.
90 Ibid s 5.
In her Second Reading Speech, Minister Maxine Morand stated that the choice of 24 weeks as the upper limit for abortion on demand was because it was a common threshold for complex cases and was consistent with the clinical practice in Victoria, Australia and overseas.\(^\text{91}\) Concern for fetal viability, arguments regarding personhood or the possibility the child might be born alive were notably absent although Mendelson notes that the statutory distinction of 24 weeks retains the traditional temporal criterion for the law’s understanding of pre and post quickening.\(^\text{92}\)

Oreb describes the repeal of child destruction and the abortion law reform in Victoria as creating an actionable right to abortion in Victoria, as opposed to a ‘merciful allowance’.\(^\text{93}\) As discussed above, the consequences of these changes to the law and the impact it has on doctors who conscientiously object to participating in abortion will be discussed further in Chapters Seven and Eight.

Likewise, Tasmania repealed the offence of ‘causing the death of a child before birth’\(^\text{94}\) that provided that any person who caused the death of a child who had not yet become a human being in such a manner that he would have been guilty of murder if such a child had been born alive, was guilty of an offence. Tasmania now permits abortion on demand up to 16 weeks gestation and thereafter where two doctors certify in writing that they have a reasonable belief that continuation of the pregnancy involves greater risk of injury to the pregnant woman’s physical or mental health than if the pregnancy was not terminated.\(^\text{95}\)

Like Victoria, the upper age limit was chosen on the basis of clinical practice and approaches in other jurisdictions, with no mention of concerns regarding fetal viability or personhood.\(^\text{96}\) In a similar vein to Oreb, Sifris notes that as abortion has already been conceptualised as falling within a number of rights such as the right to health, right to autonomy, and right to be free from torture or cruel, inhuman or degrading

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\(^{91}\) Victoria, Legislative Assembly (2008) Debates, Bk 11, 2951.
\(^{94}\) Criminal Code Act 1924 (Tas) s 165(1), now repealed.
\(^{95}\) Reproductive Health (Access to Terminations) Act 2013 (Tas) s 5(1)(a).
\(^{96}\) Population Health Equity, ‘Information Paper Relating to the Draft Reproductive Health (Access to Terminations) Bill’ Department of Health and Human Services, March 2013, 6-11. It should be noted that the upper limit here appears to be well below the age of viability or grey zone referred to earlier.
treatment or punishment, abortion ought to be re-framed as a standard medical procedure.

However as Parker notes,

‘...even if abortion comes to be seen as a woman’s rights/health issue, this presupposes that a decision (more likely an unreflective assumption) has been made concerning fetal status, since abortion consists of the killing of a fetus. Coming to conceive of abortion as nothing more than a woman’s health issue is thus a critically important statement on the part of society about fetal status, and also of great significance for those doctors who do not share that moral view.’

This thesis agrees with this view and shares those concerns. Clearly, in these two jurisdictions any concern for mature fetal wellbeing is not reflected in its laws, particularly with abortion characterised as a standard medical procedure. The possibility of injecting an alternative characterisation of the fetus into the debate will be discussed further in Chapters Seven and Eight.

How to characterise the loss of a fetus at any time throughout the prenatal period, destroyed through a third party act without the consent of the mother, is another dilemma in the criminal law. This thesis now reviews how the law deals with third party assaults on pregnant women resulting in destruction of the fetus in utero.

2.4 Destruction of the fetus in utero

Several jurisdictions recognise that the act of destroying a wanted, unborn child that is destroyed without the mother’s consent is a crime. Whilst the destruction of a wanted, unborn child is acknowledged by all as a tragedy, the ‘single entity’ characterisation of the loss is often unsatisfactory to the parents of the stillborn child.

98 Sifris, above n 97, 902.
100 Criminal Code 1899 (Qld) s 313(2); Crimes Act 1900 (NSW) ss 4, 13; Crimes Act 1958 (Vic) s 15; Criminal Code Act 1924 (Tas) s 184A.
The failure of the criminal law to formally recognise the death of the fetus, or as Robert notes, to recognise and name the harm to it, can negatively impact on families grieving for the loss of their unborn child, regardless of whether other offences exist that will ensure punishment of the guilty third party. Attempts by grieving parents to have the law recognise personhood in their unborn child have not been successful to date largely because of the fear that to do so will jeopardise lawful abortion. Dalmau comments that there is no reason to think that any solution can satisfy all interested parties, or entirely avoid inconsistencies and grey areas.

This thesis agrees with that conclusion. Without a touchstone principle that values the fetus, dissatisfaction about the limitation of the law to fully recognise the loss of a wanted fetus, will no doubt continue. Additionally, clarity and constancy in application of the law, considered to be hallmarks of good law, may be degraded where the law accommodates multiple legal characterisations of the fetus.

2.4 (a) Queensland

In addition to the child destruction offence in section 313(1) of the Criminal Code 1899 (Qld), section 313(2) of the Criminal Code, provides that ‘any person who unlawfully assaults a female pregnant with a child and destroys the life of, or does grievous bodily harm to, or transmits a serious disease to, the child before its birth, commits a crime’ with a maximum penalty of life imprisonment. This offence therefore has a broad application in that it does not require any proof that the unborn child was ‘viable’ or that the offence took place during childbirth in order for a crime to have been committed. The recognition of the unborn child as being something of value in and of itself is evident in the harsh and equal penalties applying to its destruction or harm at any stage of development and regardless of whether it goes on to be born.

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101 Robert, above n 11, 323.
103 Lon L. Fuller, The Morality of Law (Yale University Press, 1964) 48, 63.
The genesis of this offence of destruction of the unborn child arose from an unreported District Court decision of *R v Lippiatt*,\(^{104}\) where the defendant assaulted his pregnant girlfriend by kicking her in the stomach. He knew she was pregnant and wished to avoid paying child maintenance. The woman went on to suffer a miscarriage and the fetus was stillborn at 32 weeks gestation.\(^{105}\)

The charge of murder or manslaughter could not be brought because an unborn child did not satisfy the definition of a human being capable of being killed as set out under section 292 of the *Criminal Code*. Additionally, the offence of ‘killing unborn child’ under section 313(1) of the *Criminal Code* was not thought to apply, as the woman was not about to deliver the child.\(^{106}\) The case therefore highlighted a gap in the Queensland criminal law with regards to the destruction of an unborn child capable of being born alive, but not destroyed during the act of childbirth.

The complainant in *Lippiatt* argued for an amendment to section 292 of the *Criminal Code*, which defines when a child becomes a human being, so that the definition of a child ‘capable of being killed’ included a fetus at or over the age of 20 weeks gestation or a fetus weighing 400 grams or more who could reasonably be expected to live if born, regardless of whether the child had proceeded in a living state from its mother, breathed, had an independent circulation or had its navel string severed.

As a result, the Criminal Law Amendment Bill 1996 was introduced to amend section 313(1) of the *Criminal Code*, so as to define a child of 24 weeks or more gestation being prima facie evidence that the child was capable of being born alive, thus broadening the coverage of the offence.\(^{107}\) This amendment, however, was rejected by the Queensland Parliament because of concerns that the definition of a child ‘capable of being born alive’ might conflict with lawful abortions performed at this time.

\(^{104}\) *R v Lippiatt* (Unreported, District Court of Queensland, Hoath J, 24 May 1996).
\(^{105}\) Ibid 130.
\(^{106}\) Ibid 131.
\(^{107}\) Explanatory Notes, Criminal Law Amendment Bill 1996, 12.
As a compromise, Parliament enacted section 313(2) of the *Criminal Code* to create an offence for the destruction of a child before birth. Later, section 282 of the *Criminal Code* was amended, so that the surgical operation or medical treatment considered reasonable in all the circumstances of the case to preserve the mother’s life is not a crime. This was said to clarify the law, particularly for doctors, given the lack of appellate level decisions to interpret the lawful circumstances for abortion.\(^{108}\)

### 2.4 (b) New South Wales

In 2001, Michael Harrigan drove a motor vehicle in which a seven months pregnant woman, Renee Shields, was a passenger. The accident caused the death of the unborn child and Ms Shields was required to undergo a hysterectomy. At trial, the judge did not sentence the accused for manslaughter and instead the accused was jailed for 18 months, and a maximum six years and three months for dangerous driving.\(^{109}\)

This led to proposed changes to the criminal law to recognise the death of the fetus known as ‘Byron’s Law’ (named after the baby of Ms Shields). In his 2003 *Review of the Law of Manslaughter in New South Wales*, the Honourable Murray Finlay QC was asked to consider whether the New South Wales *Crimes Act 1900* ought to be amended to include a structured scheme of manslaughter offences and penalties.\(^{110}\) This was to include whether manslaughter provisions ought to be brought when an unborn child dies, whether New South Wales ought to legislate to introduce the offence of child destruction, and whether it would be necessary to establish that the offender knew that the mother was pregnant.\(^{111}\)

Ultimately, Finlay did not recommend that the *Crimes Act 1900* be amended to allow a charge of manslaughter upon the death of an unborn child, but rather made a policy recommendation that an offence of ‘killing an unborn child’ be created whereby the unborn child was defined as one capable of being born alive, with a pregnancy of greater than 26 weeks being prima facie evidence that the woman was carrying a

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\(^{108}\) Queensland, Parliamentary Debates, Legislative Assembly, 1 September 2009, 1981-2 (Cameron Dick, Attorney-General). This will be discussed further in Chapter Four.

\(^{109}\) *R v Harrigan* (unreported, District Court, Parramatta, Judge Tupman, 27 February 2003).


\(^{111}\) Ibid 14-15.
child capable of being born alive.\textsuperscript{112} This conclusion was to be capable of being dispelled by medical evidence.\textsuperscript{113}

Finlay was persuaded that ideological problems existed in granting a zygote, embryo or fetus the same status as that of a fetus so advanced that it could live outside its mother’s body.\textsuperscript{114} Additionally, he concluded that a fetus capable of being born alive was not merely a body part of its mother nor was it a person at law but it was a distinct entity, the existence and value of which the law should recognise, in some circumstances.\textsuperscript{115}

The recommendation to enact a child destruction offence was not, however, taken up by Parliament. Instead, section 42 of the \textit{Crimes Act 1900} was introduced to create the offence of ‘Injuries to child at time of birth’ which currently provides that ‘any intentional or reckless infliction during or after delivery of a child, whether wholly born or not, causing any grievous bodily harm shall be liable for imprisonment for 14 years’.

In 2005, the \textit{Crimes Amendment (Grievous Bodily Harm) Act 2005 (NSW)} amended the definition of grievous bodily harm in the \textit{Crimes Act} to include ‘the destruction (other than for a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers harm’.\textsuperscript{116} This expanded definition of the offence of grievous bodily harm so as to include death of the fetus whether viable or not came after the decision in the Court of Appeal case of \textit{R v King} (‘King’).\textsuperscript{117} Here, the accused assaulted a woman who was 23 to 24 weeks pregnant with his child.\textsuperscript{118} When she refused to agree to an abortion, he allegedly stomped on her stomach several times. These actions led to a placental abruption and the stillbirth of the child.\textsuperscript{119}

\begin{footnotesize}
\begin{enumerate}
\item Ibid 160.
\item Ibid 135.
\item Ibid 110.
\item Ibid 114.
\item \textit{Crimes Act 1900 (NSW)} s 4.
\item (2003) 59 NSWLR 472.
\item Ibid [6].
\item Ibid.
\end{enumerate}
\end{footnotesize}
The accused was charged under section 33 of the *Crimes Act* of maliciously inflicting grievous bodily harm against a person with intent. The situation differed therefore to that of *Iby*, where the child was born alive, albeit living for only a short period after birth. Here the unborn child was both injured, and died, in utero. The Court therefore had the opportunity to consider the continued usage of the born alive rule as against modern medical knowledge of the viability of the unborn.

The trial judge accepted the defendant’s argument that the fetus was a unique organism, genetically different to its mother and therefore not technically part of its mother (the separate entities argument). The trial judge noted that the cause of the injury was to the placenta and accepted that the placenta was not a part of the woman but rather a structure attached to the woman’s blood stream and in turn to that of the fetus.

There was no evidence that the woman suffered grievous bodily harm and as the fetus is not recognised by the law as a person and therefore capable of being the victim of a crime, the accused was acquitted. This case brought to a head the issue of whether strict application of the born alive rule leaves the law without a remedy where a pregnant woman loses a wanted, unborn child. The Prosecution appealed. In considering the issue, the Court of Appeal noted no binding authorities on whether the fetus could be regarded as part of the mother so that harm to the fetus would be harm to the mother, satisfying the requirement that harm be done to a person.

A review of decisions of superior courts in other jurisdictions was undertaken by Speigelman CJ in *King* in which His Honour concluded that

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120 Ibid [2].
121 Ibid [10].
122 Ibid [9].
123 Ibid [8].
124 Ibid [14].
125 Ibid [36].
[t]here is no clear rule, applicable in all situations, as to whether the mother and the foetus will be considered as one or as separate. The answer will turn on the incidents of the particular legal situation under consideration including, where relevant, the scope, purpose and object of the particular statutory scheme.\textsuperscript{126}

Ultimately, the Court of Appeal overturned the trial judge’s decision, preferring the single entity argument and ruling that for the purpose of section 33 of the \textit{Crimes Act}, ‘[t]he close physical bond between the mother and the foetus is of such character that, for purposes of offences such as this, the fetus should be regarded as part of the mother.’\textsuperscript{127} The Chief Judge also noted, that

\[t]he aggravated forms of assault reflect the community’s legitimate concern to control violence between persons. The greater the degree of injury, as compared with the result of common assault, the greater the community’s concern. Where such enhanced injury is inflicted on a foetus alone, I can see no reason why the aggravated form of offence should depend on whether the foetus is born alive. The purpose of the law is best served by acknowledging that, relevantly, the foetus is part of the mother.\textsuperscript{128}

By deciding as it did, the Court of Appeal did not bestow personhood on the fetus, rather the fetus was considered, in this limited context, to be so much a part of its mother that harm to it was considered to be harm to its mother thus allowing punishment to flow from the incident. Thus, as the act of violence was committed against the woman (as representative of herself and the fetus, the single entity approach) and as the woman did not die, then logically, the charge could only be that of aggravated assault of the woman.

Accordingly, prosecution under section 33 of the \textit{Crimes Act} is a crime against the pregnant woman, even if she does not suffer harm to the requisite level herself but the fetus is destroyed, with the maximum penalty being imprisonment for 25 years. Ultimately the Court sanctioned the idea that retention of the born alive rule is best for our society and that the physical nature of prenatal life should not be the ultimate determinant of its legal status. Rather, flexibility is permitted so that one can re-characterise the legal status of the fetus in other scenarios so as to achieve a bespoke outcome.

\begin{flushleft}
\textsuperscript{126} Ibid [87].
\textsuperscript{127} Ibid [96].
\textsuperscript{128} Ibid [97].
\end{flushleft}
Another push to further amend the New South Wales Crimes Act to recognise the death of a fetus as manslaughter and even murder came in 2009, when Ms Brodie Donegan, an eight months pregnant woman, was run down by a motor vehicle driven by a driver affected by drugs. The injuries occasioned by the accident caused a placental abruption to Ms Donegan leading to the stillbirth of her child, Zoe.\footnote{R v Hampson (unreported, District Court of NSW, Judge Ellis, 31 March 2011).}

Thereafter, the New South Wales Attorney General appointed the Honourable Michael Campbell QC to undertake a review of section 33 of the Crimes Act 1900. However, in his 2010 ‘Review of the Laws Surrounding Criminal Incidents Involving the Death of an Unborn Child’, Campbell recommended no changes be made to the Act, concluding that the previous changes in 2005 allowed the justice system to respond appropriately to the death of an unborn child.\footnote{Michael Campbell, ‘Review of Laws Surrounding Criminal Incidents involving the Death of an Unborn Child’ (Report New South Wales Department of Justice and Attorney General, Legislation, Policy and Criminal Law Review, 2010), 5.}

In November 2013, the Crimes Amendment (Zoe’s Law) Bill 2013 (No 2) passed by a majority of the Legislative Assembly. The Bill proposed that the list of offences for grievous bodily harm set out in section 8A(1) of the Crimes Act be extended to the fetus of 20 weeks gestation or weighing greater than 400 grams,\footnote{Crimes Amendment (Zoe’s Law) Bill 2013 (No 2) s 8A(1)(a)(b).} so that it would be an offence against the fetus as a legal person, rather than an offence against the pregnant woman alone.\footnote{Ibid s 8A(2).} Importantly, the Bill specifically exempted medical abortion.\footnote{Ibid s 8A(4).}

Writing an opinion piece for The Guardian, Ms Donegan noted;

\[\ldots\] I couldn’t reconcile that my daughter – which I’d held, cried over and willed to breathe – was placed in a list of broken bones and soft tissue injuries. I couldn’t reconcile that the child I’d applied for a stillbirth certificate for, held a funeral for, received the baby bonus for and received paid parental leave from work for wasn’t recognised separately to me… I am pro-choice. I do not want to see any rights taken from women. But I cannot reconcile how the
current law works. Zoe’s law works well with existing legislation, and I believe it would help give victims closure and also ensure the offender takes responsibility for their actions.\textsuperscript{134}

Whilst providing a level of comfort to an aggrieved mother, it would clearly create tension with the born alive rule. By accepting the born alive rule, the consequences of fetal destruction are measured by a combination of its relational and physical attributes. With Zoe’s Law, legal personhood becomes relative and subject to change.

However as has been stated earlier in this Chapter, against the backdrop of positive law, ascribing legal personhood to human life at the point of birth is not the equivalent of passing a moral judgment about its status. Rather, as Kelsen notes, in legal positivism,

\begin{quote}
While the individual human being is a natural reality, the ‘physical’ person is a heuristic notion of legal cognition – a notion that might well be dispensed with, that facilitates the exposition of the law, but is not necessary to it.\textsuperscript{135}
\end{quote}

The Women’s Electoral Lobby of New South Wales protested that the move to give the fetus legal rights would be a ‘disturbing step backwards for women in NSW’ that would ‘set an unacceptable precedent for the way fetuses are considered in the law through granting them rights.’\textsuperscript{136} The Australian Medical Association registered their objection directly with the Health Minister noting their concern that the proposed law could have unintended consequences on doctors in the areas of genetics and obstetrics.\textsuperscript{137}

\begin{itemize}
\item \textsuperscript{135} Hans Kelsen, \textit{Introduction to the Problems of Legal Theory} (Clarendon Press, 1994) 22.
\item \textsuperscript{136} Women’s Electoral Lobby of NSW, ‘“Zoe’s Law” A Trojan Horse for Nile’s Anti-choice Agenda,’ 1 July 2013 http://welnsw.org.au/2013/07/01/zoes-law-a-trojan-horse-for-niles-anti-choice-agenda/.
\item \textsuperscript{137} Brian Owler, ‘Crimes Amendment (Zoe’s Law) Bill No. 2 2013’ (Factsheet, Australian Medical Association New South Wales) <http://amavic.com.au/icms_docs/160608_Abortion_conscientious_objection_template_and_information_for_GPs.pdf>.
\end{itemize}
The New South Wales Bar Association noted that to define a person as being above 20 weeks gestation or 400 grams in weight was arbitrary and a risky principle. They enquired how abortion, a medical procedure designed in the interests of the mother, could also be characterised as harming or killing another person and how a mother could consent to the destruction of a fetus where what is occurring is the destruction of another person.\textsuperscript{138} Such a change to the law highlights the awkward situation where personhood is based on the context of one’s destruction. But how different is this really when gestational age is used as a marker for when destruction of the fetus is lawful? Is this not also an arbitrary and risky principle when seen from the perspective of the fetus?

Hamblin noted in an opinion piece that it would be ‘foolhardy’ to believe that Zoe’s Law would have no impact on the legal status of abortion in New South Wales because judges strive for consistency and coherence in the principles they apply to legislative interpretation, with an overwhelming tendency for judges to take into account the fact that the Parliament has declared a fetus in one situation to be a legal person when interpreting the lawfulness of an abortion.\textsuperscript{139}

This thesis disagrees with this contention. Accepting the born alive rule as a technical legal rule rather than a philosophical certainty of personhood, Zoe’s Law would just be another artificial construct created to try and achieve justice. Judges should be able to understand this and simply apply the law, utilising the perspective that fits with the particular characterisation the fetus has for that case. It is not possible to say what practical effect the Bill would have had on a doctor’s understanding of the lawfulness of abortion in New South Wales other than to note that the Bill clearly exempted lawful abortion. Precedent exists in the United States, where Casey notes that feticide laws in some jurisdictions operate side by side with laws regulating abortion. They do so by simply distinguishing third party crimes from abortion.\textsuperscript{140}

\textsuperscript{138} Letter from Mr Phillip Boulten QC, the New South Wales Bar Association, to Mr Chris Spence MP dated 6 September 2013.


\textsuperscript{140} Casey, above n 41, 106.
Debate of Zoe’s Law in the Upper House failed to take place in 2014 and currently it has lapsed, with the suggestion it would be reintroduced in 2015 after the March State elections. At the time of writing, no such Bill has been proposed. As the law stands at the moment in New South Wales, the decisions in the cases of *Iby* and *King* illustrate the discomfort the Court of Appeal feels in allowing a third party to escape punishment for acts that cause harm to a fetus, albeit in two very specific circumstances. It also highlights the hesitation of the legislature in proscribing the same recognition to the fetus as given to a child, given the community’s reactions to the broader legal consequences.

Noting that opponents to the Bill were concerned primarily with matters of legal substance whilst supporters were more concerned with procedural and symbolic changes, Dalmau proposes an alternative to Zoe’s Law. Essentially, by changing the wording of the charge to refer to death of the fetus, and maintaining a separate charge to be brought in respect of any other harm occasioned to the pregnant woman, he argues that such a framework strikes the right balance.

By doing so, the law is not changed in substance, yet the amendments may better appeal to community standards. He argues that the gist of either offence is the grievous bodily harm not the specific injury caused. Any rule of law allowing double jeopardy benefit to the defendant would be denied.

The thesis agrees that changes to the wording of the offence to recognise separate entities would assist the community to perceive the law as good law because it achieves justice, which Kelsen referred to as being necessary even in a positivist state system. This might be similar to child destruction offences, where the unborn child is clearly recognised within the wording of the offence but technically, no offence is committed against it.

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142 (2005) 63 NSLR 278.
144 Dalmau, above 102, 705-6.
145 Ibid 709.
146 Ibid 707.
147 Kelsen, above 135, 22.
Prenatal destruction through a third party assault is not recognised as a specific crime in the Northern Territory and Western Australia though arguably it is open to the courts to follow *King* and use public policy grounds to characterise the harm against prenatal life as harm against the pregnant woman so as to ensure that a third party is punished.

This thesis now reviews how laws in Victoria, Tasmania and the Australian Capital Territory deal with the destruction in utero of a fetus without the consent of the mother. It considers how these jurisdictions with liberal abortion laws integrate laws that acknowledge fetal harm and destruction in other contexts.

2.4 (c) **Victoria, Tasmania, Australian Capital Territory**

These jurisdictions are in line with Queensland and New South Wales in possessing offences that recognise loss of the fetus as harm to the mother. The Australian Capital Territory’s *Crimes Act 1900* allows for the upgrade of various offences to aggravated offences under section 48A. Here the offence is characterised as having been committed against a pregnant woman causing her loss or serious harm to the pregnancy or the death or serious harm to a child born alive as a result of the pregnancy (section 48A(2)). Pursuant to section 48A(3), aggravated offences require the defendant to have known or ought reasonably to have known, that the woman was pregnant.

In Victoria, it is an offence under sections 16 and 17 of the *Crimes Act 1958*, to destroy the fetus of a pregnant woman without lawful excuse, intentionally or recklessly. The maximum penalty is imprisonment for 20 and 15 years respectively. Section 15 of the *Crimes Act 1958* amends the definition of ‘serious injury’ via section 10 of the *Abortion Law Reform Act 2008* (Vic) to include ‘the destruction, other than in the course of a medical procedure, of the fetus of a pregnant woman, whether or not the woman suffers harm.’ Destruction of a fetus is characterised as a crime against the pregnant woman as opposed to a crime against the fetus, thus maintaining the born alive rule.

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148 *Crimes Act 1900* (ACT) ss 15, 19, 20, 21, 23, 29(2) or (4).
Like Queensland and Victoria, Tasmania has a related offence affecting pregnant women who are assaulted. Section 184A of the Tasmanian *Criminal Code 1924* provides that any person who unlawfully assaults a woman knowing her to be pregnant is guilty of the crime of ‘Assault on a pregnant woman,’ an offence punishable by imprisonment for 21 years or by fine, or by both such punishments.\(^{149}\)

The degree to which the pregnancy has advanced is not set out in the legislation but the fact that the accused must know that the woman is pregnant provides the starting point.

The crime is characterised as a crime against the pregnant woman and follows the other jurisdictions discussed above in choosing to maintain the born alive rule, choosing not to recognise the unborn child as a legal person but providing punishment against a third party who seeks to destroy prenatal life, except where the act is consistent with a lawful abortion. Accordingly, a person who knows a woman is in the early stages of pregnancy can be guilty of a crime regardless of whether the unborn child has reached the age of viability.

Of note, section 178E of the *Reproductive Health (Access to Terminations) Act 2013* (Tas) inserts a new offence into the *Criminal Code Act 1924* (Tas) of ‘termination without woman’s consent’. Robert notes that the wording of the offence is unique and makes it a crime where a person who intentionally or recklessly performs a termination on a woman without the woman’s consent, whether or not she suffers harm.\(^{150}\) The definition of ‘termination’ extends to discontinuing a pregnancy through instruments, drugs or the very broad phrase ‘any other means’.

Robert argues that this offence properly focuses on the lost pregnancy and treats the harm as a violation of the mother’s reproductive autonomy as opposed to an offence structured around the fetus as a legal person and having a right to life.\(^{151}\) Roberts argues that the wording is important and gives recognition of loss of human life without giving the fetus legal personhood.\(^{152}\) However Dalmau, observes that there is

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\(^{149}\) *Criminal Code 1924* (Tas) s 389(3).

\(^{150}\) Robert, above n 11, 333.

\(^{151}\) Ibid.

\(^{152}\) Ibid.
no reason to think that any solution can satisfy all parties or entirely avoid inconsistencies or grey areas.\footnote{Dalmou, above n 102, 710.}

This thesis agrees with Robert’s observations that such an offence could provide a grieving mother with satisfaction that justice was achieved. However it of course creates a demarcation between the wanted, as opposed to the unwanted, fetus and firmly embeds the ‘relational’ school of thought of characterising the fetus as an entity that has no inherent value in and of itself, but rather its value depends in part on that which the pregnant woman or others give to it.

This thesis takes the position that the relational analysis of the fetus is complicated and can lead to less than clear-cut results.

2.5 Summary

Despite the problems with logic when considering destruction of the fetus from its perspective, the born alive rule remains the law within Australia. Accordingly, the unborn child cannot be the victim of an assault or a homicide. Despite this, all criminal statues throughout Australia recognise in one way or another, that harm to or destruction of prenatal life can be a crime. The way in which the various jurisdictions characterise these crimes however can vary both within and between the states.

This thesis argues that failing to acknowledge harm to prenatal life requires perceiving the fetus as an artificial construct. Choosing birth as the time when a human being becomes a person reflects a legal rule rather than a universally accepted and provable truth. Using that rule as a non-negotiable starting point for related laws such as those that deal with conscientious objection by doctors to participating in abortion, can potentially lead to an injustice. Where alternative positions such as the fetus as a person from conception or the fetus as a human being with a right to be protected from destruction, are dismissed due to the rule, the capacity for doctors to argue for freedom of conscience seems limited.
The task of the positive law is not to answer the question of what is personhood, but to regulate the rights and obligations of people in the community. Arguably if the natural law were applied, it would likely disallow many reproductive medical procedures where prenatal life is destroyed. Where the lawmaker rejects the natural law in favour of legal positivism, as here, they have the flexibility to decide when destruction of the fetus is a crime. They can do so without subscribing to immutable principles based on any objective, provable truths that could be replicated and applied in related laws.¹⁵⁴ Such laws created in a positivist State need not integrate with each other and can be subject to change.¹⁵⁵

This thesis has argued here in Chapter Two that whilst on the face of it, the criminal laws affecting destruction of prenatal life may seem confusing at times, it is more correct to say they are merely examples of legal positivism where the line in the sand, the born alive rule, does not have the moral or scientific authority to assess what the fetus is during the antenatal period. As a consequence, the laws fail to provide clear, unchanging criteria for why it is right or wrong to destroy prenatal life.

In Chapter Two, this thesis reviewed three contexts involving destruction of the fetus that are regulated by the criminal laws in Australia; harm to the fetus that goes on to be born; destruction of the mature fetus in the process of childbirth; and harm to the fetus resulting in stillbirth. It confirmed inconsistencies between jurisdictions such as whether an offence existed, the elements of the offence and how the law characterises this loss. A summary of the inconsistencies follows.

If a fetus is harmed in the womb and goes on to be born, the law will recognise that the harm occurred, but only after the birth.¹⁵⁶ This is because the law does not recognise the existence of the person in the prenatal state as a legal entity. Therefore, though they were in fact harmed at that time, the law will only retrospectively acknowledge that fact.

Child destruction laws recognise the destruction of the very developed fetus about to be born. The offence is a serious crime, mostly carrying a sentence of life imprisonment. The gist of the offence is the physical development of the unborn child, who is capable of surviving outside the womb. However the co-existence of child destruction laws in jurisdictions that also allow late term abortion (under certain conditions) is contradictory. It allows, in theory, the destruction of the fetus in one scenario, but not in another even though nothing intrinsic has changed about the fetus. This perceived conflict illustrates the shortcomings of the born alive rule, which can produce seemingly incoherent outcomes.

Where the fetus does not survive the assault, some jurisdictions specifically characterise the act as a crime against the pregnant woman. The law rationalises this by extending her legal personality to include that of the fetus. From time to time, attempts have been made to recognise the ‘death’ of a wanted, unborn child destroyed as a result of a third party assault, by making the fetus in that limited circumstance, a legal person. Whilst sympathetic to the plight, lawmakers have resisted the urge to make legal personhood a relative legal state.

Retaining the born alive rule obviously produced an unjust outcome for the fetus, and for the parents who mourn its passing. As has been demonstrated in this Chapter, the consequence of having a touchstone principle in law that is based on an artificial construct is that laws that derive from it may be confusing, vulnerable and subject to change. However maintaining the born alive rule as the touchstone for all laws affecting prenatal life in Australia provides the required platform for abortion to be lawful.

Chapter Three of this thesis considers second and third party assaults on the fetus in the civil law. It discusses the materno-fetal conflict in the literature, which involves the rights of the pregnant woman to bodily autonomy pitted against the law’s recognition of the existence of the fetus and its capacity to be harmed by the mother’s acts and

157 Criminal Code 1899 (Qld) s 313(1); Criminal Code 1988 (NT) s 170; Criminal Code Compilation Act 1913 (WA) s 290; Crimes Act 1900 (ACT) s 43.
158 Crimes Act 1900 (NSW) ss 4, 42; Crimes Act 1900 (ACT) ss 43, 38A; Criminal Code 1899 (Qld) s 313(1); Crimes Act 1958 (Vic) s 15; Criminal Code 1924 (Tas) s 184A.
159 See, eg, Robert, above n 11, 327; Dalmau, above n 102, 709.
160 See, eg, Savell, above n 2, 631; Faunce, above n 44, 315.
omissions. It considers the development of a maternal duty of care to the fetus in tort law, which perceives the fetus as a separate entity from the mother, and attempts to place restraints on her behaviour for the benefit of the fetus. Such a duty sits uncomfortably with lawful abortion, which is a direct action consented to by the mother to destroy the fetus, and which is discussed in detail in Chapters Four to Seven.
CHAPTER THREE

THE MATERNAL DUTY OF CARE TO THE UNBORN CHILD

3.1 Introduction

The conflict between the primacy of maternal autonomy over foreseeable harm to the fetus is at the heart of the vexed legal issue of whether the pregnant woman owes the fetus a duty of care, and if so, what the scope of that duty is, and in what circumstances it is breached. In accepting the existence of a maternal duty of care to the unborn child, the law is asked to recognise the fetus as an entity separate from the pregnant woman and capable of being harmed. Given her acts and omissions may indirectly affect the fetus, she is expected to alter her behaviour so as not to cause harm to the fetus.

As was discussed in Chapter Two, in third party criminal offences, the law has refused to recognise personhood in the fetus, and has developed a logic whereby harm is recognised through the pregnant woman.\(^1\) If the child goes on to be born, the temporal disconnection between the assault and the acquisition of personhood does not operate as a bar to the offence.\(^2\) Child destruction offences, which weaken the single entity logic by recognising the mature fetus as a separate entity in the law,\(^3\) have disappeared from jurisdictions like Victoria and Tasmania, where there is abortion on demand up to a certain gestational age\(^4\) (discussed in Chapter Seven).

Abortion on demand conflicts with the notion of a maternal duty of care to the unborn as the former requires no justification for destruction of the fetus other than maternal consent. It centres on bodily autonomy and the concept that the pregnant woman and the fetus are a single entity and that she may do to it whatever she wishes.

\(^1\) Criminal Code 1899 (Qld) s 313(1); Criminal Code 1988 (NT) s 170; Criminal Code Compilation Act 1913 (WA) s 290; Crimes Act 1900 (ACT) s 43.

\(^2\) Crimes Act 1900 (NSW) s 42; Criminal Code 1899 (Qld) s 313(2); Crimes Act 1900 (ACT) s 43.

\(^3\) Criminal Code 1899 (Qld) s 313(2); Crimes Act 1900 (NSW) ss 4, 13; Crimes Act 1958 (Vic) s 15; Criminal Code Act 1924 (Tas) s 184A.

\(^4\) See Abortion Law Reform Act 2008 (Vic); Reproductive Health (Access to Terminations) Act 2013 (Tas).
Australian law continues to recognise that a competent adult may consent to or refuse medical treatment notwithstanding the particular reasons. This is irrespective of whether the reasons are ‘rational, irrational, unknown or even non-existent’. However, although technically the reasons for the pregnant woman’s non-consent to intervention are not relevant in the law, where medical evidence suggests that non-intervention will likely cause fetal demise, with little comparable harm to the pregnant woman, overseas case law has demonstrated that her capacity to make such a decision may be scrutinised.

The use of capacity to undermine autonomy underlines the law and medicine’s uneasiness in allowing a pregnant woman to do what she wishes to the fetus. It exposes the reality that although the law may not recognise the fetus as a person, it does not necessarily follow that it is a thing of no value. Ultimately, it highlights the unique status of pregnancy and the difficulty in trying to compare it to any other relationship in society. Potentially, this unique status of pregnancy holds back ultimate decision-making power from the pregnant woman to do with her body whatever she wishes in circumstances where prevention of harm to the fetus can be achieved.

This thesis considers this to be an appropriate position for the law to take as it reflects scientific knowledge about the fetus and its capacity to be harmed, and the need to ethically justify its destruction. However this thesis concludes that whilst there is a continuing tension between fetal beneficence and maternal autonomy, law reform to increase state intervention in favour of fetal rights is a dwindling proposition. Such intervention would likely be seen as an unwelcome interference in a personal, medical decision of the pregnant woman and her doctor. The current trend in laws governing third party assaults on the fetus and abortion laws support this conclusion. Accordingly, intervention in a pregnant woman’s bodily autonomy may be restricted to rare and exceptional cases only.

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5 See, eg, Secretary Department of Health and Community Services v JWB (Marion’s Case) 1992 175 CLR 218, 234; Brightwater Care Group Inc v Rossiter (2009) 40 WAR 84, 91 [24]-[26].
8 St George’s Healthcare NHS Trust [1998] 3 WLR 936, 952. Here the Court noted, ‘Whatever else it may be, a 36-week foetus is not nothing; if viable it is not lifeless and it is certainly human.’
This Chapter will discuss the key approaches to perceiving pregnancy in academic legal discourse,\(^9\) as well as a selection of relevant cases where the courts have been required to consider if and when a pregnant woman’s wishes about what may or may not be done to her body will be set aside in favour of saving the life of the fetus. Where there is no Australian case law on point, well-known cases from the United Kingdom, the United States and Canada will be considered although it should be noted that Australian law closely follows the law of the United Kingdom.\(^10\)

3.2  **Approaches to perceiving pregnancy**

This section of the Chapter reviews key legal academic perspectives on pregnancy. It considers the constructs of the fetus and the pregnant woman as separate entities, and the more fluid relational analysis approach to the fetus and the pregnant woman, where there is no one way of perceiving the pregnant state. Further on in section 3.3, this thesis will consider whether and how those opinions are taken up in the law, where judges are required to grapple with notions of separateness or interconnectedness in real life scenarios.

3.2 (a)  **Separate entity**

If it were accepted that the fetus was a person, than perceiving the fetus and the pregnant woman as separate entities with equal rights would be logical. The teachings of the Roman Catholic Church advocate this view. It consistently teaches that life must be absolutely respected and protected from the moment of conception, because from the time that the ovum is fertilised, a new life is begun which is neither that of the father nor of the mother; rather it is the life of a new human being with its own growth and its own rights as a person.\(^11\)

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\(^9\) The materno-fetal conflict is the subject of voluminous commentary from the disciplines of philosophy, theology and science. It is beyond the scope of this thesis to critique these approaches.

\(^10\) See *Brightwater Care Group Inc v Rossiter* WASC 229, 90-91 [24]-[27].

The Church’s position is that there is an objective truth about the value of prenatal life and therefore purposefully destroying prenatal life goes against the natural law.\textsuperscript{12} Accordingly, many reproductive medical practices are deemed immoral.\textsuperscript{13} Having said that, the Church permits destruction of the fetus in limited circumstances. These circumstances, however, must conform to the Church’s moral principles to pursue good and avoid evil.\textsuperscript{14}

Where there is a vital conflict between the pregnant woman and the unborn child, defined as an action that will likely save one of two lives but if not performed, both lives will be lost, the Church does not permit direct abortion.\textsuperscript{15} Accordingly, in those rare vital conflict situations, the Church’s position is controversial as it seeks to intervene in the woman’s right to preserve her life.\textsuperscript{16}

Tonti-Filippini gives examples of acceptable destruction of the fetus including ectopic pregnancy, severe pre-eclampsia, acute leukaemia and certain forms of cancer where pregnancy hastens the development of a potentially fatal cancer in the mother.\textsuperscript{17} Taking ectopic pregnancy as an example, the fetus implants itself into somewhere other than the uterus such as the fallopian tube and threatens the life of the woman should the tube rupture. The removal of the fallopian tube with the fetus within it is an indirect abortion as destruction of the fetus is a side effect of the woman’s medical treatment, and in any case, the fetus could not survive.\textsuperscript{18}

In contrast, Thompson in her seminal 1971 essay, ‘A Defense of Abortion’ took the alternative position of defending the morality of abortion whilst accepting that the fetus is a person.\textsuperscript{19} Thompson’s argument derives from the position that any special relationship a woman has with the unborn child can only exist where the woman has given the fetus permission to use her body.\textsuperscript{20}

\textsuperscript{12} Ibid 10.
\textsuperscript{13} Ibid.
\textsuperscript{14} Catechism of the Catholic Church (2\textsuperscript{nd} ed, 2000) 1732.
\textsuperscript{15} Kevin L Flannery, ‘Vital Conflicts and the Catholic Magisterial Tradition’ (2011) 11 National Catholic Bioethics Quarterly 691, 694.
\textsuperscript{16} Nicholas Tonti-Filippini, Bioethics – Motherhood, Embodied Love and Culture (Cooper Consulting Victoria, 2013) 225.
\textsuperscript{17} Tonti-Filippini, above n 16, 180.
\textsuperscript{18} Ibid.
\textsuperscript{20} Ibid 61.
The fact the fetus requires the continued use of its mother's body for nine months is not considered by Thomson to be a basis to establish that the fetus has a right to do so. In her view, the fetus does not possess any inherent dignity. Notwithstanding this, Thompson conceded the existence of situations where a fetus has a right to use its mother’s body and where an abortion would be an unjust killing. She noted:

There may well be cases in which carrying the child to term requires only Minimally Decent Samaritanism of the mother and this is a standard we must not fall below... It would be indecent in the woman to request an abortion, and indecent in a doctor to perform it, if she is in her seventh month, and wants the abortion just to avoid the nuisance of postponing a trip abroad.\(^{21}\)

Thompson’s concept of the ‘minimally decent Samaritan’ concedes the need for the law to display a degree of justice or morality. As has been noted throughout this thesis, the concept of minimal justice is not completely foreign to legal positivism. It sits neatly with Kelsen’s comment that

In order to be ‘law’ so theory has it, the positive state system must have concern for justice, be it a matter of assuring an ethical minimum, be it a matter of attempting however inadequately to be ‘right’ law, that is simply, to be just. In order to be ‘law’, the positive law must correspond in some measure, however modest, to the idea of law, to justice.\(^{22}\)

The acceptance by Thompson of limits to a woman’s right to abortion when the fetus is clearly viable, sits neatly with criminal laws that maintain child destruction offences for the fetus about to be born or capable of being born alive, and with abortion laws that regulate the lawfulness of abortion based on gestational age of the fetus. This is an important concession that underlines the moral dimension of abortion and the right to life. However Scott is critical of Thomson’s exceptions, which she describes as a narrow, rights-based morality position where the fetus has a right to the woman’s body, based on her special responsibility towards the fetus, which derives from her consent to become pregnant.\(^{23}\)

\(^{21}\) Ibid 65-6.
This thesis agrees with this assessment of Thomson’s theory, which lacks clarity regarding where and when abortion is morally wrong and why. Exceptions, such as late term abortion for social reasons, are not adequately addressed by Thompson. It is not clear why the fetus’ dependence on the woman’s body for survival makes it morally right to destroy it. The potential to extend this rationale to other dependant persons such as the infirm, disabled or even temporarily dependant persons is obvious. Thompson’s reliance on the values of a minimally decent Samaritan for challenging scenarios seems strange where such values are not referred to in the initial premise of why it is permissible to destroy a fetus that she concedes is a person.

3.2 (b) Relational analysis of pregnancy

The relational analysis approach to pregnancy challenges common social and legal constructions of pregnancy and essentially perceives personhood as an integration of intrinsic and relational aspects as opposed to just the biological realities of the fetus. Known as the ‘not one, but not two’ approach to pregnancy, it has been propounded by Karpin, who has long been critical of the traditional legal conceptions of the female body.24 She has criticised the concepts of self and non-self in pregnancy as being decided by lawyers and biologists in what she refers to as ‘a strange legal-scientific coalition, using prenatal technologies to establish the fetus as a victimised subject.’25

Karpin argues that legal personhood, being an abstract notion, should not be subject to traditional constructions of pregnancy as correct and privileged in their priority or importance.26 Rather, she recommends such constructions should be resisted where they result in legislation of the female body that leads to disempowerment of women and makes them available for public use.27

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26 Karpin, above n 24, 349.
27 Ibid.
Savell argues that maintaining birth as the time when the human being becomes a person is defensible, notwithstanding technological advances where the fetus can be seen and where its developmental progression raises issues about ‘personhood’ in a philosophical sense.\textsuperscript{28} She argues that comparisons between late term fetuses and newborn babies are crude, and that the resemblance between a fetus and a person is by virtue of the value ascribed to them through their relations with kin, particularly mothers, as opposed to just the fetus’ intrinsic properties.\textsuperscript{29}

Seymour observes that this approach will invariably encounter opposition from those who wish to define the fetus and to punctuate arguments about its destruction with assumptions about the essential nature of the fetus.\textsuperscript{30} He argues that this relational approach presents a more sophisticated analysis based on the context of destruction and avoids perceiving pregnancy as a conflict between competing entities.\textsuperscript{31}

Arguably, this construction allows the possibility for late term abortions to sit neatly with third party destruction of the fetus, and with refusal to undergo medical treatment to save the unborn child. Knowledge of physical realities of the developed fetus would be subjugated to the value ascribed to the fetus by the mother and her consent (or refusal) to continuing the pregnancy. Such a construction would seem to disallow state intervention in pregnancy, certainly in a criminal sense, and permit abortion on demand. It is not clear when fetal interests overtake maternal ones. Seymour concedes that this flexibility in outcome can be seen as either a strength or an ‘unprincipled refusal to acknowledge the true nature of the fetus’.\textsuperscript{32}

Whilst this approach to pregnancy permits the flexibility to change the value of the fetus, it might still be subject to criticism by those pregnant women wanting firm legal recognition of the loss of their unborn child in a third party assault on them. It still withholds from the fetus legal personhood and by extension, the right to be recognised as having died. The degree to which the parent may require a specific legal result as opposed to being able to say the law recognises the fetus ‘died’ is

\textsuperscript{29} Ibid.
\textsuperscript{31} Ibid 40.
\textsuperscript{32} Ibid 40.
unknown. The former requires a change in legal principle, the latter might be satisfied by a change in phraseology (as proposed by Dalmou in his alternative to Zoe’s Law, referred to in Chapter Two of this thesis).  

However the interdependence required of this relational analysis of pregnancy does not provide clear solutions to conflict between the pregnant woman and the fetus. Thampapillai observes that it cannot escape the requirement that a choice be made in favour of one or the other. Having either the pregnant woman or a third party to be the judge of this decision, simply morphs the theory back into the single entity theory.

This theory seems to simply provide a basis for the pregnant woman to justify any decision she makes that affects the fetus. Arguably there is no baseline on which to judge the appropriateness of the pregnant woman’s acts or omissions that will harm the fetus.

### 3.3 Duty of care to the unborn child

The Victorian case of *Watt v Rama* provides precedent in Australian law for a duty of care to the fetus, on the basis that the fetus may only exercise their right to sue for injuries occasioned within the womb, after they are born. A significant case, it is precedent for the notion of a contingent relationship capable of developing into the kind required by tort law. It held that the fact there was separation in time between the negligent act or omission and the injury was not a bar to the action.

Casey notes that this reasoning depends on a ‘metaphysical miracle’. He suggests that the law is better off ‘…identifying the fetus with its biological successor. The

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35 Ibid.
36 Ibid.
38 Ibid 359.
physical damage subsisting in the newborn child could then constitute evidence of
the damage inflicted by the defendant on that same child as a fetus in utero. However
this would require the law to abandon the born alive rule or to simply extend
legal personhood to the unborn child in that particular circumstance.

Obviously, this has the same practical problems encountered with attempts to
provide legal personhood to the unborn child for criminal assaults by third parties,
discussed in Chapter Two. Case law has developed incrementally to expand this
principle to driving offences where a pregnant woman, through negligent driving, has
caused injury to the fetus in utero. After surviving the accident, the fetus, now a legal
person, brings a negligence action against its mother for harm caused in the womb
resulting in ongoing injuries suffered as a person.

3.3 (a) Negligent driving

In the New South Wales Court of Appeal decision Lynch v Lynch, Clarke JA noted
that although very difficult public policy decisions might arise when determining
whether certain types of conduct by a pregnant woman cause her to be liable for her
child’s disabilities occasioned in the womb, when it comes to negligent driving, the
question is narrow. The relevant Act central to the case in Lynch v Lynch involved
the creation of a scheme whereby persons injured as a result of negligent driving
could be compensated so that a claim would not be defeated by a tortfeasor being
impecunious.

The Court held that in determining whether the mother had a liability towards the
child injured by her driving, it would not be required to scrutinise the mother’s conduct
in the years prior to the incident. Rather, the Court would have to decide the very
narrow question of whether the mother drove the vehicle negligently and caused
injury to the child, resulting in cerebral palsy. Accordingly, the Court held that a
tortfeasor’s liability to an unborn child in the context of a motor vehicle accident is
maintained even where the tortfeasor is the pregnant woman who was negligently

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40 Ibid.
driving the motor vehicle. To provide the mother with immunity from suit in these circumstances was said to single out children injured in the antenatal period as being a class of individuals to be denied access to a fund that every other car accident victim can access.\textsuperscript{44}

Critical of this decision, Karpin notes the ‘political expediency of the notion of separateness’ between the fetus and the pregnant woman.\textsuperscript{45} In order to make the woman responsible, she says, it is necessary to emphasise their separateness, so as to exteriorise the fetus and empower it. Yet at the same time, their connectedness must also be accepted as the fetus’ claim for damages is sustained through the argument that when the woman is injured, so too is the fetus. Pitting the mother against the child is, she argues, ‘a political decision which affords greater control over the female body and over women’.\textsuperscript{46}

This view regarding the motivations behind such legal rationales is unconvincing. Tort law deals with the economic outcome of harm caused by wrongdoing as well as with justice. To withhold compensation for injury from the child merely to stay true to an abstract notion of pregnancy seems impractical and unjust. It is not consistent with how the laws of negligence have developed in Australia where it has found ways to deliver justice in a particular situation whilst balancing other potential interests.

Certainly driving offences, where an insurance scheme covers compensation in a simple liability scenario, is a very narrow basis to consider a maternal duty of care. The acts or omissions of the pregnant driver affect not just her and the fetus, but potentially all drivers using the road at the same time as her. More controversial is developing the scope and content of a duty of care by the mother to the unborn child in other scenarios. Kerr notes

\begin{quote}
If, from the point of view of the law, an unborn child is not a person and therefore is not the subject of rights and duties, it must follow that a pregnant woman and her unborn child are one. Consequently, a pregnant woman cannot owe a duty of care to her fetus any more than she can owe a duty of care to herself. Thus the only possible rights that the child could be
\end{quote}

\textsuperscript{44} Ibid 416.
\textsuperscript{45} Karpin, above n 24, 330.
\textsuperscript{46} Ibid.
said to have prior to birth are those which can be derived from the rights of the pregnant woman.47

Certainly, there is logic to this statement. As has been discussed earlier in Chapter Two, the law is hesitant to dislodge the born alive rule even though it is acknowledged as being ‘an artificial and non-scientific construct of when life begins.’48 Whilst the law recognises that the fetus can be harmed in utero, it has steadfastly refused to re-consider personhood for the fetus and has demonstrated a clear commitment to tolerate a legal artificial construct of the person, and to use it as a starting point which other laws must conform to.

Stewart and Stuhmcke argue that a uniform legal approach to defining the fetus is an impossibility and that in reality, every legal area has a separate way of determining how to recognise the fetus in the law.49 They consider this to be appropriate where various areas of law have different policy requirements that serve differing social, economic and moral interests. Whilst this thesis concedes that there may be scope to separate out criminal assaults by third parties from second party assaults occasioned by the pregnant woman on the fetus, the circumstances discussed in this Chapter have a common core of maternal autonomy and therefore the same approach to the fetus ought to be taken. Additionally, it seems illogical to separate out materno-fetal conflicts from abortion and by extension, conscientious objection by doctors to participating in abortion.

The following section focuses on behaviour of pregnant women known to cause fetal harm such as drug taking, smoking or exposure to danger. Here the courts have acknowledged the reality of fetal harm separate to the pregnant woman, and is asked to reconcile the lawfulness of allowing the pregnant woman to cause harm to the fetus on the basis of autonomy, with what are sometimes terrible consequences for the fetus who goes on to be born. Articulating a maternal duty of care to the unborn child is a great challenge given every act the pregnant woman makes may impact the fetus in one way or another.

48 R v Iby (2005) 63 NSWLR 278 [78].
3.3  (b) Reckless maternal behaviour during pregnancy

Paltrow argues that no mother can provide the perfect womb and that recognition of fetal abuse criminalises pregnancy. The mother could be reluctant to seek pre-natal care or to give honest and accurate information to health care providers for fear of reprisals, and this in turn could negatively affect the fetus’ well being.  

In contrast, the author of Maternal Rights and Wrongs, argues that narrow laws that target specific conduct might well strike the correct balance, particularly where such behaviours are already criminal when engaged in by the non-pregnant woman, such as taking heroin, and the crime is one that imposes a special penalty as against the pregnant woman. As the link between heroin abuse and fetal distress is strong, such a law might well be valid. However Faunce makes a good point that to apply such laws to women who do not know they are pregnant creates not just two entities competing for rights, but an extended obligation on fertile women to know at all times whether they are pregnant and to modify their behaviour.

Robertson argues for post birth sanctions on pregnant women in ‘egregious cases’ only, with the State pursuing criminal prosecution of the mother for pre-natal conduct causing severe impairment to the child. However mainstream behaviours that are not criminal could still result in significant harm to the fetus such as eating junk food or not taking medications.

Faunce notes that with those behaviours, there must be a turning point where the desire to contravene fetal rights does not exceed the desire to infringe the mother’s autonomy. Otherwise, the unborn child’s autonomy has legal primacy over the mother’s interests. However if autonomy means a person with capacity may do whatever they wish, and if the fetus is considered part of the mother, then it is hard to identify such a turning point without compromising the principle of autonomy.

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51 Ibid.
54 Robertson, above n 50.
55 Faunce, above n 53, 312.
Deciding on a standard of care for the reasonable pregnant woman would indeed be difficult. Roberts argues that it is possible to articulate a standard of care for the pregnant woman towards her fetus. This could be done by measuring the degree to which her freedom to engage in certain behaviours is infringed, by the extent to which fetal protection can be assured.

Two well-known international case law examples follow where the court refused to elevate the interests of the fetus over the autonomy of the pregnant woman. In *Winnipeg Child and Services (Northwest Area) v G*, the Canadian Supreme Court considered whether a pregnant woman could be negligent for sniffing glue during the pregnancy and causing harm to the fetus that was at 37 weeks gestation. The majority denied liability on the basis that to do so would introduce ‘a radically new conception to the law, the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation.’ The pregnant woman’s autonomy to do as she sees fit, even where it has a serious, indirect consequence on the fetus, was upheld on the basis that in one sense she is the fetus and the court may not intervene. The dissenting judgment however criticised the use of the born alive rule as being based on basic medical knowledge long overtaken by advances in medical science.

The Court of Appeal in the United Kingdom in *In re F (in utero)* considered whether a fetus could be made a ward of the state on the grounds that the behaviour of the pregnant woman was endangering it. Here, the fetus was accepted to be one that was capable of being born alive. The pregnant woman was mentally disturbed and led a nomadic existence. Local authorities held fears for the safety of the unborn child and wanted her found and admitted to a hospital.

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57 Ibid 1041.
59 Ibid.
60 Ibid 227.
62 Ibid 1294.
63 Ibid 1291.
64 Ibid 1292.
The Court held that as a fetus has no existence independent of its mother, the Court could not exercise its rights, powers and duties of a parent over the fetus without controlling the actions of the pregnant woman. Confirming the Court’s hesitation to becoming involved with changing the fundamentals of the law, Balcombe L.J noted:

If the law is to be extended in this manner, so as to lose control over the mother of an unborn child where such control may be necessary for the benefit of that child, then under our system of Parliamentary democracy it is for Parliament to decide whether such controls can be imposed and, if so, subject to what limitations or conditions. In such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary to extend the law.

These decisions apply foundational principles such as the born alive rule, with its denial of fetal personhood, and bodily autonomy, with its focus on beneficence, to ground rationale to reject any maternal duty of care to the unborn. Given the existence of similar principles in Australia, it seems unlikely that a different result could occur here without the introduction of laws that reverse these principles. Authority exists for the lack of basis for guardianship orders in respect of the unborn child based on the born alive rule.

Whilst an argument might be made that in other Australian laws affecting the fetus, viability or gestational age are used to give value to the fetus as an entity, harm to the fetus through reckless maternal behaviour might well occur at earlier gestational ages. This would be another hurdle to defining the scope of any duty and the class of persons foreseeably affected by the negligent acts or omissions. Ultimately, the concept of maternal duty of care is difficult to apply in practice and seems very unlikely to be introduced into Australian law.

This thesis now considers the more contentious issue of a pregnant woman’s refusal of medical treatment that creates risk of harm to the fetus. It is a good illustration of the consequences of exercising bodily autonomy and what circumstances, if any, will override the mother’s wishes.

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65 Ibid 1301, 1306, 1307.
66 Ibid 1306.
67 Attorney-General (Qld) (Ex el Kerr) v T (1983) 57 ALJR 285.
3.3 (c) Maternal refusal of medical treatment

If one accepts that the fetus has no legal rights until birth, and a person with capacity can refuse medical treatment because of the principle of beneficence, then at first blush it is difficult to see how the law can make an exception and force a woman to undergo any type of surgical procedure that may result in harm to her in order to benefit the fetus, even where the outcome may be fatal for the fetus.

Compelling a pregnant woman to undergo medical treatment differs from endangering the fetus by glue sniffing and other behaviour because the pregnant woman is required to undergo a medical procedure against her will that affects her wellbeing and carries with it the usual medical risks of surgery. Requiring a pregnant woman to undergo a caesarean section delivery is comparable to a person being compelled to undergo surgery to save another person’s life, such as donating a body part.  

Annas argues that with no one ever being forced to undergo surgery for another, then to be forced to undergo surgery for a fetus is ironic as the fetus has less legal status than the born child. Annas makes the practical observation that the cases that come before the courts that involve the refusal of a woman to undergo a caesarean section are decided within hours, without time for thoughtful judicial consideration of the rights of the pregnant woman. Additionally, he argues that physician prediction of harm to the fetus can be inaccurate, with investigations such as cardiotocograph monitoring of the fetal heart rate being notoriously sensitive, leading to an overstatement of the potential risk of danger.

Of course caesarean section is only one of a number of medical treatments that a pregnant woman might be recommended to undergo for the benefit of her unborn child. Others include blood transfusions. Pregnant women belonging to the Jehovah’s Witness faith may refuse to undergo blood transfusion on religious grounds. Additionally, treatment may result in very little infringement on her bodily integrity such as the taking of a pill, thus raising moral issues as to what possible

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70 Ibid 17.
71 Ibid 16.
72 Ibid 17.
circumstances permit the law to uphold her refusal to take it where the fetus might suffer significant harm.\textsuperscript{73}

A line of authority exists in the United Kingdom demonstrating that whilst maternal autonomy takes precedence over concern for the fetus, front and centre of such decisions is a review of the pregnant woman’s capacity to make the decision to refuse treatment. In the decisions noted below, the Courts have been keen to note that an irrational decision by a pregnant woman that may well cause harm or death to her or the fetus should not be assumed to indicate a lack of capacity. Whilst the discomfort of health care professionals is understandable, the Court is clear that demise of the fetus is the price to be paid for maintaining autonomy.

In \textit{Re T (Adult: Refusal of Treatment)}, a declaration was sought from the father of a woman who had recently given birth and who had refused a blood transfusion, for the hospital to administer the transfusion without her consent, based on her best interests.\textsuperscript{74} The woman’s mother was a practising Jehovah’s Witness and was against a blood transfusion and there were concerns the woman was unduly influenced by her and also by erroneous information by hospital staff that other means were available and effective if she refused blood transfusion.\textsuperscript{75}

Although the woman was not a practising Jehovah’s Witness, she signed forms to refuse a blood transfusion for the birth and on deterioration of her condition following birth, she became unconscious and unable to re-consider this decision in light of her new medical circumstances.\textsuperscript{76} Ultimately, the Court held there was no valid refusal of treatment and that the hospital was right in treating her on the basis of necessity.\textsuperscript{77}

Lord Donaldson noted that

\begin{quote}
\ldots a patient’s right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent. That his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his
\end{quote}

\begin{flushright}
\textsuperscript{73} Scott, above n 23, 422.
\textsuperscript{74} [1993] Fam 95.
\textsuperscript{75} Ibid 105, 110.
\textsuperscript{76} Ibid 105.
\textsuperscript{77} Ibid 120, 122.
\end{flushright}
capacity to decide. The nature of his choice or the terms in which it is expressed may then tip the balance.\textsuperscript{78}

In \textit{Re MB (Medical Treatment)}, the appellant was a pregnant woman whose 40-week fetus was in breech presentation.\textsuperscript{79} She was advised that without a caesarean section delivery, there was a 50\% risk to the fetus of death or brain injury, with little danger to her.\textsuperscript{80} Although she originally consented to the caesarean delivery, the woman withdrew her consent right before the surgery was to take place due to a needle phobia.\textsuperscript{81}

The health authority applied for a declaration from the High Court that it would be lawful to operate on the woman to affect a caesarean delivery and to use reasonable force if necessary. A psychiatric assessment was performed and concluded that the woman was competent and understood the need for the caesarean and consented to it, but the needle phobia caused a panic in the final phase that dominated her thinking. He felt the woman lacked the capacity to see very far beyond the immediate situation and there was likely to be long-term significant damage if the operation did not go ahead and the baby died or was handicapped.\textsuperscript{82}

In its reasoning, the Court reviewed case law, statute and overseas authorities but restated the principle in \textit{Re T}, that it had no jurisdiction to take into account the unborn child that might be injured by a mentally competent woman’s refusal to undergo a caesarean section regardless of whether it is for any reason, rational or irrational or for no reason at all and even where that decision might lead to their death.\textsuperscript{83} The evidence here was that the woman wanted a healthy baby and had consented to the caesarean and only withdrew that consent because of her needle phobia.\textsuperscript{84} There was enough evidence to satisfy the Court that the woman had a temporary lack of capacity and that it was in the woman’s best interests to have medical intervention using reasonable force if necessary.

\textsuperscript{78} Ibid 113.
\textsuperscript{79} [1997] 2 FLR 426.
\textsuperscript{80} Ibid [2].
\textsuperscript{81} Ibid [3]-[4].
\textsuperscript{82} Ibid [8], [36].
\textsuperscript{83} Ibid [17].
\textsuperscript{84} Ibid [36].
In arriving at its decision, the Court acknowledged the lack of logic in having child destruction laws which punish those who destroy the child capable of being born alive, as well as boundaries for abortion set by the Abortion Act 1967 (UK) but not protect the fetus from an irrational decision of a competent mother to refuse medical treatment that will avert death. However it simply noted ‘… this appears to be the present state of the law.’

The plurality held

The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though, as we have already stated, the consequence may be the death or serious handicap of the child she bears or her own death….The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.

Following Re MB, an example of an irrational yet competent decision of a pregnant woman to refuse a caesarean section was seen in St George’s Healthcare NHS Trust v S. Here the woman was 36 weeks pregnant and diagnosed with pre-eclampsia. Both her life and that of the fetus were at risk. Understanding this advice, she refused on the basis that she wanted a natural delivery. Found to be competent, the Court held that the relevant Mental Health legislation could not be used by the hospital to detain her merely because the woman’s thinking process was ‘unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large.

85 Ibid [50].
86 Ibid [60].
87 [1998] 3 All ER 673.
88 Ibid 677.
89 Ibid 677.
90 Ibid 692.
Scott argues that apart from reiterating that the fetus is not a person, these cases fail to address the question of why a pregnant woman, clearly different to a non-pregnant woman, should have the same right as any other competent adult to refuse treatment. In *St George’s Healthcare v NHS*, Scott observes that the Court merely confirmed that despite the pregnant woman’s moral obligations to the fetus, her legal rights remained intact. Therefore, the failure of the courts to enforce moral duties the pregnant woman may have to the fetus, this line of cases merely leaves the impression of an uncomfortable split between the law and ethics relating to a pregnant woman’s rights.

This thesis agrees with this assessment. In support, Thampapillai notes that implicit in the arguments in favour of intervention are a judgment that the pregnant woman’s decision to refuse intervention is immoral. Ultimately such applications to courts assume that a woman cannot objectively decide between her health and that of the fetus and if she decides in her favour, she will be regarded as self-serving or weak.

A recent example of capacity and a pregnant woman from the United Kingdom is that of *Re AA*. Here, the Court of Protection ruled that a hospital could use restraints and perform a caesarean section delivery on a mentally ill pregnant woman, scheduled under the Mental Health Act who was 39 weeks pregnant. The woman expressed a desire to have a natural vaginal delivery despite the fact she had delivered two previous children by caesarean section and was told of the risks to the fetus of brain damage, and a 1% risk to herself of a ruptured uterus.

The treating psychiatrist gave evidence that she lacked the requisite capacity to refuse a caesarean due to her mental illness. Importantly, the option of allowing a natural delivery with intervention only should complications occur, was dismissed as not being a workable option. This was because the pregnant woman would need to advise hospital staff when she went into labour so as to allow them to monitor her.

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91 Scott, above n 23, 408.
92 Ibid.
93 Ibid.
94 Thampapillai, above n 34, 459.
95 Thampapillai, above n 34, 459.
96 [2013] EWCOP 4378, 1.
97 Ibid [2].
98 Ibid [4].
This was considered to be a difficult proposition, given she had delusions and anxiety about the birth itself. Mostyn J noted the case fell squarely within the ambit of Re MB.\textsuperscript{99} In finding that the caesarean was in the woman’s best interests, Mostyn J noted that the 1\% risk of uterine rupture was significant. Additionally His Honour noted that it was in her best mental health interests that her child be born alive and healthy.\textsuperscript{100}

It is debatable whether risks to the pregnant woman were serious enough to override her actual refusal. Medical opinions relating to hypothetical future events are not guarantees of outcome. However here, the pregnant woman was legally represented and no contrary evidence was adduced.

An often criticised decision from the United States is that of In re A.C\textsuperscript{101}, where the District of Columbia Circuit court ordered a Hospital to perform a caesarean section delivery on a 26 and a half weeks pregnant woman who was terminally ill with cancer and whose membranes had ruptured 60 hours earlier.\textsuperscript{102} The medical evidence was that to allow the labour to proceed naturally, would lead to a 50-75\% risk that the baby would suffer from infection which could be fatal or lead to brain damage, and that caesarean section was the only method to avoid this risk to the fetus. The risk to the mother of adverse consequences with caesarean section delivery was assessed at 25\%.\textsuperscript{103}

The court at first instance (making the decision at the Hospital and under time constraints) held that it had a compelling interest that would override the woman’s objections to undergoing the surgery.\textsuperscript{104} In line with relevant United States abortion law, the court reasoned that the State had an important and legitimate interest in protecting the potentiality of human life and that at the point of viability, that interest becomes compelling.\textsuperscript{105} Given the significant risks to the fetus as compared to the

\begin{footnotesize}
\footnotesize\textsuperscript{99} Ibid [1].
\footnotesize\textsuperscript{100} Ibid [5].
\footnotesize\textsuperscript{101} 573 A2d 1235 (DC App 1990).
\footnotesize\textsuperscript{102} Ibid 1239.
\footnotesize\textsuperscript{103} Ibid 1239.
\footnotesize\textsuperscript{104} Ibid 1240.
\footnotesize\textsuperscript{105} Ibid 1240.
\end{footnotesize}
pregnant woman, the court held that there was a compelling interest for the court to intervene and protect the life and safety of the fetus.\(^{106}\)

The woman consented to the caesarean after she was informed of the court’s decision but then withdrew that consent.\(^{107}\) The caesarean delivery took place but tragically, both the woman and the child that was born, died. The District of Columbia Court of Appeal re-heard the case a few months later on application by the estate of the deceased woman. The Court of Appeal reversed the decision, noting that although the possibility of a conflicting state interest might be so compelling that the patient’s wishes are overridden, such cases would be ‘extremely rare and truly exceptional’ and this was not such a case.\(^{108}\)

Karpin notes that cases such as \textit{In re AC} are the ultimate scenario for the construction of the female body as ‘a replaceable container for the separate and alienable fetus and the annihilation of the female as active participant.’\(^{109}\) The court, she observes, chose to ‘treat her body as permeable, penetrable and insignificant, as mere flesh to be cut into to save the “innocent”\(^{110}\) where the effect was to de-value the mother’s life.

This thesis suggests that this particular case does not present the ‘ultimate scenario’. The outcome itself, with death of mother and child, suggests it was a highly unusual, emergency medical situation, where the capacity to determine the issues at hand were limited. An irrational reason given by the mother to refuse any intervention, where it is documented and given in advance of any emergency setting, may arguably cause less anguish to the health professionals involved with care.

\(^{106}\) Ibid 1240.
\(^{107}\) Ibid 1252.
\(^{108}\) Ibid 1252.
\(^{109}\) Ibid.
\(^{110}\) Karpin, above n 24, 346.
Lyng et al argue that in an emergency situation, doctors have the right to perform a caesarean section without the woman’s consent in order to save the fetus.\textsuperscript{111} In taking into account the weakest right and the greatest health benefit, they conclude that deliberate violation of the mother’s bodily autonomy can still occur.\textsuperscript{112} This of course is a medical reaction to a legal issue but serves to highlight the point made in this thesis that the born alive rule cannot please everyone’s conception of what the fetus and its value is.

Certainly, doctors who are charged to care for the pregnant woman may well have the fetus strongly in mind. With advances in medicine, fetal surgery now occurs where the fetus is in the mother’s uterus. Uppal et al note the incongruity of a fetus having no legal rights or identity being treated as a patient from a medical perspective.\textsuperscript{113} This is a perplexing problem as it unmasks the fiction of pretending the fetus is not a separate entity capable of being harmed.

Cases involving religious convictions can be differentiated from irrational refusals to undergo treatment in that there is an acceptance by the medical profession and the courts that those convictions are held by a number of people, not just the pregnant woman in issue. So, however unusual the conviction may be to others, the decision to refuse is not immediately seen as evidence on incapacity. This raises some interesting issues regarding tolerance in both medicine and the law for non-mainstream points of view about life issues and lifestyles, particularly those based on religious beliefs.

Gyamfi et al recommend that where physicians take on the care of a patient who refuses treatment, such as a Jehovah’s Witness refusing a blood transfusion, the physician should do so only after deciding that they can let the patient die when all other options have been exhausted.\textsuperscript{114} They note that although the physician may want to ‘do no harm’ they need to consider that in the case of a Jehovah’s Witness,

\begin{itemize}
\item \textsuperscript{111} Kristin Lyng, Aslak Syse and Per E Bordhal, ‘Can Cesarean Section Be Performed Without Woman’s Consent?’ (2005) 84 Acta Obstetrics and Gynaecologica Scandinavica 39, 42.
\item \textsuperscript{112} Ibid.
\item \textsuperscript{114} Cynthia Gyamfi, Mavis M Gyamfi and Richard L Berkowitz, ‘Ethical and Medicolegal Considerations in the Obstetric Care of a Jehovah’s Witness’ (2003) 102(1) Obstetrics and Gynecology 173, 174.
\end{itemize}
most members of the sect would consider it worse off to be eternally damned than to die from refusing a blood transfusion.\footnote{Ibid 173.}

Earlier this year, Biscoe and Kidson-Gerber published a case note of the tragic death of a pregnant woman at Sydney Hospital who refused a life-saving blood transfusion that would more likely than not have saved her and the unborn child’s life.\footnote{Alison Biscoe and Giselle Kidson-Geber, ‘Avoidable Death of a Pregnant Jehovah’s Witness with Acute Promyelocytic Leukaemia: Ethical Considerations and the Internal Conflicts and Challenges Encountered by Practitioners’ (2015) 45(4) Internal Medicine Journal 416, 462.} The woman, who was a Jehovah’s Witness, was seven months pregnant and suffered from acute prolycloytic leukaemia and pre-eclampsia. She had an advanced care directive refusing blood transfusion and was fully informed of the circumstance-specific consequences, including death. In line with the law, both she and the unborn child perished. They warn that as more fetal-specific treatments become available, conflict between the best interests of mother and fetus will increase.\footnote{Ibid.}

Biscoe and Kidson-Gerber recommend that the development of a clear understanding by the physician of their own attitudes and beliefs will, with the assistance of open communication between hospital staff and, if time allows, identifying alternative treating doctors, improve care to the patient.\footnote{Ibid.} This would avoid the emergency situation such as \textit{In re AC} referred to earlier, and suggests best practice.

Tonti-Filippini observes that doctors used to have clear duties to serve the health needs of a patient, but today their obligations are determined by what the patient wants.\footnote{Nicholas Tonti-Filippini, \textit{About Bioethics – Philosophical and Theological Approaches} (Connor Court Publishing, 2011), 24.} This in turn may cause conflict between doctor and patient.\footnote{Ibid.} This is seen in the cases discussed in this Chapter, and it has a parallel in conscientious objection by doctors to participating in abortion, discussed in Chapter Eight of this thesis. In both scenarios, the lack of legal recognition of the fetus as a person, does not dissolve concerns by medical staff that they are dealing with two patients.
It remains to be seen whether refusal to undergo a caesarean based on personal choice by a pregnant woman can be elevated to the same level of respect as that of a religious conviction that serves to underpin a similar refusal. One assumes that a legal system that does not recognise personhood in the fetus and values bodily autonomy will have to accommodate this outcome. However whether the community and its political representatives have the same capacity, is uncertain.

These case examples demonstrate the ethical conundrum of balancing fetal beneficence with maternal autonomy. Generally speaking, the cases consistently favour recognition of bodily autonomy. Where they do not, the case falls under an exception, whereby the woman is said to lack the requisite capacity to refuse the caesarean section. Obviously proving lack of consent where a person has a pre-existing mental health illness can be complicated and no doubt any judgment call is bound to be open to criticism.

The question at the centre of such refusals to undergo medical treatment, particularly where there is grave danger to the fetus and little inconvenience to the woman, is the rubric of what a good mother would do. This situation underscores the unique position of the pregnant woman and the law’s desire for ethical minimums that has been elsewhere argued in this thesis. It demonstrates the divide between the theory of bodily autonomy for the pregnant woman and the reality of medical practice, which recognises two patients.

The legal position in Australia is likely to be the same, where respect for bodily autonomy and the competent adult’s decision to refuse medical treatment are long standing principles. Upholding foundational principles that the pregnant woman has bodily autonomy to decide what medical procedures will or will not be performed on her, and that the fetus is not a person, lead to reasonably clear outcomes in favour of the pregnant woman. However as the Court noted in Re MB, irrationality sits uneasily with competence and therefore, the graver the consequences of the decision, the greater the level of competence required to accept the decision.122

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122 [1997] 2 FLR 426 [26].
3.4 Summary

These cases demonstrate the unusual situation that the pregnant woman finds herself in that really has no equivalent counterpart in the tort world. As the purpose of the positive law is not to legislate morality,\textsuperscript{123} the courts have not been keen to develop a line of reasoning to create a definitive legal duty of care for the mother to the unborn child. However these cases demonstrate the reality of pregnancy, where the medical world perceives they have two patients despite what the law says. It highlights the divide between academic legal discourse and the reality of medical practice.

Changing societal views on bodily autonomy for pregnant women or indeed the status of the fetus may result in uncomfortable situations for medical professionals forced to accede to a legally valid maternal directive where the indirect result may be the demise of the fetus. There is obvious consistency in outcome in allowing a maternal directive, which has an indirect result of fetal destruction, and abortion, which is essentially a maternal directive to directly destroy the fetus.

However as Scott notes, given the undeniable difference between a pregnant and non-pregnant patient, an ethical justification for abortion is desirable.\textsuperscript{124} Requiring a justification for abortion is consistent with the legal position in Australia, except for those jurisdictions that allow abortion on demand, discussed in Chapter Seven. However as this Chapter has shown, a pregnant woman’s refusal of medical treatment that will harm the fetus does not require justification in the law, only confirmation that she has the capacity to make the decision.

Arguably, the principle of bodily autonomy and the born alive rule provide a platform for lawful abortion for any reason. As will be seen in the following Chapters, a disparate approach exists in Australia regarding when abortion is lawful. It is based on a need to show evidence of negative impact on maternal health or the gestational age of the fetus or the presence of disability in the fetus.

\textsuperscript{123} H L A Hart, The Concept of Law (Oxford University Press, 2nd ed, 1994) 184. Hart notes that ‘not all extensions of morality beyond obligations and ideals generally recognised in a given society need take the form of social criticism’.

However as will be argued by this thesis in the following Chapters, where the law provides an unclear or discretionary basis for doctors and judges to consider the lawfulness of an abortion, the ethical relativism that is undeniably present in our society, weakens the law and makes it vulnerable to criticism. Its capacity to deliver consistent legal results and provide clear guidelines to both the community and the medical professions as to when it is right and just to allow abortion, becomes questionable.

This thesis now reviews the regulation of abortion in New South Wales and Queensland, where maternal health concerns are the sole determinant of the lawfulness of an abortion.
CHAPTER FOUR

MATERNAL HEALTH CONCERNS AS THE SOLE BASIS FOR LAWFUL ABORTION

4.1 Introduction

As discussed in Chapters Two and Three, both the criminal and civil law respect the born alive rule and deny personhood to the fetus. This is despite criticism of the rule as being ‘an artificial and non-scientific concept of when life begins.’ Should the fetus survive any wrongdoing in the antenatal period and go on to be born, the laws in both areas provide a remedy by recognising harm in specific ways.

Savell argues that continuing to recognise birth as a legally significant event even when the historical basis for the rule no longer exists is appropriate because it preserves the autonomy that women have with regards to abortion and decisions with obstetric care. Clearly, the recognition of the fetus’ right to be born is in direct conflict with lawful abortion. Gough notes that, ‘Any society that wishes to distinguish abortion from homicide must draw a (more or less) arbitrary line between people who qualify for the full panoply of legal rights and fetuses, which receive reduced protection.’

In Chapter Three this thesis discussed cases where despite this arbitrary line in the sand as to when personhood commences, conduct of a pregnant woman that may indirectly but foreseeably harm the fetus resulted in legal actions seeking to create a maternal duty of care to the unborn child. Such actions have at their core, concern for the life of the fetus and any harm that may come to it.

Abortion involves the same issue of maternal bodily autonomy, however fetal destruction is the direct and desired outcome of the medical procedure. How the Australian law regulates abortion is discussed in Chapters Four to Seven.

1 R v Iby (2005) 63 NSWLR 278 [78].
Over the last 25 years, abortion meeting specific requirements has been decriminalised in five jurisdictions and dealt with under health legislation; the Australian Capital Territory, Victoria, Tasmania, Western Australia and the Northern Territory. This is not to say that unlawful abortion is not still a crime. In the remaining states, New South Wales, Queensland and South Australia, abortion remains a criminal act unless it is found to be lawful.

In deciding whether an abortion is lawful or not, three broad themes are set out in the legislation and/or case law. These are the effect continuation of the pregnancy will have upon maternal life or maternal health, the gestational age of the fetus and the presence of severe disability in the fetus. Not all themes are present in each jurisdiction. Table One provides a current snapshot of abortion legislation in Australia.

From a technical perspective, there is a disparate national approach to the lawfulness of abortion in Australia that is often the subject of criticism and calls for reform. Abortion law in Australia is a mess but reform is a complex issue. This thesis takes the position that achieving a balance between the various jurisdictions requires a common understanding of the purpose of the law, as well as agreement as to whether a specific value will be given to the fetus or whether alternate views about the value of the fetus will be accommodated in an appropriate fashion. Consistency between abortion law, civil law and third party assaults that destroy the fetus would assist with making good law.

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5 Health Act 1993 (ACT), ss 80-3.
6 Abortion Law Reform Act 2008 (Vic).
7 Reproductive Health (Access to Terminations) Act 2013 (Tas).
8 Health Act 1911 (WA) s 334.
9 Medical Services Act (NT) s11.
10 R v Wald (1971) 3 DCR (NSW) 25; R v Sood [2006] NSWSC (31 October 2006); R v Bayliss (1986) 9 Qld Lawyer Reps 8; R v Davidson [1969] VR 667; Criminal Law Consolidation Act 1935 (SA) s 82A.
Table One – Comparison of Criteria for Lawful Abortion in Australia

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Maternal health</th>
<th>Gestational Age</th>
<th>Foetal disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Not relevant</td>
<td>Not relevant</td>
<td>Not relevant</td>
</tr>
<tr>
<td>NSW</td>
<td>A doctor must hold a reasonable belief that it is a proportionate response to preserve the woman from serious danger to their life, or harm to their physical or mental health</td>
<td>Not relevant</td>
<td>Not relevant</td>
</tr>
<tr>
<td>NT</td>
<td>Up to 14 weeks, a doctor must medically examine the woman and a 2(^{nd}) doctor must agree that there is a greater risk to her life or to her physical or mental health if the pregnancy is not terminated. Between 14 and 23 weeks, a doctor must believe it is immediately necessary to prevent serious harm to the physical or mental health of the woman.</td>
<td>Relevant in conjunction with maternal health or foetal disability concerns at 14 and 23 weeks</td>
<td>Relevant up to 14 weeks if there is substantial risk the child would be seriously handicapped because of physical or mental abnormalities</td>
</tr>
<tr>
<td>QLD</td>
<td>A doctor must believe it was necessary to preserve the mother's life and it was reasonable having regard to the patient's state at the time and to all circumstances of the case</td>
<td>Not relevant</td>
<td>Not relevant</td>
</tr>
<tr>
<td>SA</td>
<td>Two doctors must personally assess the woman and believe there is a greater risk to her life or to her physical or mental health if the pregnancy is not terminated</td>
<td>At 28 weeks, a child is prima facie capable of being born alive and abortion at that time can only be lawful if it is to preserve the life of the woman</td>
<td>Relevant up to 28 weeks if two doctors have personally assessed the woman and believe the child would be born with physical or mental abnormalities as to be seriously handicapped</td>
</tr>
<tr>
<td>TAS</td>
<td>After 16 weeks, two doctors (one being an obstetrician or a gynaecologist) must certify in writing that continuation of the pregnancy will involve greater risk of injury to the woman's physical or mental health or is to save the life of the woman</td>
<td>Abortion on demand available on request up to 16 weeks</td>
<td>Not relevant</td>
</tr>
<tr>
<td>VIC</td>
<td>After 24 weeks, two doctors must believe it is appropriate in all the circumstances</td>
<td>Abortion on demand available on request up to 24 weeks</td>
<td>Not relevant</td>
</tr>
<tr>
<td>WA</td>
<td>Up to 20 weeks if the pregnancy is causing serious danger to the woman’s physical or mental health or will cause serious personal, family or social consequences. After 20 weeks, two doctors must believe the woman has a serious medical condition</td>
<td>Relevant in conjunction with maternal health concerns</td>
<td>Not relevant up to 20 weeks</td>
</tr>
</tbody>
</table>

After 20 weeks, two doctors believe the unborn child has a serious medical condition
Most recently, De Costa et al have concluded that there is an urgent need for abortion law reform in order to ensure equal access to abortion services throughout Australia and consistent standards of service.\textsuperscript{12} Given the nature of Federation in Australia, they suggest that constitutional constraints preclude the creation of a national law, but that uniform legislation in each jurisdiction is possible.\textsuperscript{13}

They suggest all jurisdictions adopt the Victorian legislation, (to be discussed in Chapter Seven), which represents at its core, a very liberal approach to accessing abortion. However there are many things to consider in adopting this approach. Abortion on demand must meet the ethical minimum expected of the community, particularly where it characterises abortion as merely a woman’s health issue\textsuperscript{14} and disregards the existence of the fetus and the moral implications of its destruction. If adopted, consideration needs to be given to whether it creates an actionable right to abortion\textsuperscript{15} and in so doing, creates a legal duty or obligation on doctors and hospitals to perform abortion (discussed further in Chapter Eight).

Due to the cross over of themes, there are several ways of considering the regulation of abortion in Australia. This thesis chooses to consider abortion regulation in three stages: Firstly, it reviews the law in the jurisdictions of New South Wales and Queensland, where maternal health concerns are the sole basis to consider abortion lawful. Secondly, it reviews the jurisdictions of Western Australia, Northern Territory and South Australia, where maternal health concerns coupled with gestational age and/or disability in the fetus are the basis for the lawfulness of abortion.

Thirdly, it reviews the jurisdictions of Victoria and Tasmania, where there is abortion on demand to a certain gestational age and thereafter, maternal circumstances are considered as the basis for lawful abortion. The Australian Capital Territory is discussed with Victoria and Tasmania, even though its legislation does not technically refer to any of the three themes discussed above.


\textsuperscript{13} Ibid.


The focus of this Chapter is the law in New South Wales and Queensland, specifically, what constitutes sufficiently serious harm to the physical and mental health of the woman to justify abortion. This Chapter considers what guidance, if any, can be gleaned from domestic case law. This Chapter concludes that whilst a basic framework exists for when maternal health concerns override concern for the life of the fetus in Australia, there is obvious scope for individual interpretation by judges based on personal values.

As this Chapter shows, in practice very few cases are prosecuted. However without clearer guidelines in legislation or case law, there can be no guarantee of a particular legal outcome for either the pregnant woman or the fetus. Therefore, criticism that these laws are unstable or unable to provide constancy in outcomes is arguably not without basis.\(^\text{16}\)

### 4.2 New South Wales

In New South Wales, the District Court case of *R v Wald*\(^\text{17}\) is considered to be the benchmark for the lawfulness or otherwise of a medical abortion. Here five people were charged under section 83 of the *Crimes Act 1900* (NSW) for unlawfully using an instrument with intent to procure miscarriage of a woman, as well as conspiracy to commit the offence and aiding and abetting the commission of the offence.\(^\text{18}\)

Arguments for one of the defendants included that under the common law at the time, termination of the pregnancy with consent of the pregnant woman did not constitute a crime unless harm befell the pregnant woman.\(^\text{19}\) Additionally, Counsel for the third and fourth defendants argued that


\(^{17}\) (1971) 3 DCR (NSW) 25.

\(^{18}\) Ibid 26.

\(^{19}\) Ibid 27.
...laws operate in a secular environment with no theological or deistic underlying content... the social utility of the law which makes an abortion a crime in a time of worldwide concern with the threat of population explosion, which includes the demand of women for a new status in the life of society, must clearly be open to question.\textsuperscript{20}

This secular, humanist position is, of course, not a neutral position. This thesis takes the view that even in a positive legal framework, given the subject matter involved, ethical considerations should not be banned from the discussion. However Levine J accepted the defendant’s proposition and took the position that it was not for him to indulge in judicial legislation, rather, he was merely to construe the statute.\textsuperscript{21} Levine J held that the legislature seemed to have had in mind circumstances where use of an instrument to affect abortion could be lawful.\textsuperscript{22} On this basis, his Honour held that procurement of an abortion was defined as lawful if a medical professional holds an honest belief on reasonable grounds, that what they did was necessary to preserve the woman involved from serious danger to their life, or physical or mental health, which a continuation of the pregnancy would cause.\textsuperscript{23}

In regards to the level of danger to health, Levine J directed that it be distinct from the normal dangers of pregnancy and childbirth and that, the danger of the operation must not be out of proportion to the danger to be averted.\textsuperscript{24} Levine J went on to note that it would be for a jury to decide in each case whether there was any economic, social or medical ground or reason which in their view would constitute reasonable grounds upon which an accused could honestly and reasonably believe there would be a serious danger to the pregnant woman’s physical or mental health.\textsuperscript{25}

Additionally, Levine J noted that it would be sufficient if at the time of being interviewed by the doctor, the pregnant woman’s mental health although not at the time in serious danger, but could reasonably be expected to be seriously endangered at some time during the pregnancy.\textsuperscript{26}

\begin{footnotes}
\item[20] Ibid 27-8.
\item[21] Ibid 28.
\item[22] Ibid 28.
\item[23] Ibid 29.
\item[24] Ibid 29.
\item[25] Ibid 29.
\item[26] Ibid 29.
\end{footnotes}
Clearly, Levine J had discretion as to how to interpret the term ‘lawful’. Casey notes that where a judge is required to interpret the term ‘unlawfully’, there emerges a ‘curious circularity inasmuch as a certain act turns out to be against the law only when done unlawfully but to determine whether it was done unlawfully or otherwise one must determine whether or not it was against the law.’ This thesis agrees.

In coming to his finding, his Honour disclosed his personal attitudes regarding the parameters to when abortion is appropriate and not a crime. Whilst this is not unusual in a legal case, the responsibility of the judge to do this for abortion is very significant. Decisions like these create legal precedent as well as impact on medical practice and moral principles. As a parallel, this thesis refers back to commentary in Chapter Two regarding judicial hesitation to set aside the born alive rule.

It seems an impossible task to critique the reasoning used by judges in reaching their decisions on the definition of the term ‘unlawful’. The same applies to doctors. Are they obliged to reference current community values, or may they insert their personal views? What if their personal views about abortion are at odds with community values or include beliefs about fetal personhood?

The difficulty of critiquing any person’s views on the rightness or wrongness of abortion in any particular case was remarked upon in the landmark United States case of Roe v Wade. The Supreme Court noted

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One’s philosophy, one’s experience, one’s exposure to the raw edges of human existence, one’s religious training, one’s attitude towards life and family and their values and the moral values one establishes and seeks to observe, are likely to influence and colour one’s thinking and conclusion about abortion.

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28 410 US 113 (1973) 114 (‘Roe’).
29 Ibid 116 per Buckman J.
The law can influence our attitudes as to the rightness or wrongness of abortion. George notes that ‘people shape their own lives (and often treat others differently) in light of these notions’. This suggests that people tend to conflate what is lawful with what is moral.

Strikingly, for Levine J, there was no direct consideration of the fetus or any characteristics of it that might impact on whether maternal health concerns were proportionate to its destruction. Levine J did not require the mother’s physical life to be in immediate danger but rather offered lesser circumstances as potential considerations for lawfulness. Known as the ‘Levine ruling,’ this decision has never been challenged to date in New South Wales. Accordingly, a single judge’s personal views on what circumstances excuse abortion as a crime has continued to be accepted as the correct legal position in New South Wales for over 40 years.

Arguably, the Levine ruling was expanded in the New South Wales Court of Appeal decision of CES v Superclinics a medical negligence case arising from a pregnant woman suing her doctor for failing to diagnose her pregnancy and causing her to lose the opportunity to have an abortion. The fetus did not suffer from any abnormalities. Here, the trial judge ruled that the appellant would not have satisfied the requirements for a lawful abortion in the first place and therefore no damage flowed from the doctor’s alleged breach of duty of care.

On appeal, Kirby P made obiter comments suggesting an extension of the Levine ruling to include threats to the mother’s health after the child is born as being a serious danger to the pregnant woman’s physical or mental health. Kirby P went on to state that these threats might well include social and economic difficulties that arise from the responsibility of caring for a child. Again, the judgment did not dwell on the fetus or any knowledge regarding its biological traits that might require the law to set boundaries for its destruction.

31 (1995) 38 NSWLR 47.
32 Ibid [23]-[26].
33 Ibid [83]-[85].
As will be seen here and in Chapter Five of this thesis, this widened interpretation of serious harm to the mother’s physical or mental health has been adopted in legislation in other jurisdictions. Arguably, it was also adopted in the most recent New South Wales decision on abortion in *R v Sood* (*Sood*)\(^{34}\) where it was used not to sanction an abortion as lawful, but rather to successfully prosecute a doctor for performing an unlawful abortion. This case involved a late term abortion at 24 weeks gestation using prostaglandin drugs to induce labour.\(^{35}\)

The pregnant woman had apparently experienced difficulty in trying to locate a doctor willing to perform an abortion so late in the pregnancy.\(^{36}\) She was 20 years of age, in an unstable relationship with the father of the baby, in financial distress and lacked family assistance.\(^{37}\) She took the drugs and gave birth to the baby boy at home.\(^{38}\) There was some concern that the baby was born alive as both a nurse and a medical practitioner saw what they thought were signs of life in the baby.\(^{39}\) A decision was made not to resuscitate him as his condition was not consistent with survival.\(^{40}\) Ultimately, the baby did not survive.\(^{41}\)

The defendant was charged with both manslaughter and the lesser charge of unlawful administration of a drug with intent to procure miscarriage under section 83 of the *Crimes Act 1900* (NSW).\(^{42}\) In choosing not to overrule the Levine ruling, the fact this was a late term abortion was not considered a relevant consideration by the court. Rather, the focus was on the prediction of harm to the physical or mental health of the woman if the abortion was not performed.\(^{43}\)

Simpson J noted that the requirement that there be serious concerns for maternal life or health was broad enough to include ‘economic, social, or medical factors, including matters that can arise after the birth.’\(^{44}\) Simpson J noted

\(^{34}\) [2006] NSWSC 1141(31 October 2006).
\(^{35}\) Ibid [9].
\(^{36}\) Ibid [6].
\(^{37}\) Ibid [24].
\(^{38}\) Ibid [11].
\(^{39}\) Ibid [12].
\(^{40}\) Ibid [12].
\(^{41}\) Ibid [12].
\(^{42}\) Ibid [1], [2], [4].
\(^{43}\) Ibid [19], [23].
\(^{44}\) Ibid [24].
I am unable to find that this termination was one which, if the proper inquiries had been made, would not or could not have been lawfully performed. In other words, it was not an unlawful termination because of the circumstances of LT; it was an unlawful termination because Ms Sood failed to make the requisite inquiries in order to satisfy herself of the necessity to terminate the pregnancy. Had she made those inquiries, she may well have, quite properly, formed that belief and proceeded lawfully to terminate the pregnancy.\footnote{Ibid [25]. The doctor had been de-registered by the time of the trial and was therefore known as ‘Ms’ Sood as opposed to ‘Dr’ Sood.}

The jury acquitted the defendant of the manslaughter charge but the defendant was found guilty of the lesser charge.\footnote{Ibid [1].} Simpson J, noted the policy arguments contained in the Crown’s submissions regarding sentencing,

We submit that the policy behind the law is to protect women from taking such an irrevocable step unwisely and without due consideration. And we submit that your Honour’s sentence of this medical practitioner should send a clear message to medical practitioners performing terminations in New South Wales that the law requires them to ensure that a woman receives that proper counselling prior to having an abortion. ... This case is not about changing the law of abortion; however, it is an appropriate opportunity for this Court to reinforce what the law is and has been for many years in this State, that the law requires the medical practitioner who is performing the termination to form a view that it is necessary, in the interests of the life or the health of the mother, and that that is a reasonable belief.\footnote{Ibid [20].}

Concepts such as viability of the fetus and its capacity to be born alive, as well as issues of personhood referred to in Chapter Two, were not considered. Instead, the opportunity was used to expand the definition of serious health concerns for the mother’s physical or mental health. The case was controversial not just because it involved the modern day prosecution of a medical doctor for performing an abortion, but because it involved a late-term abortion. Ultimately, the age of the fetus was not considered to be a reason to characterise the abortion as unlawful.

As pointed out by Simpson J, had the defendant made the required enquiries, the abortion might well have been lawful and if so, there would have been no basis for any criminal charges to flow from it.\footnote{Ibid [25].}
This disregard for the physical maturity of the fetus for lawful abortion, or indeed any other feature of the fetus such as the presence of disability, is consistent with the fact that in New South Wales, there is no offence of child destruction and third party destruction of a fetus is characterised as grievous bodily harm to the pregnant woman.\footnote{ Crimes Act 1900 (NSW) ss 4, 33.} Fetal attributes do not enhance criminal offences that result in fetal destruction. Gleeson argues that abortion law in New South Wales (and Queensland) concern women and therefore it is illogical to identify certain fetuses as more expendable than others via abortion and not make the same demarcation for grievous bodily harm, child destruction or damages for wrongful birth.\footnote{ Kate Gleeson, ‘Bracket Creep in Australian Abortion Indications: When Did Rubella Arrive?’ (2007) 15 Journal of Law and Medicine 423, 433. }

In practice doctors may feel uncertain about what circumstances meet the legal threshold for abortion. A qualitative study performed by De Costa et al of medical practitioners resident in New South Wales and Queensland who perform abortions concluded that the participants felt the law was out of date, particularly with regard to fetal disability and that the law did not provide adequate guidance to assist with a defence to a prosecution for unlawful abortion.\footnote{ Caroline De Costa, Heather Douglas and Kirsten Black, ‘Making it Legal: Abortion Providers’ Knowledge and Use of Abortion Law in New South Wales and Queensland’ (2013) 53 (2) Australian and New Zealand Journal of Obstetrics and Gynaecology 184. } In another study by the same authors, they concluded that abortionists even went as far as to manufacture mental health illness in patients in order to meet the legal requirements for lawful abortion.\footnote{ Heather Douglas, Kirsten Black and Caroline De Costa, ‘Manufacturing Mental Illness (and lawful abortion): Doctors’ Attitudes to Abortion Law and Practice in New South Wales and Queensland’ (2013) 20 Journal of Law and Medicine 560, 572. }

Policy directives from government health departments overseeing public hospitals may cause additional confusion. The current policy directive for abortion in public hospitals in New South Wales Health notes that the doctor must consider the woman’s physical and psychological condition; the gestational age of the fetus; the diagnostic probability of any birth defect; and in the case of birth defect, the prognosis for the fetus.\footnote{ Policy Directive, New South Wales Health, Pregnancy – Framework for Terminations in New South Wales Public Health Organisation, PD2014_022, 2 July 2014. }
Accordingly in practice, gestational age and the presence of fetal disability would appear to be factors taken into account by the doctor, despite not being a formal requirement in the law. This suggests that the law in New South Wales may be out of step with the clinical practice of doctors or alternatively, that doctors are not following the law in regards to abortion.

Arguably, the fact that the Levine ruling requires the doctor to hold an honest belief that maternal health concerns are proportionate to the abortion seems to recognise that abortion is not a standard medical procedure because it involves destruction of human life. The thesis suggests that the failure of the Levine ruling, and those that have followed, to specifically include aspects of the fetus as a basis to consider the lawfulness of an abortion brings into question whether or not consideration of the fetus as an entity of value may be taken into account by doctors when considering whether the abortion is appropriate.

However the ruling requires the doctor’s belief to be not just an honest belief, it must also be based on reasonable grounds. This thesis takes the position that as a matter of common sense, despite the Levine ruling focussing the lawfulness of abortion on maternal health concerns, it is inescapable not to acknowledge that abortion involves destruction of the fetus. The moral views about the value of the fetus should be permitted into a doctor’s decision about abortion. This will be discussed further in Chapters Seven and Eight where it discusses abortion on demand and limitations to conscientious objection by doctors to performing or participating in abortion.

4.3 Queensland

Abortion is still a crime in Queensland, with the practice regulated by the Criminal Code 1899 (Qld). Section 224 of the Criminal Code provides that where any person ‘… with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind or uses any other means whatsoever is guilty of a crime.’ The offender is liable to imprisonment for 14 years.
A pregnant woman undergoing an abortion, and those assisting her, can still be charged with a crime for administering to herself any poison or noxious thing or by use of force of any kind with the intent to procure an abortion on herself with the penalty being imprisonment for seven years.\textsuperscript{54}

Medical practitioners and health professionals can rely on a defence available in section 282 of the \textit{Criminal Code} where it provides:

\begin{quotation}
A person is not criminally responsible for performing or providing in good faith and with reasonable care and skill a surgical operation on or medical treatment of

(a) a person or an unborn child for the patient's benefit; or

(b) a person or an unborn child to preserve the mother's life;

If performing the operation or providing the treatment is reasonable, having regard to the patient's state at the time and to all circumstances of the case.
\end{quotation}

This defence is extended to the mother, and those who administer, supply or procure any substance to be used on the patient under the lawful direction or advice of the health professional. In issue is that there is no definition of the phrase ‘preservation of the mother’s life’. The seminal 1986 case of \textit{R v Bayliss} (‘\textit{Bayliss}’),\textsuperscript{55} which involved the prosecution of two medical practitioners charged under section 224 of the \textit{Criminal Code} with unlawfully using force on a woman with intent to procure her miscarriage, is the starting point for guidance on what will be lawful.

The judgment of Maguire DCJ is well researched and elaborates on the history of abortion law in Australia, England and other jurisdictions. In reviewing the relevant case law, Maguire DCJ noted that there had been no reasoned judgment of the relevant sections of the \textit{Criminal Code} since their inception in 1901.\textsuperscript{56} In approaching this formidable task, Maguire DCJ made reference to the fact that

\textsuperscript{54} \textit{Criminal Code 1899} (Qld) ss 225, 226.
\textsuperscript{55} (1986) 9 Qld Lawyer Reps 8.
\textsuperscript{56} Ibid 9.
The function impliedly entrusted to the Courts in interpreting the law of abortion is not to say who is right and who is wrong as between the extreme views held by different sections of the community as regards this highly controversial subject. Rather the Courts have to do their best to draw a line at a point where the procuring of a miscarriage ceases merely to be a matter of debate from a religious, moral or ethical point of view, and becomes activity of a kind which warrants its designation as criminal.57

In giving the jury a direction on the law, Maguire DCJ reviewed the English case of *R v Bourne* ("Bourne"),58 the first case where the courts had to consider a therapeutic abortion performed in a modern way by a medical practitioner in a hospital. It involved a first trimester abortion on a 14-year-old girl, pregnant as a result of being gang raped. The doctor was charged under section 58 of the *Offences Against the Persons Act 1861* (UK) which provided that any person who with intent to procure the miscarriage of a woman unlawfully administers to her any poison or noxious thing or unlawfully uses any instrument or other means with the like intent is guilty of felony.

The trial judge interpreted the term ‘unlawfully’ to require proof beyond reasonable doubt that the doctor did not procure miscarriage for the purpose of preserving the life of the mother. The defence led evidence of the pregnant woman’s probable physical and mental outcome if the child were born. Dr Bourne was acquitted.

Maguire DCJ followed *Bourne* and applied a broad interpretation of section 282 of the *Criminal Code* to include ‘the preservation of the mother’s life’, thus allowing a medical practitioner the flexibility to consider whether the abortion, was reasonable in all the circumstances of the case.59 In doing this though, Maguire DCJ noted

I hope that this ruling will not be misunderstood or misconstrued. The spirit of the Bourne …cannot be made the excuse for every inconvenient conception. It would be wrong indeed to conclude that Bourne equates to carte blanche. It does not. On the contrary, it is only in exceptional cases that the doctrine can lawfully apply… The law in this state has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on whim or caprice does not insidiously filter into our society. There is no legal justification for abortion on demand.60

57 Ibid 10.
58 [1939] 1 KB 687.
59 *R v Bayliss* (1986) 9 Qld Lawyer Reps 8, 45.
60 Ibid.
This comment from Maguire DCJ, which is almost 30 years old, is one judge’s view of the reach of section 282 of the Criminal Code. It requires a judge to review the circumstances of the case so that the abortion is based on necessity and proportionality, both relative terms. The wording of Maguire DCJ characterises the destruction of a fetus as a serious act and one where the State may punish the offender for a crime. It is not, therefore, a standard medical procedure or a private act left to the discretion of pregnant woman and her doctor.

Maguire DCJ concluded the judgment with the following comment

This ruling serves to illustrate the uncertainty of the present abortion laws of Queensland. It will require more imperative authority (either the Court of Appeal or Parliament) to effect changes if changes are thought to be desirable or necessary with a view to amending and clarifying the law.61

Following this decision in Bayliss, there was judicial approval of the approach of Maguire DCJ in the medical negligence case of Veivers v Connolly.62 Here, the events in issue occurred in 1975. The plaintiff sued her doctor for failure to diagnose rubella infection in the fetus and causing her to lose the opportunity to undergo an abortion and avoid the birth of a child with serous disabilities.

In the course of establishing the facts of that case, the court confirmed that an abortion in those circumstances would have been lawful under Queensland law with De Jersey J noting

I would therefore reason that continuing with a pregnancy which would so likely result in the birth of a severely affected rubella baby, entailed a serious danger to the first plaintiff’s mental health, albeit a danger which would not fully afflict her in a practical sense until after the birth…63 A therapeutic termination could lawfully have occurred in this case, because it was, as would have been gauged in 1975, necessary to preserve the first plaintiff from the serious danger to her mental health – and not merely the normal dangers of pregnancy and childbirth – which would have been entailed were her pregnancy to continue.64

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61 Ibid 45-6.
63 Ibid 329.
64 Ibid 330.
It is interesting to note that the court assumed knowledge of fetal disability would have caused mental illness in the mother sufficient to justify an abortion. Gleeson notes that de Jersey J was treading on egg shells so as not to directly make disability in the child the basis for abortion.\textsuperscript{65} Rather it was said to be the maternal reaction to the disability that was the basis for the justification of the abortion. Gleeson notes that to base abortion on fetal disability says something about the fetus and this takes away from the primary focus of abortion being about women.\textsuperscript{66} This is in contrast to other jurisdictions, to be discussed in Chapter Six, where fetal disability coupled with gestational age, is an articulated basis to condone the lawfulness of an abortion, subject of course to maternal informed consent.

Section 282 of the \textit{Criminal Code} was amended in September 2009 through the \textit{Criminal Code (Medical Treatment) Amendment Act 2009} (Qld) to include a medical abortion by the administration of drugs, such as RU 486, as opposed to surgical abortion. Hansard of the second reading speech and debate in the Queensland Parliament makes clear that abortion remains a divisive issue.

In his second reading speech, the Attorney General noted that the purpose of the bill was to ensure that the \textit{Criminal Code} remained relevant to the realities of life in Queensland and into the foreseeable future. There was said to be no attempt to alter the law at that time on abortion so as to either increase or decrease its prevalence.\textsuperscript{67} In supporting the bill, the Deputy Leader of the Opposition stated:

\begin{quote}
This is a highly personal and emotive issue for most members of this place. As I said yesterday when I stood to speak on the motion moved by the government to make this an urgent bill, there would be an extraordinary diversity of views within this parliament. Indeed there are probably as many views on this particular issue as there are members who occupy this House.\textsuperscript{68}
\end{quote}

\textsuperscript{65} Gleeson, above 50, 427.
\textsuperscript{66} Ibid.
\textsuperscript{68} Queensland, \textit{Parliamentary Debates}, Legislative Assembly, 3 September 2009, 2120 (Lawrence Springbord).
In recent times, Queensland has had two abortion cases involving medical abortions via administration of a drug. In September 2008, the Supreme Court was asked via its parens patriae jurisdiction to sanction a late term abortion on a 12-year-old pregnant girl by the administration of the drug Misoprostol. The pregnant girl was 18 weeks pregnant by the time the case came before the Court. A declaration was sought on her behalf that termination by that method was lawful in all the circumstances of the case and that Hospital staff could administer the drug.

The Court comprised a single judge, Wilson J, who heard evidence from two psychiatrists and an obstetrician to the effect that continuation of the pregnancy would result in serious danger to the pregnant girl’s mental health well beyond the normal dangers of pregnancy and childbirth. Administration of the drug was considered to be a safer alternative than a surgical abortion. Wilson J decided in favour of allowing the abortion on the grounds that it was reasonable to avert the danger to the pregnant girl’s mental health and that it was in her best interests to do so.

There was no reference to the fetus or even concern for it. This reasoning is consistent with that used in Bayliss and approved in Veivers, where a threat to the mother’s life is to be interpreted broadly by the court to include effects on mental health that need not include a threat of imminent death.

In the 2009 case of R v Leach, a pregnant woman was charged under sections 225 of the Criminal Code with intent to procure an abortion by unlawfully administering a noxious thing in the form of the drug Misoprostol. Her partner procured the drug and was charged under s 226 of the Code with procuring something that he knew was to be used to cause a miscarriage. The woman was 8 weeks pregnant at the time.

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70 Ibid [2].
71 Ibid [1].
72 (1986) 9 Qld Law Reps 8, 45.
73 [1995] 2 Qd R 326.
74 R v Brennan (unrep. Dist Ct, Qld, Criminal Jurisdiction, 13 October 2010).
Section 282 of the *Criminal Code* was not relevant as a defence, given there was no evidence that continuation of the pregnancy would have produced a life threatening or serious medical condition for the pregnant woman, rather she simply did not want to be pregnant and did not want to give birth to the child. The accused were both found not guilty. The jury placed emphasis upon the expert evidence, which stated that the drug was widely and safely used overseas and in some places in Australia to effect abortion. It was not, therefore, a noxious thing to the pregnant woman. Specifically, the judge directed the jury not to determine this issue from the fetus’ perspective. The case was not appealed.

These two recent cases and the reasoning of Maguire DCJ in *Bayliss* confirm that the focus of the Queensland laws is the requirement that the doctor hold an honest belief that abortion was necessary to preserve the mother’s life. In practice, the few instances where cases have been before the courts in the last 50 years, surgical or medical abortion is lawful where it can be proven that the mother will suffer serious physical or psychological harm if the pregnancy is continued.

There is no requirement in the law that the mental harm must reach a particular threshold, such as being a recognised psychiatric injury diagnosed by a psychiatrist. This could suggest that the threshold is low. The extent to which the mother’s physical health needs to be endangered by the pregnancy or birth of the child in order to consider abortion lawful has not been considered by the Queensland courts to date.

However, in other criminal matters involving the fetus, the *Criminal Code* acknowledges as a serious crime the third party destruction of an unborn child at any time. Additionally, Queensland maintains the offence of child destruction. In either circumstance, the maximum penalty is life imprisonment. Accordingly, while Queensland’s abortion laws focus on maternal health concerns, recognition of the fetus and its value in the criminal law suggests to this thesis that the maternal health concerns must be serious to justify abortion.

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75 *R v Brennan* (unrep. Dist Ct, Qld, Criminal Jurisdiction, 14 October 2010), 3-7.
76 (1986) 9 Qld Law Reps 8, 45.
77 *Criminal Code 1899* (Qld) s 313(1).
78 Ibid s 313(2).
Therefore, it would be reasonable to suggest that there is uncertainty in the application of the Queensland law when it comes to concerns about the degree of mental health illness required to be experienced by the pregnant woman seeking abortion. It is therefore understandable why Queensland doctors who perform abortions might be concerned about the potential criminality of their conduct. Whether this will result in abortion law reform remains to be seen.

In Queensland, Douglas et al have noted there is limited access to abortion in the public health system.\(^{79}\) For late term abortions, the decision must go through a clinical ethics committee, which they say is often slow in responding to applications and inconsistent in its decisions, and therefore another barrier to access.\(^{80}\) They concluded there was a general unwillingness by doctors in Queensland to pursue abortion as a practice area. This has apparently led to deficiencies in medical training and to abortion tourism, where women travel to other states, notably Victoria, at added expense and discomfort to achieve an abortion.\(^{81}\)

### 4.4 Summary

In practice, abortion laws in both New South Wales and Queensland delegate to the doctor, the decision making process of considering whether the abortion was reasonable in all the circumstances of the case and a proportionate response to harm to the mother. Few cases are prosecuted and doctors use their professional judgment in making such decisions without formal review.

If concerns were held by a doctor about whether or not the particular circumstances met the legal criteria for lawfulness, it is open to them to seek a declaration to that effect from the court, as was sought in *State of Queensland v B*.\(^{82}\) Presumably, in a true emergency situation of life and death, such a concern would not exist as the life of the mother would be in jeopardy and therefore by definition, would meet the legal threshold.

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\(^{79}\) Douglas et al, above n 52, 561-2.


\(^{81}\) Douglas et al, above n 52, 576.

\(^{82}\) [2008] QSC 231.
In both New South Wales and Queensland, the characteristics of the fetus, particularly the gestational age of the fetus, are not considered to be relevant factors in considering the lawfulness of an abortion. Accordingly, late term abortion is technically permissible in both jurisdictions if the doctor held valid concerns for the mother’s physical or mental health. Specific circumstances that lead to physical or mental health issues are not indicated. For example, in neither case does the lawmaker set out ‘rape’, or ‘dire financial straits’ even though these may be the proximate reasons that lead to serious physical or mental harm.

The High Court has not yet had occasion to specifically review abortion law in Australia. With only a few common law decisions, the legal principles in both jurisdictions are open to review. The potential exists, therefore, for the common law in both New South Wales and Queensland to be appealed to a higher court for assessment.

In Bayliss, Maguire DCJ noted

> The issue of abortion is a divisive and sensitive subject matter. It engenders in the community every sort of response. It is a controversial subject involving moral and social judgment in which opinions differ. It is fair to say that in Australia, the law leaves the determination of the lawfulness of an abortion to the discretion of doctors. It is impossible to police such decisions. The law exists however to consider those unusual cases where a doctor’s decision to perform the abortion may go against what is considered appropriate by reasonable community standards. 83

This thesis concludes here in Chapter Four that in New South Wales and Queensland, courts are unlikely to second guess the decision of doctors who have made a judgment based on their medical opinion that the abortion met the relevant threshold in the circumstances of the case. Rare circumstances, as arose in the Sood case and which is reminiscent of the Dr Kermit Gosnell cases in Philadelphia (referred to in Chapter Two), where the doctor concerned is unprofessional and has not bothered to consider the reasons the abortion is sought, seem to be the current day purpose of abortion laws. The function of these laws is arguably primarily to

83 (1986) 9 Qld Lawyer Reps 8, 45.
protect the pregnant woman from unscrupulous conduct by doctors who fail to make a proper assessment of the situation.

The hesitancy of the law to become overly involved in what is perceived to be a moral and medical issue between the pregnant woman and her doctor, suggests an assumption that the doctor will do the right thing. Whilst there have been studies referred to in this Chapter to support the view that abortionists find the lack of clear legal guidelines for lawfulness confusing in practice and a deterrent to specialising in the area, this does not of itself lead to a conclusion that there ought to be law reform so as to allow more lawful abortions to take place. Whether there is enough support generally in the medical profession or indeed the community to create an impetus for such reform in either New South Wales or Queensland remains to be seen.

An alternative method of considering the lawfulness of abortion is to focus on measureable attributes of the fetus, such as its gestational age. A 2008 survey of attitudes to abortion amongst Australian people found nuanced views as to whether they would or would not support abortion in particular circumstances. The findings suggested that abortion in the first trimester of pregnancy was far more acceptable than late term abortion. Few people supported abortion at any time and in any circumstances.

This provides an indication of community support of gestational age as a basis for abortion. Whilst arguably a less complicated way of determining the lawfulness of abortion compared with maternal health concerns, it represents a mental shift in the way abortion is perceived, and raises significant questions about what age limit is appropriate and why. Chapter Five will discuss the use of gestational age in conjunction with maternal health concerns as a basis for lawful abortion in the laws of Western Australia, South Australia and the Northern Territory.

85 Ibid 10.
86 Ibid 10.
CHAPTER FIVE

GESTATIONAL AGE AND MATERNAL HEALTH AS THE BASIS FOR LAWFUL ABORTION

5.1 Introduction

In drawing a line in the sand regarding when a human being becomes a legal person, the born alive rule leaves open for interpretation the basis upon which the law should perceive the fetus between conception and birth. Given the arbitrariness of this line, the legal definition of a person ought not shut down intelligent debate about the attributes of personhood. However it can be hard to turn back the clock once a practice like abortion is considered lawful and has become embedded in a culture.¹

Using the gestational age of the fetus as a basis for lawful abortion is arguably no different to using other fetal attributes such as viability, disability or gender as a basis for abortion. Using any type of fetal attribute as a basis for lawful abortion moves the discussion away from abortion being primarily about women’s health to abortion being about the fetus.² More specifically, it creates a demarcation between fetuses that may be lawfully destroyed with maternal consent, and those that may not.³

In this Chapter, this thesis examines the legislative provisions in Western Australia, Northern Territory and South Australia, where gestational age of the fetus, together with maternal health concerns, is the basis for lawful abortion. It demonstrates that there is a disparate approach to not just the appropriate gestational age limit for abortion, but other requirements too such as the nature of maternal health concerns that must be present, the number of doctors who must confirm that those concerns satisfy the legislation, the specialist qualifications of those doctors, and even where the abortion must take place.

¹ R v Bayliss (1986) 9 Qld Lawyer Reps 8, 45.
³ Gleeson, above n 2, 433.
Ultimately, using gestational age limits to determine the lawfulness of abortion is a far easier way for doctors to assess the lawfulness of abortion compared to maternal health concerns, however it commits the State to the position that the fetus of a certain gestational age has no independent value in the law. The overlaying of maternal health concerns merely permits the age limit to be breached when the law does recognise the fetus, and permits late term abortion in certain circumstances.

5.2 Use of gestational age for abortion in the USA and UK

The use of gestational age as a threshold for lawful abortion is incompatible with the relational analysis of pregnancy discussed in Chapter Three. It moves the argument away from woman’s rights. Physical realities of the fetus become a reason for the law to give certain fetuses a measure of protection from destruction, although it never quite gets to the point where the law requires the mother to give up her life for the fetus.

Gestational age underpins the law of abortion in jurisdictions like the United Kingdom and the United States of America, however it has proven to be a shifting standard. Where technology can improve the survival chances of a preterm baby, thus lowering the age of viability, and scientific advancements suggest attributes of the fetus such as sentience and the capacity to feel pain at lower and lower gestational ages, the debate around when it is ethical to destroy a fetus will no doubt continue.

Failed late term abortion that results in a live birth present a conundrum for those who perceive personhood as a complex issue that is much more than just biological traits. At the moment of birth, biological traits become legally relevant when moments before, they may have been academic.

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4 Greasley, above n 2, 433.
5 Abortion Act 1967 (UK).
9 See R v lby (2005) 63 NSWLR 278.
Described by Savell as ‘an awkward outcome’ and ‘an unexpected and unwelcome result, for the woman’, the legal consequences of the born alive rule law are clear. Once born and with even minimal signs of life, the entity is a person and has all the usual rights and protections that other people have. As noted by the Supreme Court of New South Wales in *R v Iby*, there is no requirement for the child born alive to be capable of surviving as a functioning being. Choosing a gestational age limit to avoid this outcome is therefore imperative.

In the United States, the Supreme Court addressed the lawfulness of abortion in the seminal decision of *Roe v Wade* (*Roe*). The case involved the interpretation of a Texan statute that made it a crime to procure an abortion except on medical advice for the purpose of saving the life of the pregnant woman. In *Roe*, the State was said to have an interest in protecting ‘potential life’. That interest however was not judged to outweigh the health or life of the mother.

The Supreme Court characterised abortion during the first trimester of pregnancy as a matter left to the judgment of the woman and her doctor; thereafter the State may intervene to regulate the abortion procedure in ways reasonably related to maternal health; and after the fetus is considered viable, the State recognises the potentiality of human life and may regulate or proscribe abortion based on medical judgment in order to preserve the life or health of the mother.

An opportunity to re-consider *Roe* came in the 1992 case of *Planned Parenthood v Casey* (*Casey*). Almost 20 years after *Roe* was decided, advancements in medical knowledge had shifted the time when a fetus is viable outside the womb from 28 weeks gestation to 22 to 23 weeks. The plurality of judges replaced the trimester model used in *Roe* and held that viability of the fetus was the most workable model to determine when the State’s interest in the life of the fetus outweighs the woman’s right to an abortion, except for reasons of threat to her life or health.

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10 Savell, above n 7, 112.
11 (2005) 63 NSWLR 278 [79].
13 Ibid 114.
15 Ibid 860.
The plurality of judges emphasised that the change in the viability time frame was not an invitation to review the original reasoning in *Roe* because the Court had already upheld the constitutional right to abortion in certain circumstances. Accordingly, to overrule the Court was said to both ‘profoundly and unnecessarily damage the Court’s legitimacy and the nation’s commitment to the rule of law.’

Such a position suggests to this thesis the assumption that either there will never be evidence that can require a review of the potentiality of human life in early gestation, or that even if there were such evidence, the Court would not alter its position regarding the lawfulness of abortion at that time. If it is indeed the latter, then the law has to concede that it is not particularly interested in seriously exploring the notion of personhood, but rather it wishes to maintain a historical right that has been created and proliferates in society. This is an important distinction where the law advances a nil value on the fetus and seeks to impose this on doctors in order to effect abortion.

Arguments about the lawfulness of techniques used for late term abortion were agitated in the controversial 2007 decision of the Court in *Gonzales v Carhart*. This case involved the constitutionality of the *Partial Birth Abortion Ban Act 2003*, 18 USC. This Act bans second trimester abortions when the fetus is delivered vaginally, feet first to the navel, and its head crushed to allow delivery of a dead fetus. Congress accepted the moral, medical and ethical consensus, that partial birth abortion was a gruesome and inhumane procedure that is never medically necessary.

Whilst assuming the premise of *Roe* and *Casey* regarding a woman’s constitutional right to abortion prior to viability of the fetus, the plurality of judges in *Gonzales* held that there was no undue burden placed on a pregnant woman in being prohibited from abortion in this fashion, given that alternatives to that procedure exist.

Ultimately, the Court ruled that the federal law on partial birth abortions was constitutional. In the minority, Ginsburg J expressed concern that the plurality opinion substituted their personal morality over precedent.

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16 Ibid 869.
18 Ibid 164.
The decision in *Gonzales* was criticised by some for the Court and the legislature wrongly interfering with a medical decision,\(^{20}\) and by others as raising questions about the five plurality Justices being Catholic and to what extent judges are and should be influenced by their religion, their ethnic background, their race, their life experiences and their personal values.\(^{21}\)

This thesis takes the view that if the underlying medical evidence in *Gonzales* was true, then removing the maternal health provision sits within the framework of laws that respect prenatal life after a certain gestational age. The furore around *Gonzales* confirms the continuing political nature of the abortion issue in the United States. It also highlights the difficulty in contracting the circumstances where abortion once lawful is now unlawful, and the challenge of accepting the consequence of changing perceptions about the fetus based on scientific knowledge.

In the United Kingdom, abortion law is a creature of statute. Like the jurisdictions discussed in this Chapter, the law provides specific exceptions to what is otherwise an unlawful act.\(^{22}\) In 1991, the legislature lowered the upper limit for abortion from 28 weeks to 24 weeks on the basis of updated scientific knowledge regarding viability of the fetus.\(^{23}\) Further unsuccessful attempts have been made via private members’ Bills to lower the age again, based on new technologies that demonstrate in a startling way, the morphological similarities between the mature fetus and a baby.\(^{24}\)

In the Australian community, the gestational age of the fetus has proven to be a primary indicator of Australians’ views on the rightness or wrongness of abortion. A 2008 survey of attitudes to abortion amongst Australians found that people tended to have nuanced views with high levels of support for early abortion in the first trimester, with 61% of respondents unconditionally supportive and 26% supportive depending on the circumstances.


\(^{22}\) Greasley, above n 2, 14.

\(^{23}\) Abortion Act 1967 (UK), s 1(1)(a).

\(^{24}\) Savell, above n 7, 107-110.
However by the third trimester only 6% of respondents were unconditionally supportive, 48% were against and 42% felt it depended on the circumstances. Accordingly late term abortion is a sticking point in the community. These attitudes towards the mature fetus sit comfortably with the laws in Western Australia, the Northern Territory and South Australia that provide greater protection for the more mature fetus.

Against this backdrop of common issues that arise from using gestational age limits in the United States and the United Kingdom, this Chapter will now critically compare and contrast these three Australian jurisdictions, searching for areas of commonality and disagreement between them. It is relevant to note at this point that there is no case law that assists with interpretation or application of the legislation in any of these states.

5.3 Western Australia

In Western Australia, abortion laws were reformed in 1998, following the failed prosecution of two doctors with unlawful abortion. Whilst abortion is still a crime, a pregnant woman can no longer be charged with intent to procure miscarriage. An abortion is lawful when it is performed by a medical practitioner with reasonable care and skill and where it is justified under section 334 of the Health Act 1911 (WA).

The Act sets out a two-stage process for assessing lawful abortion. At no more than 20 weeks gestation, one doctor must form in good faith the view that the woman will suffer serious personal, family or social consequences, or serious danger to her physical or mental health if the abortion is not performed, or the pregnancy is causing serious danger to her physical or mental health. Interestingly, the provisions elevate circumstances that may provide grounds for the abortion into the actual grounds for abortion. The legislation’s provision for financial, social and family consequences, including future impact, which may affect physical or mental health, suggest a wide range of reasons will suffice.

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26 Criminal Code Compilation Act 1913 (WA) s 199(1).  
27 Health Act 1911 (WA) s 334(3)(a)-(d).
Indeed, it is hard to imagine a doctor not agreeing that the birth of a child will not seriously impact the financial, social or family consequences of the woman. In support of this interpretation of the provisions, the Western Australian Department of Health’s guidelines for doctors on the legal implications of abortion specifically states, ‘In other words, abortion is available on request up to 20 weeks of pregnancy provided that informed consent has been given.’

As a counter balance to this, the legislation is unique in its emphasis on the need for informed consent. This is defined as including not just the usual requirements for advice and information about risks of abortion and carrying the baby to term, but also requires the doctor to offer to refer the pregnant woman for counselling about both options, and to inform her that such counselling will be available in either scenario.

The consent and counselling requirements for abortion in Western Australia attempt to ensure that there is no pressure or judgment on the pregnant woman and presumably increase likelihood of informed, voluntary consent being obtained. Greasley notes that many freely chosen abortions are actually made in response to stressful circumstances outside the pregnant woman’s control. Hence, she notes that some argue that it may be difficult to obtain true voluntary, informed consent for abortion from a pregnant woman in this environment.

In furtherance of informed consent, the doctor who performs the assessment may not be the same doctor who performs or assists at the abortion. This would seem to protect against unscrupulous conduct by abortionists, out for financial gain, as seen in the Dr Gosnell case referred to in Chapter Two. Greasley notes that most of Gosnell’s patients were poor, black or immigrant and in many cases, used his clinic as a last resort as it had acquired a reputation for performing abortions on anyone who asked for one.

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29 Health Act 1911 (WA) s 334(5).
30 Ibid ss 334(a), (b), (c).
31 Greasley, above n 2, 7-8.
32 Health Act 1911 (WA) s 334(6).
34 Ibid.
After 20 weeks gestation though, lawful abortion can be effected on the grounds that two doctors who are members of a panel of at least six doctors appointed by the Minister have agreed that the pregnant woman or the unborn child has a severe medical condition that in the clinical judgment of those two doctors, justifies the abortion. At this point, serious social consequences cease to be a ground for abortion, unless of course they are the cause of a serious medical condition in the pregnant woman.

Overall, Western Australia has liberal abortion laws that commit to a biological perception of the fetus. This is also reflected in its maintenance of the child destruction offence. The upper limit of 20 weeks falls below the grey zone for viability. Oversight by the medical profession ensures the doctor gives appropriate information and advice to the pregnant woman, and the pregnant woman gives informed consent. Late term abortion is permissible and confirms that serious maternal health concerns will prevail over any legal recognition of the mature fetus. De Costa et al report that only about 0.5% of abortions in Western Australia occur after 20 weeks gestation and further, they note evidence of abortion tourism. This would suggest that these laws are working well within their framework to prevent late term abortion except for exceptional cases.

5.4 Northern Territory

Abortion lawfully performed by a medical doctor has been decriminalised in the Northern Territory and its practice is regulated under the Medical Services Act (NT). A complex regime exists in the Northern Territory regarding the lawfulness of abortion with three different time frames being relevant in different attendant circumstances. Fetal disability as a basis for lawful abortion will be discussed in Chapter Six.

35 Health Act 1911 (WA) ss 334(3),(4), (7). The current approved medical facility is the Kind Edward Memorial Hospital.
36 Criminal Code Compilation Act 1913 (WA) s 290.
Abortion is lawful at up to 14 weeks gestation when two doctors believe in good faith that continuation of the pregnancy would involve greater risk to the mother’s life or greater risk of harm to the mother’s physical or mental health than if the pregnancy was terminated.\(^{39}\) One of those doctors must have medically examined the woman and where practicable, must be a gynaecologist or obstetrician.\(^{40}\) Unlike Western Australia, there is no prohibition on doctors who give the advice to perform or assist with the abortion.

The requirement becomes stricter in the second trimester. Abortion is lawful a further nine weeks along, at not more than 23 weeks. Here, one doctor must believe the abortion is necessary to prevent immediate serious mental or physical harm to the mother.\(^{41}\) There is no case law interpretation to give guidance as to the types of situations that qualify as being of immediate serious threat to a woman’s mental or physical health. It seems that this judgment call is made at the discretion of a doctor. The fact that a second doctor is not required seems to speak to the immediacy of the medical event. Finally, abortion is permissible at any stage of the fetus’ development where the sole purpose is to preserve the mother’s life.\(^{42}\)

Like New South Wales, Queensland, Victoria and Western Australia, it is the belief of the doctor who performs the abortion that is relevant. Arguably, this makes it easier for a court to determine the issue given it is more difficult to determine that the doctor did not hold the requisite view, and less difficult to assess whether an assessment was made by him/her that lead to the forming of the belief.\(^{43}\)

The abortion laws in the Northern Territory reflect a growing recognition of the value of the fetus as it becomes capable of being born alive, with a corresponding need to demonstrate proportionate justification in the decision-making. This is also reflected in the requirement that, where there is not an immediate health threat, two doctors are required to form a view regarding the appropriateness of the abortion, and one of them must be a specialist gynaecologist.

\(^{39}\) Medical Services Act (NT) s 11(1)(a)(b)(i).
\(^{40}\) Ibid ss 11(1)(a), 11(2).
\(^{41}\) Ibid s 11(3).
\(^{42}\) Medical Services Act (NT), s 11(4).
\(^{43}\) Cf R v Sood [2006] NSWSC 1141 (31 October 2006) [25].
De Costa et al note that a practical result of this requirement for specialist involvement is that abortions can only be performed in three hospitals in the Northern Territory.\textsuperscript{44} Early abortion using the drug Mifepristone (as was used in the \textit{Sood} and \textit{Leech} cases discussed in Chapters Two and Four) is not available.\textsuperscript{45} Accordingly, they conclude that there is a limitation to the availability of abortion services in the Northern Territory.

This thesis agrees that the Northern Territory requirements suggest fairly tight control over abortion. The framework is complex and heavily reliant on gestational age. There have been no attempts to date to amend the gestational time limits since the inception of the provisions. Like Western Australia, the co-existence in the Northern Territory of a child destruction offence with a maximum penalty of life imprisonment is consistent with the jurisdiction’s recognition of the growing value of the developing fetus in the law.\textsuperscript{46} This position of giving legal value to the fetus based on biological traits is not consistent with the position of fetal personhood from conception.

\textbf{5.5 South Australia}

In South Australia, unlawful abortion is still a crime against the pregnant woman. A fetus of 28 weeks gestation is prima facie considered to be capable of being born alive and abortion undertaken at that time is lawful only to preserve the life of the woman.\textsuperscript{47} In effect, this provision operates as a child destruction offence.

There are two things to note here. Firstly, despite being modelled on the \textit{Abortion Act 1967} (UK), the reduction in the United Kingdom of the upper limit for lawful abortion from 28 to 24 weeks in 1991 was not replicated in South Australia, and 28 weeks sits significantly above the grey zone of viability generally acknowledged by the medical profession.\textsuperscript{48} Accordingly, of all jurisdictions that value biological traits of the fetus, South Australia permits abortion at the latest gestational age.

\textsuperscript{44} Ibid s 11(1)(c).
\textsuperscript{45} De Costa et al, above n 38, 109.
\textsuperscript{46} Criminal Code (NT) s 170.
\textsuperscript{47} Criminal Law Consolidation Act 1935 (SA) ss 82A(7)-(8).
\textsuperscript{48} Keogh et al, above n 37.
Secondly, a restraining hand is evident in the maternal health concerns that must accompany the gestational age of the fetus. The interpretation of the phrase ‘to preserve the life of the woman’ suggests either literal concern for loss of life or alternatively, serious physical or mental health conditions that does not cause death. As the legislation does not indicate that the harm must be immediate, it is possible a court will provide a broad interpretation of that phrase, similar to that which has been used in Queensland. Accordingly, the advancing age of the fetus is recognised, however concern for the mother’s life (and possibly her physical or mental health) will still override any concern to protect it.

Up until that time, abortion is lawful so long as there are greater risks to her life or to her physical or mental health. These are similar grounds to those set out in the Queensland and New South Wales case law (discussed in the previous Chapter). A point of difference though is that in South Australia, two doctors must personally examine the woman and form the same view regarding risks to the woman. Unlike the Northern Territory, neither doctor assessing and advising the woman is required to hold any particular sub specialisation in medicine such as obstetrics.

South Australian law requires the pregnant woman to be resident in South Australia, for a period of two months prior to the abortion. This could theoretically increase the possibility of abortion tourism, which has been noted earlier to occur in Queensland and Western Australia. This would make it difficult for pregnant women to obtain abortion services in this particular jurisdiction.

Overall, although South Australia permits abortion at the latest gestational age, the ease in obtaining abortion must be considered in light of the maternal health concerns that overlay the upper gestational age threshold, and the practical requirements on the woman of being physically assessed by two doctors and being resident in the State.

49 R v Bayliss (1986) 9 Qld Lawyer Reps 8, 45.
50 Criminal Law Consolidation Act 1935 (SA) s 82A(1)(a)(i).
51 Ibid s 82A(4).
5.6 Summary

Gestational age is a key criterion to lawful abortion in Western Australia, the Northern Territory and South Australia, however none of these jurisdictions share the same upper gestational age threshold. There is, however, commonality in the framework used between them that as the gestational age increases, so too does the requirement for proportionate justification via maternal health concerns. This suggests that the lawmaker correlates biological traits of the fetus with ethical issues that arise from its destruction.

Greasley notes that outrage over failed late term abortion delivering a live baby relies on similarities between the fetus and the newborn and therefore argues against fetal rights across the board.\(^{52}\) This thesis agrees with this conclusion that logically, belief in fetal personhood precludes the use of gestational age to decry abortion. This is important to understand when considering law reform.

With regard to maternal health concerns, whilst all jurisdictions use similar wording such as the ‘physical and mental health’ of the mother, there are slight differences between them such as whether the harm needs to be serious, immediate or life threatening. The definition of preserving the life of the mother has been interpreted in Queensland to include serious harm to the physical or mental health of the mother.\(^{53}\) Additionally, Western Australia specifically provides for what might properly be considered to be circumstances that underpin the serious physical and mental health concerns as well as those grounds itself. The practical effect is that it facilitates a doctor’s capacity to validate the presence of maternal health concerns for abortion under 20 weeks gestation.

However it is not clear whether this approach could be applied in jurisdictions with tiered approaches to abortion, where the preceding time frame specifically provides for serious harm to the mother’s physical or mental health and the latter refers to concerns for her life. It is reasonable to assume that there is a difference between the two, however either way the laws in these jurisdictions do not equate the life of the pregnant woman with the fetus in that she is not required to give up her life for it.

\(^{52}\) Greasley, above n 33, 420.
\(^{53}\) R v Bayliss (1986) 9 Qld Lawyer Reps 8.
As with maternal health concern requirements in New South Wales and Queensland, concerns regarding the physical and mental health of the mother are judged from the perspective of the doctors. The number of doctors involved with making the clinical decision regarding maternal health justification also differs. In Western Australia and the Northern Territory, one doctor is relevant for earlier abortion and two for a later abortion. In South Australia, two doctors must not only form an opinion but must have personally examined the pregnant woman.

Overall, the legislation in these three jurisdictions provides a framework and leaves it up to the pregnant woman and her doctor(s) to decide on the reasonableness of abortion in all the circumstances of her case. Davis and Douglas provide a useful example that demonstrates the difficulty in meeting the legal requirements in these three jurisdictions. They note the increase in selective termination for multiple pregnancies, often occurring in twins in the second trimester of pregnancy. Time wise, they conclude that such abortions would fall under the more stringent requirements of each jurisdiction.

Such abortions are performed for a variety of reasons including legitimate concerns for the mother’s physical or mental health but also for less serious reasons such as financial and social concerns of raising twins, improving the prognosis for the remaining twin (given twin pregnancy carries increased risks) and for social sex selection reasons. They conclude that the prospect of obtaining an abortion in these circumstances in these jurisdictions is quite uncertain. Unless the doctors involved are willing to say that any financial and social concerns can cause serious physical or mental health illness, it would appear that abortion in these circumstances would be technically unlawful.

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55 Ibid.
56 Ibid 164, 168, 171.
57 Ibid 173.
58 Ibid.
As was discussed in Chapter Four, Douglas et al found from a study of doctors performing abortion in New South Wales and Queensland, that doctors often manufactured mental health illness in the woman so as to ensure their decision to perform an abortion was lawful.\(^{59}\) Whether this occurs in these jurisdictions is unknown but the requirement for two doctors to agree on the seriousness of harm to befall the pregnant woman should the pregnancy continue, could make such a subterfuge more difficult to achieve.

Savell notes that fetal imagery is standard management of pregnancy throughout Australia, however 4D images may reinforce scruples people have about the wrongness of late term abortion.\(^{60}\) She concludes that the visibility of the fetus as a result of ultrasound, rather than its viability, poses a special challenge for the law.\(^{61}\) As noted above in the commentary on abortion law cases in the United States, if one were committed to pursuing the permissive abortion agenda or the primacy of maternal bodily autonomy, knowledge about the fetus is problematic where the law uses gestational age as a primary factor upon which lawful abortion is assessed.

Writing in 2007, Savell predicted that 4D ultrasounds and the like might lead to further restrictions on abortion that yield to the recognition of fetal personhood.\(^{62}\) Ultimately, this has not occurred in Australia. In fact, quite the opposite has occurred, with Victoria and Tasmania decriminalising abortion and creating abortion on demand up to 24 and 16 weeks respectively.\(^{63}\) This situation will be examined further in Chapter Seven.

Accordingly, whilst advances in medical technology make the viability of the fetus a shifting standard,\(^{64}\) it is not clear that this will necessarily result in changes to the law. This is particularly so where there is no real discussion by lawmakers as to why a particular gestational age has been chosen or where it is simply described as reflective of contemporary medical consensus.

\(^{60}\) Savell, above n 7, 103-4.
\(^{61}\) Ibid 104.
\(^{62}\) Ibid 116.
\(^{63}\) Abortion Law Reform Act 1998 (Vic) s 5; Reproductive Health (Access to Termination) Act 2013 (Tas) s 5.
Whilst further challenges to gestational age limits cannot be ruled out, this thesis suspects that they will never completely displace abortion as a lawful procedure, given its medical and social acceptance in our society. This thesis now discusses another attribute of the fetus used to justify abortion in these same jurisdictions. The presence of disability in the fetus, together with gestational age, is a lawful basis for abortion in Western Australia, the Northern Territory and South Australia. The articulation of disability as a reason for abortion is a big statement by the lawmaker of the inherently less valued status of disabled life and by extension, disabled people.
CHAPTER SIX

FETAL DISABILITY AS THE BASIS FOR LAWFUL ABORTION

6.1 Introduction

Articulating disability in the fetus as a basis for lawful abortion creates another sub category of the fetus that may be destroyed on the basis of a specific attribute. Whilst disability is a biological trait like gestational age, it differs from gestational age in that it is a static attribute that is not remedied by time. Therefore, disability abortion says something broader about the inherent value of disabled people in our society. Pringle notes that provisions that single out disability fall little short of discrimination.¹

Reproductive discrimination occurs where a person or couple experience pressure not to reproduce a child who has their familial genetic traits or where a particular type of person is not reproduced because it is judged that his or her genetic traits ought not to be reproduced.² In Australia there is no legal obligation on doctors to advise a pregnant woman to undergo an abortion for fetal disability, nor does the State place pressure on a pregnant woman to abort a disabled fetus. In practice however prenatal fetal testing is commonplace and provides the means to detect abnormalities in the fetus that may in turn lead to a woman seeking advice about an abortion.³

The current statement of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (‘RANZCOG’) recommends testing for pregnant women in the first and second trimester for certain medical conditions in the fetus.⁴ The understanding in the medical community appears to be that disability detected in the fetus is a guaranteed basis for lawful abortion in Australia.

² Nicholas Tonti-Filippini, Bioethics - Motherhood, Embodied Love and Culture (Cooper Consulting, 2013) 47.
³ This is not to suggest that all fetal disabilities are currently capable of diagnosis. See, eg Pre-Natal Testing for Trisomy 21 (Down Syndrome), Trisomy 18 (Edwards Syndrome) and Neural Tube Defects (College Statement C-Obs 4, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, July 2007).
⁴ Ibid.
The statement notes

In the event of a diagnosis of anomaly, the woman and her partner may choose to terminate or continue with the pregnancy…. There is an understanding that a termination of pregnancy would be available in the event an abnormality was diagnosed, and that the mode of termination available will be influenced by gestational age.\(^5\)

Karpin and Savell note that the understanding of disability in medicine tends to be inherently negative and can differ from how the law views disability.\(^6\) Savell notes that when it comes to fetal abnormality, tension exists between those who frame the legal argument as that of individual reproductive autonomy and those who seek to contextualise prenatal testing and abortion as social practices with broader impact.\(^7\) She argues that the fetal disability debate has raised important questions for the law including:

> Should the law permit abortion without restriction as to time or reason, provided that the woman consents and a doctor performs the procedure? If more restrictive regulation is deemed appropriate, should the law recognise fetal disability as a distinct ground for abortion? If so, should legislation stipulate a later time limit for this reason than other reasons? Moreover, should the law provide some guidance on the scope and meaning of ‘serious handicap’?\(^8\)

It is arguable that doctors have a legal duty of care to inform their pregnant patient of any abnormalities in the fetus so that the woman may seek advice, that may lead to an abortion.\(^9\) Of course such a duty is predicated on whether the particular jurisdiction permits abortion on the grounds of fetal disability or else, whether the pregnant woman’s reaction to news of the disability creates in her a physical or mental health concern sufficient to discharge the maternal health requirement of the jurisdiction (discussed in Chapters Four and Five).

\(^5\) Ibid. 1.


\(^8\) Ibid.

\(^9\) See, eg Harriton v Stephens [2006] HCA 15. This case is discussed further on in this Chapter at 6.5 (a).
In Australia, only three jurisdictions specifically provide for abortion on the basis of fetal disability. Even where there are no such provisions in a jurisdiction’s abortion law, Gleeson notes clear instances of judicial acceptance of fetal disability as a circumstance that automatically qualifies a pregnant woman grounds for abortion, based on the serious affect giving birth to a disabled child would have upon her.¹⁰

Whilst such news may indeed provide the circumstances that lead to a woman developing a serious mental health condition, laws that permit a pregnant woman to seek abortion on maternal health grounds can be differentiated from laws that make an explicit judgment on the inherent value of disabled life.¹¹

This Chapter reviews those jurisdictions in Australia where fetal disability is a basis for lawful abortion. It considers any differences between the provisions and whether it integrates with the gestational age of the disabled fetus and child destruction offences. Given the absence of case law interpretation, this Chapter considers how disability is characterised in other legal scenarios, specifically, wrongful birth claims, preimplantation genetic diagnosis, and end of life decisions for disabled neonates.

6.2 Western Australia

In Western Australia, abortion after 20 weeks gestation is lawful where two doctors who are members of a panel of at least six doctors appointed by the Minister agree that the unborn child has a severe medical condition that justifies abortion in the clinical judgment of those doctors.¹² The doctors’ view of disability in the fetus determines the lawfulness of an abortion. Interestingly, there is no legal requirement that either of the doctors must have any sub specialisation in medicine to assist them in this decision and there is no case law to assist with the interpretation of what types of conditions would meet the requirement of a ‘severe’ medical condition.


¹¹ Pringle, above n 1, 217.

¹² Health Act 1911 (WA) ss 334(3),(4),(7). The current approved medical facility is the Kind Edward Memorial Hospital.
Clearly, serious fetal disability as a ground for lawful abortion is complicated because of value judgments regarding quality of life of disabled people. Karpin and Savell note that empirical evidence suggests that people with disabilities rate their quality of life higher than those without disabilities, who tend to overrate the impact of impairment. This is an important observation where doctors are the ones advising on whether a disability is serious enough to justify destruction of the fetus.

It is significant to note that any previous concern for the mature fetus in Western Australia is overridden by concern for the existence of fetal disability. Very late term abortion on the basis of severe disability in the fetus would appear to be lawful. This is in contrast to the Northern Territory and South Australia where maternal health concerns are the only reason for lawful late term abortion.

Given Western Australia also has provisions for lawful late term abortion on the basis of a serious medical condition on the part of the pregnant woman, the disability provision covers any gap whereby the pregnant woman’s reaction to news of the disability does not meet the maternal health requirement. This thesis refers back to discussion in Chapter Four regarding doctors manufacturing maternal mental health illness to meet the requirement for lawful abortion. In a study by Douglas et al on doctors from New South Wales and Queensland, where maternal health concerns are the only basis to consider abortion lawful, the authors sought participants’ views on the lawfulness of a second trimester abortion due to a non-life threatening fetal disability (Down Syndrome) detected at 14 weeks where the mother denied any impact on her mental health.

Interestingly, the majority of participants felt the fact of fetal disability alone was not sufficient grounds for abortion on maternal health grounds. However, many reported that they would still provide abortion despite the woman falling short of serious dangers to her mental health should the pregnancy proceed. The Western Australian legislation, therefore, provides a remedy for this dilemma.

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13 Karpin and Savell, above n 6, 24-5.
14 Health Act 1911 (WA) s 334.
16 Ibid 569-71.
The detailed consent requirements in the Act involving counselling, discussed in Chapter Five, make clear that it is not a eugenic clause and that it is instigated by the pregnant woman after she has received counselling for the decision to undergo abortion or proceed to birth of the child. Accordingly, abortion on the basis of disability is a strong statement by the Western Australian legislature about the negative quality of life of disabled people.

6.3 **Northern Territory**

In addition to maternal health concerns and gestational age, the Northern Territory articulates disability in the fetus as a valid basis for lawful abortion. When referring to the degree of disability in prenatal life that will cause an abortion to be lawful, section 11 of the *Medical Services Act* (NT) provides that lawful abortion requires ‘...a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities ...’

Accordingly, there need not be proof that the fetus has a serious medical condition at the time of the decision for abortion. The terms ‘substantial’ risk and ‘serious physical or mental handicap’ are not defined in the Act, nor is there any case law to assist with the interpretation of these sections. It is clear from the wording of the provisions that both factors must exist. A quantifiably small risk of a serious handicap would arguably not meet the requirements nor would a substantial risk of a moderate handicap. How would infractions to the law be policed? Overall, the correctness of any advice might be impossible to prove if the abortion occurs.

Two medical practitioners must opine that there is a substantial risk of serious physical or mental handicap. One of them must be a gynaecologist or obstetrician. There is no requirement that one of the doctors be a specialist in genetics. This gives rise to a concern as to whether the two doctors have sufficient knowledge to discuss the risk of a serious physical or mental handicap in the fetus and what it is likely to mean should the child be born.

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17 *Health Act 1911* (WA) ss 334 (5)-(6).
18 *Medical Services Act* (NT) s 11(2). The provision makes an exception where it is not reasonably practicable in the circumstances to get a gynaecologist or obstetrician to examine the woman.
A lawful abortion for a substantial risk of serious physical or mental handicap may only occur where the woman has been pregnant for not more than 14 weeks.\textsuperscript{19} Clearly, this provision will not assist the pregnant woman who is ignorant of the risk of serious disability in the fetus after this time frame. Also, it does not acknowledge any limitation on testing that may require maturation of the fetus in order to determine either the existence of the medical condition or the likely severity of such a condition on the child, should they be born.

As discussed in Chapter Five, between 14 and 23 weeks gestation, the justification for a lawful abortion in the Northern Territory centres solely on the pregnant woman and an \textit{immediate} need to prevent serious harm to her physical and mental health.\textsuperscript{20} After 23 weeks gestation, the sole concern is for preservation of the pregnant woman’s life.\textsuperscript{21}

For a pregnant woman discovering a substantial risk of a serious physical or mental handicap in the fetus between 14 and 23 weeks gestation, it is arguable that she could rely on the effect such news had upon her immediate mental health. Such news could cause fears of additional work, burden and expense in caring for a special needs child and how this will curtail her freedom to enjoy life into the future, or indeed the woman’s concern for the suffering and difficulties the child will have to face. If two medical practitioners considered such concerns seriously affected the mother’s mental health \textit{at that time}, then the abortion could well be lawful.

It is not clear whether there is the political will to increase the upper gestational age threshold for abortion on the basis of fetal disability. Such an amendment would determine whether the legislature preferences gestational age over fetal disability. This thesis suspects that if the core of the provisions is a de-valuing of life based on disability, then there may be little opposition to increasing the gestational age threshold for disability abortion. Indeed, this is more probable when one considers end of life decisions for disabled neonates, discussed further in 6.5, below.

\textsuperscript{19} \textit{Medical Services Act} (NT) s 11(1)(d).
\textsuperscript{20} Ibid s 11(3).
\textsuperscript{21} Ibid s 11(4).
As it stands, the Northern Territory’s abortion laws give precedence firstly to the mother’s life, then her health, and lastly to fetal disability. It is in synch with the gradualist approach to the lawfulness of abortion, as discussed in Chapter Five. More serious concerns are required as the gestation of the fetus increases. Unlike Western Australia, a serious condition in the fetus will not overshadow the gestational age of the fetus.

6.4 South Australia

South Australia uses almost exactly the same wording as the Northern Territory when referring to the degree of disability in prenatal life that will cause an abortion to be lawful. Both are modelled on the Abortion Act 1967 (UK). Gleeson notes that historically, the Abortion Act 1967 was passed in response to the thalidomide crisis, and the provisions can be read as expressing a redundant concern for a pregnant woman’s well being in the extraordinary case that the fetus is impaired.

Section 82A(1)(a)(iii) of the Criminal Code Consolidation Act 1935 (SA) provides for lawful late term abortion up to 28 weeks gestation on the basis ‘... that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.’ Accordingly, maternal health concerns and fetal disability, whilst being separate bases for a lawful abortion in South Australia, are both limited by the same gestational age threshold.

There is no definition of the terms ‘substantial’ risk and ‘serious physical or mental handicap’. Two legally qualified medical practitioners must give such advice to the pregnant woman. Their sub speciality is not indicated. Accordingly, the accuracy of advice pregnant women may receive regarding the degree of risk and the likely level of handicap could be in doubt.

22 Gleeson, above n 2, 429.
23 Ibid 431.
24 Criminal Code Consolidation Act 1935 (SA) s 82A(1)(a).
The medical practitioner performing the abortion may be the same practitioner advising the pregnant woman on the presence of a substantial risk of serious handicap in the fetus, and it must occur in hospital.\textsuperscript{25}

Ultimately, in South Australia, abortion laws give precedence firstly to the mother’s life, then fetal disability. It is in synch with the gradualist approach to the lawfulness of abortion, as discussed in Chapter Four. Unlike Western Australia, and in line with the Northern Territory, a serious condition in the fetus will not overshadow the gestational age of the fetus. However the upper gestational age limit for abortion for fetal disability in South Australia is twice that of the Northern Territory. Concerns about failed late term abortion, addressed in Chapter Five of this thesis, apply here but where the child is disabled, there may be a basis to withdraw or withhold medical treatment on the basis that it is not in the best interests of the child. This will be discussed further at 6.5(c).

By making severe disability, or the risk of it, a basis for abortion, it begs the question of what constitutes a severe disability. Given the absence of case law interpretation for abortion disability, this thesis discusses how disability is perceived in associated areas of law.

\section*{6.5 Related Legal Issues Regarding Disabled Prenatal Life}

\subsection*{6.5 (a) Wrongful birth claims}

Whilst the legislation in each of these jurisdictions is not coercive or mandatory, at the very least its practical outcome is to enshrine a value judgment that disability can be unacceptable in a fetus and not in their best interests to be born. If that is the case, then two questions arise; can a disabled person sue for negligence leading to a missed opportunity for the mother to seek an abortion? Can the person sue for the harm of being born?

\textsuperscript{25} Ibid.
This question was addressed definitively by the High Court in *Harriton v Stephens* (‘*Harriton’). Here the appellant argued that had the defendant doctor diagnosed rubella infection in her mother in a timely way, her mother would have undergone a lawful abortion. This would have resulted in the plaintiff not being born and, therefore, not suffering a life of disabilities that included being deaf, dumb and blind. The appellant sought damages for the extraordinary costs associated with having to live with disabilities.

The plurality of the judges of the High Court found against the appellant on the basis that she lacked standing to bring such a claim, with an insufficient nexus between the doctor’s failure to provide information to her mother that would have led to the plaintiff being aborted and the plaintiff being born. Such a proposition was said to offend the Sanctity of Life principle and so accordingly, public policy concerns precluded the appellant from taking her action further. This is an interesting comment in light of the fact that disability abortion provisions specifically rest on a quality of life argument in that disabled prenatal life is less valued and therefore more expendable than non-disabled prenatal life.

Parents of a disabled child may sue for the costs of raising the child born or conceived as a result of a doctor’s negligence. These cases require the plaintiff to prove that either conception would have been prevented or that earlier diagnosis of either the pregnancy or an unacceptable disability in the fetus would have led to a lawful abortion. Legislation in some jurisdictions restricts damages for the costs of raising the child to the extraordinary costs of raising a disabled child.

This seems to be tacit affirmation in those jurisdictions that the parents of a disabled child are more deserving and ought to be compensated for their burden. It supports the rationale that disability is an unwanted attribute in a person.

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26 [2006] HCA 15.
27 Ibid per Hayne J [181]-182], Callinan J [206], Crennan J [243], [252], 263.
28 Gleeson, above n 2, 423.
In the English case of *Parkinson v St James and Seacroft University Hospital NHS Trust*\(^\text{30}\) the plaintiff brought a medical negligence claim for compensation arising from a failed sterilisation leading to the birth of a child with severe learning difficulties and special needs. Brooke LJ noted the subjectivity of the debate and stated:

"... What constitutes a significant disability for this purpose will have to be decided by judges, if necessary, on a case-by-case basis. The expression would certainly stretch to include disabilities of the mind (including severe behavioural disabilities) as well as physical disabilities. It would not include minor defects or inconveniences, such as the lot of many children who do not suffer from significant disabilities.\(^\text{31}\)"

To date, there have been no Australian cases that have interpreted the degree of disability sufficient to satisfy the legislative exceptions of being awarded damages for the wrongful birth of a disabled child. It is assumed there would be a variation of positions on how significant a disability needs to be to qualify for damages.

Assisted reproductive technologies, where human embryos created outside the human body can be discarded by parents based on disability may provide further insight into the medical and legal position on the value of disabled life and are discussed below.

**6.5 (b) Disability in the Embryo**

Pre implantation genetic diagnosis (‘PGD’) is a technology that allows the detection of certain genetic characteristics prior to implanting an embryo into the womb, such as gender, serious heritable diseases and disabilities that will be apparent at birth or very early childhood or certain late onset conditions.\(^\text{32}\) Embryos can be screened and either selected or de-selected by their parents based on the results of this testing, subject to any legislative prohibitions.\(^\text{33}\)

\(^{30}\) [2002] QB 266.

\(^{31}\) Ibid [52].


\(^{33}\) Ibid.
Much like abortion for fetal abnormalities, PGD provides the platform from which the woman or couple may consider whether or not to avail themselves of further medical advice. Such advice could well lead to them de-selecting an affected embryo so that it is destroyed and never born. Although it deals with the same issue, that is the destruction of disabled prenatal life, Karpin and Bennett note that PGD has been hailed as a means of making reproductive decisions ‘without having to face the heart-wrenching decision to abort an affected fetus’.  

Karpin and Savell note the ongoing debate about whether disability avoidance strategies constitute or contribute to disability discrimination. They state that it is not clear that the pursuit of better lives can be separated from eugenics and contemporary selection practices. Further, they note that critical feminist scholars and disability rights advocates question whether the pregnant woman’s choice to abort based on fetal disability is really a free choice, given the reality that services for the disabled may be limited.

The principle underpinning the practice of PGD is that a parent has the right to choose certain characteristics of their child either because they do not want their child to suffer from a particular condition and/or they do not want to endure the effects such disability may have upon their parental responsibilities. However there are limits to its use. Whilst some states have legislation that deals with assisted reproductive technologies, where there is no specific legislative framework covering a particular practice or technology in a jurisdiction, the National Health and Medical Research Council’s (NHMRC), Ethical Guidelines on the use of Assisted Reproductive Technology in Clinical Practice and Research (‘the Guidelines’), are the nation’s reference point.

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35 Karpin and Savell, above n 6, 30-1.
36 Ibid 33.
37 Ibid 42.
38 Contra Isabel Karpin, ‘Choosing Disability: Preimplantation Genetic Diagnosis and Negative Enhancement’ (2007) 15 Journal of Law and Medicine 89. Karpin notes instances where people have chosen to reproduce a particular disability such as deafness though she notes that in Australia, the consensus is to use PGD to select against serious disability.
39 Assisted Reproductive Treatment Act 2008 (Vic); Assisted Reproductive Treatment Act 1988 (SA); Assisted Reproductive Technology Act 2007 (NSW); Human Reproductive Act 1991 (WA).
40 National Health and Medical Research Council Guidelines, above n 32.
Arguments against PGD listed in the Guidelines include that it implies that admission to life is no longer unconditional and it establishes a principle whereby parents choose the qualities their children have, with the process shaping a child to a parent’s idea of perfection and cultivating a diminished tolerance to difference or prevent the birth of people who are carriers of a disease or disability that may be passed on to their offspring even when the carrier is expected to live a normal life.\textsuperscript{41}

Arguments for PGD include that by weeding out such embryos from existence, a family may be spared the tragedy of having the burden of caring for a child with a deadly disease, it may reduce the economic and social costs of caring for the incurable in our society, and assist couples to not pass on heritable disorders by being dissuaded from having children.\textsuperscript{42}

Clearly, these are controversial issues involving a value judgment. However where the law ascribes to the gradualist approach to abortion, then against the background of denying the fetus a legal personality, a human embryo has arguably less legal relevance than the fetus in utero. Logically, it would follow that requirements for a severe disability in PGD embryo might be less onerous than those required for the fetus in utero.

Karpin and Bennett note that a distinction between what is a normal genetic variation and what is an illness is not always straightforward. With the potential for the technologies to be used for non-therapeutic purposes, and the fact that our understanding of health, disability and normality are contested, they argue that the role the law should play in regulating reproductive decision-making needs further discussion and consideration of competing claims by State, Federal and international law.\textsuperscript{43}

\textsuperscript{41} Ibid, 55 [12.1].
\textsuperscript{42} Ibid, 55 [12.1].
Karpin and Savell note the complex regulatory framework for PGD can create confusion for people, clinicians, policy makers and parents and like abortion, it can promote reproductive tourism.\textsuperscript{44} Further, they note that in those jurisdictions in Australia that allow abortion on the grounds of a risk of serious disability in the fetus, a prescriptive approach to setting out just what that means, by way of lists of such conditions or by using different language such as ‘lethal’, ‘life threatening’ or ‘incompatible with life’ have been considered, debated and rejected.\textsuperscript{45}

Parliament, they say, have left the definition to the judgment of clinicians so that the legislative parameters around fetal disability are highly dependent on the ethics of the woman seeking the abortion on that basis and the doctors making that decision.\textsuperscript{46} In practical terms, this is an easier option no doubt then politicians committing to such an ethically charged and potentially polarising subject.

It is not at all clear whether the concept of a serious medical condition for PGD purposes equates to a serious medical condition required for abortion on the basis of fetal disability. This is still a developing area of legal regulation that involves complex ethical and social issues. However it is clear that there is a basis in related law to argue that disability is not a welcome attribute in a person. It raises the issue of why there needs to be a gestational age threshold for fetal disability as a basis for lawful abortion, which in turn raises issues of end of life issues for people.

Acceptance of quality of life arguments as the basis for ending life is another strong argument that disability itself creates a sub category of people and not just a sub category of the fetus. This thesis now considers how the law deals with ending the life of the disabled neonate.

\textsuperscript{44} Karpin and Savell, above n 6, 155.
\textsuperscript{45} Ibid.
\textsuperscript{46} Ibid 156.
6.6 (c) *End of Life Decisions for Neonates*

In practice decisions to withdraw or withhold medical treatment for disabled neonates are made daily. 47 Tibballs argues that the phrase ‘best interests of the child’, whilst a rationale for both the courts and clinicians, is ill defined and that to speak of best interests is a meaningless, nonsense term. 48

He queries if it is in the best interests of a patient to have their life sustained by treatment, how can withdrawing such treatment, which will cause death, be in their best interests? 49 He concludes it is preferable to speak of the futility of such treatment or the overwhelming burden of such treatment or the lack of quality of life, with ethical and clinical guidelines developed from legal principles so as to affect a transparent basis for such an important decision. 50

In cases involving withholding or withdrawing of treatment to disabled neonates, court decisions although not abundant, are indeed available though it should be noted that they are extremely fact dependant. The courts have ruled that in certain circumstances, disabled life is still worth living.

An often-quoted decision is the United Kingdom case of in *Re B (a minor) (Wardship: Medical Treatment)* that involved a baby living with Down Syndrome who required an operation to remove an intestinal blockage. 51 The parents of B did not consent to the surgery, arguing that it was not in their child’s best interests to live another 20-30 years with severe physical and mental handicaps. 52 Although confirming that the child’s quality of life was a relevant factor to be taken into consideration when making the decision, the Court of Appeal denied the parent’s application and ordered that the surgery be performed. 53

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47 James Tibballs, 'The Legal Basis for Ethical Withholding and Withdrawing of Life-Sustaining Medical Treatment in Children' (2006) 14 Journal of Law and Medicine 244, 245.
48 Ibid 256.
49 Ibid 260.
50 Ibid 260-1.
52 Ibid 1421.
53 Ibid 1424.
Templeman LJ noted that the test was whether the life of the child was demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die.\textsuperscript{54} Ultimately, the Court held that that although the child was likely to be very physically and mentally disabled, having Down Syndrome provided the child an expectation of a reasonable quality of life.\textsuperscript{55} Importantly, both Templeman L.J and Dunn L.J noted that there was no reliable prognosis for the child until she was around two years old, and therefore no evidence that her life was going to be intolerable.\textsuperscript{56}

A more recent decision was that of \textit{NHS Trust v MB}, an English case involving a dispute between the parents of an 18-month-old child suffering from spinal muscular atrophy, a progressive and incurable condition causing complete paralysis but often intact brain function.\textsuperscript{57} The hospital sought a declaration to withdraw mechanical ventilation from the child on the basis that it was futile treatment, causing discomfort, pain and distress to the child and creating an intolerably poor quality of life in circumstances where there was no chance of recovery or prevention of death.\textsuperscript{58} The parents sought their own declaration that the hospital be ordered to perform a tracheostomy to enable their child to have long-term ventilation.\textsuperscript{59} They argued that he was cognisant and could enjoy life. He could see and hear and had a bond with his parents and siblings.

An extensive list of the benefits as opposed to burdens was tendered to the court, with the burdens outweighing the benefits, but despite this, the court determined the best interests of the child were served with continued mechanical ventilation.\textsuperscript{60} It would not order the hospital to perform a tracheostomy in circumstances where the doctors of the child did not wish to do so.\textsuperscript{61} Accordingly, withdrawal of treatment was denied but withholding treatment permitted.\textsuperscript{62}

\textsuperscript{54} Ibid1423.
\textsuperscript{55} Ibid 1424.
\textsuperscript{56} Ibid 1423-1424.
\textsuperscript{57} [2006] 2 EWHC 507 (Fam).
\textsuperscript{58} Ibid [5].
\textsuperscript{59} Ibid [10].
\textsuperscript{60} Ibid [60].
\textsuperscript{61} Ibid.
\textsuperscript{62} Ibid.
This case also highlights the conflict such decisions have on medical staff that may strongly believe that treatment to continue life is wrong. This is similar to cases referred to in Chapter Three involving maternal refusal of medical treatment likely to cause death of the fetus.

Giubilini and Minerva argue that ‘after-birth abortion’ should be permissible when the same set of circumstances apply that would have permitted a pre-birth abortion. Ultimately, they philosophically equate the fetus with the newborn as a potential person whose value and admission to life is trumped by the concerns of actual people. In respect of fetal disability, they argue there are many abnormalities that may be present in the fetus but not detectable during a woman’s pregnancy or there may be brain damage caused to the child in the perinatal period, during the labour and delivery. In respect of maternal health concerns, they argue that if social, psychological and economic concerns are good enough reasons for a lawful abortion, then they ought to be good enough reasons to justify killing a potential person.

Whilst this may sound radical, it is consistent with the observation made in this thesis in Chapters Four and Five that where maternal health concerns or fetal disability can trump gestational age as a lawful reason for abortion, the only thing preventing infanticide is the born alive rule, which provides a restraining hand. Savulescu notes that actions to end the life of a newborn are not classified as infanticide where the decision is made by a doctor for medical reasons. Accordingly, end of life decisions are made on a different basis from those for older children because parents are given a broader discretion in the decision making process. He concludes that if that is so, then the social antipathy to infanticide is not as strong as it might initially seem.

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64 Ibid 261-2.
65 Ibid 261.
66 Ibid 263.
68 Ibid.
69 Ibid.
There is some merit to the reasoning in this argument. At the end of the day, Australian law stipulates that once born alive, the child is a legal person subject to the usual rights and protections. The born alive rule acts as a point of restraint regarding behaviour that requires both legal and medical justification. Logically, it is not clear why, if disability is a bar to being born, that it is not also a reason to terminate life after death.

The court has a difficult decision to make and is required to look to a variety of sources to consider whether or not life is worth living. Community attitudes to disability, including those of experts called on in cases, and the personal view of judges makes it difficult to predict outcomes.

6.6 Summary

Fetal disability as a basis for abortion is articulated as a standalone reason for a lawful abortion in three states of Australia today. It overcomes any practical concerns about whether the mother’s reaction to the disability in the fetus needs to have a particular impact on her mental health. The limitations however are that in the Northern Territory and South Australia, a substantial risk of a severe physical or mental handicap in the fetus is still subject to gestational age thresholds.

Accordingly, considered as a whole, both the Northern Territory and South Australian abortion laws subscribe to the gradualist approach to abortion. Maternal health concerns are also important and in fact, can prevail over gestational age or fetal disability, although these need to involve a threat to her life or health as the fetal gestation increases. Western Australia however permits abortion for a serious medical condition of the fetus in spite of its gestational age. By identifying fetal disability as a valid basis for lawful abortion, all three jurisdictions would appear to de-value seriously disabled life.

In today’s society, that is not a particularly shocking statement. The acceptance and lawfulness of PGD practices provide further support for this observation. Fetal disability abortion legislation basically leaves it up to the pregnant woman and her doctors to decide on the reasonableness of the abortion, subject to the guidelines.
The laws discussed in this Chapter are created by the State rather than by development of the common law. This is not to suggest that we have State sponsored eugenics, given the requirement for maternal consent to abortion. At the end of the day, abortion on the basis of fetal disability is only ever considered where the mother requests it. It is therefore the attitude of the mother and the value she ascribes to the disabled fetus that it is the starting point for any discussion on abortion and this directly falls within the concept of maternal bodily autonomy.

The standard use of fetal diagnostic testing and the general availability of abortion in the earlier stages of pregnancy, together with assisted reproductive technology and its capacity to offer destruction of unwanted prenatal life with no physical side effects for the woman, suggests that our society expects the law to fit in with its expectation of reproductive liberty and the desire for a healthy child.

To make fetal disability a basis for a lawful abortion has the potential to negatively affect people’s attitudes to those living in the community with serious disabilities. The effect of such attitudes on our society cannot easily be measured. However as Hart notes:

…it cannot be seriously disputed that the development of law, at all times and places, has in fact been profoundly influenced both by the conventional morality and ideals of particular social groups, and also by forms of enlightened moral criticism urged by individuals, whose moral horizon has transcended the morality currently accepted.  

In support of this conclusion, and using the dramatic change in American society’s morals towards race relations following changes to the law, George notes that it is naïve to discount the effect law can have on shaping the perceptions of the morality of things. Gleeson too notes that public policy that endorses the view that the disabled fetus is more expendable and offered less protection than a non-disabled fetus, that is only expendable if they threaten the pregnant woman’s health must impact on the lives of disabled people.

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72 Gleeson, above n 2, 431.
This thesis contends that permitting disability as a lawful basis for abortion raises some concerning questions about what message it sends to the broader community about the value of disabled life, and what future laws may be generated that are underpinned by this perspective and affect disabled people. This reveals the personal bias of this thesis that may well be the minority view in the community.

This thesis now reviews the laws of abortion in the balance of the jurisdictions, being Victoria and Tasmania, where there is abortion on demand up to a certain gestational age, as well as the Australian Capital Territory, which has limited legal regulation of abortion. This review of each jurisdiction’s laws regarding destruction of the fetus forms the basis of the final discussion in this thesis on whether conscientious objection by doctors to participating in abortion can co-exist with laws that de-value the fetus.
Chapter Seven

Abortion on Demand Up to a Particular Gestational Age

7.1 Introduction

Abortion on demand makes the reasons for which a pregnant woman seeks an abortion irrelevant to the question of whether the procedure is lawful. It suggests the State has no interest in protecting the fetus, based on the position that the fetus is not an entity of value and abortion is purely about women’s rights to bodily autonomy.

Abortion law reform occurred in Victoria\(^1\) and Tasmania\(^2\) in 2008 and 2013 and provided abortion on demand to pregnant women up to 24 and 16 weeks respectively. Interestingly, whilst they have a similar overall purpose, that is to decriminalise abortion and make access to abortion easier, the lawmakers were unable to agree on the upper gestational age limit for abortion on demand. Of note, although Tasmania has the more recent legislation, it was unable to obtain parliamentary support for the 24-week threshold and instead accepted a more restrictive upper gestational age limit.

In line with widening access to abortion, both states created statutory duties on doctors who conscientiously object to performing or participating in abortion to refer the pregnant woman on to another doctor who does not conscientiously object. They also compel them to perform an abortion if the woman’s life or her health is at risk.\(^3\) Statutory duties on doctors that flow from these rights to abortion will be explored in Chapter Eight.

The focus of this present Chapter is to compare and contrast abortion law reform in these jurisdictions and consider its limitations. It will also consider the issue of social sex selection, where the fetus is aborted on the basis that the woman does not want a child of a particular gender.

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\(^1\) Abortion Law Reform Act 2008 (Vic), s 4.

\(^2\) Reproductive Health (Access to Termination) Act 2013 (Tas) s 4.

\(^3\) Abortion Law Reform Act 2008 (Vic) s 8; Reproductive Health (Access to Termination) Act 2013 (Tas) s 6(3).
Whilst the Australian Capital Territory does not technically have abortion on demand, its legislation is not in accord with the three themes of maternal health concerns, gestational age or fetal disability prescribed in the legislation and case law of the other seven jurisdictions of Australia. Given there is arguably minimal legal interference in the practice of abortion in the Australian Capital Territory, its abortion laws will be also discussed in this Chapter.

7.2 Victoria

Prior to the passing of the Abortion Law Reform Act 2008, the lawfulness of an abortion was based on the 1969 decision in R v Davidson.\(^4\) The case involved the prosecution of a doctor under section 65 of the Crimes Act 1958 (Vic) for performing an unlawful abortion. During the trial, Menhennit J directed the jury to consider whether the defendant held an honest belief on reasonable grounds that the abortion was both necessary and proportionate, with necessary meaning that the abortion was necessary to preserve the pregnant woman from serious danger to her life or to her physical or mental health beyond those of normal childbirth, and proportionate meaning the abortion was not out of proportion to the danger to be averted.\(^5\) The jury ruled in favour of the defendant and the doctor was acquitted.

The ruling was adopted in New South Wales in R v Wald\(^6\) discussed in Chapter Four. The ruling made no reference to the age of the fetus as being a relevant criterion for a lawful abortion to occur in Victoria. Late term abortions, however, still elicit concern in the community. For example, much media attention occurred around a late term abortion performed in Victoria in 2000. The woman was 32 weeks pregnant and was told by doctors that her unborn child suffered from skeletal dysplasia.\(^7\) She attended the Royal Hospital for Women and requested an abortion, threatening to kill herself if an abortion was not performed. The doctors attending to her decided that the threat was real and that the performance of a late term abortion was justified and lawful, and it was carried out.\(^8\)

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\(^5\) ibid 671 [50].
\(^6\) (1971) 3 DCR (NSW) 25.
\(^7\) (2006) VACA 85 [1].
\(^8\) ibid [85].
There were concerns that the fetus did not actually suffer from the condition that induced the mental health concern in the woman\(^9\) but ultimately the doctors involved were not prosecuted and an opportunity to clarify abortion laws and the impact of gestational age as opposed to maternal health on the lawfulness of abortion was lost.

In 2007, the Law Reform Commission of Victoria reviewed the Victorian laws regarding the crime of abortion as set out in section 58 of the *Crimes Act 1958* (Vic). The purpose of the review was so that the law could be ‘modernised, clear and [be] widely understood’ with the government’s aim to neither expand the extent to which abortion occurs nor restrict access to services.\(^{10}\) Following this review, Parliament enacted legislation to decriminalise the practice of abortion and remove the offence of child destruction through the *Abortion Law Reform Act 2008* (Vic).

As a result of the reforms, Victoria has very liberal abortion laws. Under the Act, abortion is legal in Victoria for pregnant women up to 24 weeks gestation for whatever reason and without the need for the woman to satisfy any criteria or for the doctor to act as the gatekeeper regarding the lawfulness of the act.\(^{11}\) There is no need for a doctor to provide any counselling to the pregnant woman regarding her decision to abort at that time.

The choice of the upper gestational age for abortion is in line with the United Kingdom’s *Abortion Act 1967*. This thesis notes previous comments made in Chapter Five regarding fetal viability and failed late term abortions resulting in live births. A practical concern, the purpose of an upper limit is reflective of medical opinion on the viability of the fetus, however there is no mention of the fetus in the provisions for a post 24 weeks gestation abortion. After 24 weeks gestation, a doctor may perform an abortion only when they consider the abortion is appropriate in all the circumstances and they have consulted with at least one other doctor who also reasonably believes that the abortion is appropriate in all the circumstances.\(^{12}\)

When considering whether the abortion is appropriate after 24 weeks gestation, the doctor must have regard to all the relevant medical circumstances and the woman’s

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\(^9\) Ibid [85].


\(^{11}\) *Abortion Law Reform Act 2008* (Vic) s 4.

\(^{12}\) Ibid s 5.
current and future physical, psychological and social circumstances. There is no case law currently available to assist with the interpretation of the precise maternal circumstances that will satisfy this requirement. However the phrase ‘appropriate in all the circumstances of the case’ seems to be an expanded version of the previous Menhennit ruling.

Accordingly, under the Abortion Law Reform Act, there is no requirement that the abortion be considered by the doctors to be a proportionate act. Her life need not be at stake. Immediate grave concerns for physical or mental health do not apply. As was argued in Chapter Four, the basis for any prosecution of a doctor must be that the doctor performing the abortion did not hold a reasonable belief about the matters in question. With no agreement in the community, let alone amongst doctors, as to the ethical value of prenatal life, it would seem impossible to judge a doctor’s view that the abortion was or was not appropriate in all the circumstances. To do so would be to attack the doctor’s personal views on the subject.

In commenting on the framework for the Abortion Act 1967 (UK) which is largely used in Victoria post 24 weeks gestation, Greasley notes that it cannot be the meaning of the statute that every conceivable reason for not having an abortion, including those that are trivial or irrational is deemed legally acceptable so long as the desire for abortion by the pregnant woman is sufficiently intense. She notes that the purpose of the Act is to provide exceptions to an otherwise unlawful act where but for the particular impediment, the baby was wanted by the pregnant woman.

However where the intention is to provide abortion on demand, any trivial reason for abortion would appear to be lawful. The capacity to access a lawful medical abortion in Victoria after 24 weeks would seem to be relatively easy if one can locate a doctor who shares the same views on the appropriateness of abortion and is sympathetic to the general situation.

On this point, it is worth noting the controversial case of Dr Mark Hobart, a Victorian general practitioner who refused to refer on for abortion a woman who was 19 weeks

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13 Ibid s 5(3).
16 Ibid.
pregnant with a female fetus. The woman sought the abortion because she wanted a boy. This is an interesting scenario that integrates the issue of social sex selection as a legitimate basis for abortion and conscientious objection.\textsuperscript{17} Suffice it to say that Victoria has committed to a permissive agenda regarding access to abortion, essentially leaving much of the policing in regards to the appropriateness of this practice to the medical community.

It is not clear whether a doctor’s opinion that a sex selection abortion after 24 weeks is not appropriate will fall within the scope of a reasonable belief held by them that meets the statutory requirements, or a conscientious objection. Imposing on the community the notion that a woman has a right to access abortion for any reason is also a moral belief. It seems clear that the purpose of the Victorian law is to ensure women may access abortion. Accordingly, a pregnant woman in Victoria arguably has a right to abortion, with very minimal medical input into the decision.\textsuperscript{18} The end result appears to be that a pregnant woman seeking an abortion in Victoria, even a late term abortion, will probably achieve that end.

Repeal of the child destruction offence removes any concerns that a late term abortion in Victoria might become a de facto crime. Where a late term abortion results in a live birth, reliance on end of life decisions for disabled neonates would arguably cover denial of resuscitation to the baby to ensure its death.\textsuperscript{19} Conscientious objection by doctors to late term abortion may occur and this will be discussed further in Chapter Eight.

\textsuperscript{17} Miranda Devine, ‘Doctor risks his career after refusing abortion referral’ The Herald Sun (online), 5 October 2013, \url{http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/story-fni0ffsx-1226733458187?nk=ecfb38feadba99ac69e1dc8a421a5a4}.


7.3 *Tasmania*

Abortion on demand is lawful in Tasmania up to 16 weeks gestation under the *Reproductive Health (Access to Termination) Act 2013* (Tas).\(^{20}\) After 16 weeks gestation, abortion is lawful if two doctors certify in writing that they reasonably believe that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.\(^{21}\) In assessing the risk, the woman’s current and future physical, psychological, economic and social circumstances are relevant factors for consideration.\(^{22}\)

Tasmanian abortion laws are arguably very similar to Queensland, New South Wales and Western Australia when adjusted for abortion after 16 weeks gestation. Arguably, they are not as permissive as Victoria, given the upper gestational age limit for abortion on demand is some eight weeks lower and given that an assessment that there is a serious risk of injury to physical or mental health is required as opposed to the more elastic ‘in all the circumstances’ provision in Victoria.

Like Victoria, in Tasmania, doctors with a conscientious objection to abortion are required under the legislation to perform an abortion where it is deemed necessary to save the life of the woman or to prevent her from suffering serious physical injury.\(^{23}\) This will be explored further in Chapter Eight.

However despite having a lower limit for abortion on demand compared to Victoria, the Tasmanian legislation makes it illegal for people to protest abortion where such protest can be seen or heard by a person accessing the abortion clinic.\(^{24}\) The penalty for such behaviour is harsh, being 75 penalty units or 12 months imprisonment or both.

\(^{21}\) Ibid s 5(1)(a).
\(^{22}\) Ibid s 5(3).
\(^{23}\) Ibid s 6(3).
\(^{24}\) Ibid s 9.
Accordingly, the clear purpose of this legislation is to remove as many obstacles as possible to permit pregnant women access to abortion.\textsuperscript{25} Although it retains arguably more medical oversight than permitted in Victoria, it has a broader impact on the community to support the notion of abortion as a non-controversial, standard medical service as opposed to the destruction of human life.

7.4 The Australian Capital Territory

The Australian Capital Territory does not share the three themes that have been discussed in Chapters Four to Six that specify serious maternal health concerns, gestational age limits and fetal disability. The act of abortion was decriminalised via the \textit{Crimes (Abolition of Offence of Abortion) Act 2002} (ACT) and is regulated under the \textit{Health Act 1993} (ACT). There is no gestational time limit as to when abortion may not be performed.

The presence of any fetal abnormality is not a stated relevant consideration nor is there a need to demonstrate that abortion is a proportionate response to health concerns for the pregnant woman. There is no requirement for counselling to be provided to the pregnant woman. Rather, regulation is restricted to two criteria; firstly, the abortion must be performed by a medical doctor, and secondly, the abortion must be performed in a facility approved by the Minister.\textsuperscript{26}

As was discussed in Chapter Two, the Australian Capital Territory retains the offence of child destruction. Concerns about properly performed late term abortion overlapping with child destruction are probably unfounded. In practice, the sole tertiary hospital in Canberra, The Canberra Hospital, relies upon an ethics committee to ratify a doctor’s decision about the reasonableness of a late term abortion.\textsuperscript{27}


\textsuperscript{26} \textit{Health Act 1993} (ACT), ss 81-2.

Balanced against this liberal access to abortion, no one is under any duty in the Australian Capital Territory to perform or participate in an abortion, even where it is to save the woman's life. This is contrasted with the laws in Victoria and Tasmania, discussed above and further in Chapter Eight.

Accordingly, in a practical sense, the Australian Capital Territory leaves the regulation of abortion to an Ethics Committee of a tertiary hospital and relies on doctors who, of their own free will, wish to perform the abortion in the particular case. There is something to be said for this system in terms of it being less complicated than the other jurisdictions. Under this arrangement, because of the strict requirements on who may perform abortion and where it may be performed, concerns regarding unscrupulous practices by abortionists after economic advantage, such as those previously discussed in Chapter Five, are minimised.

7.5 Social sex selection abortion

Just because gender is a part of a woman's explanation for seeking abortion, it does not necessarily mean that she has distaste for giving birth to a child of a particular gender. For example, the gender of the child may be at the crux of a disability condition. However abortion for purely social as opposed to non-medical reasons is a recognised emerging cultural issue, reported to be a particular problem in India, the People's Republic of China, and Pakistan, where the cultural norm values male children over female children.

In the United Kingdom, section 84 of the Serious Crimes Act 2015 (UK) was introduced this year to ensure that the government assessed the evidence for social sex selection abortion in England, Scotland and Wales, and to take action to change prejudices, customs and traditions that underpinned such beliefs.

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28 Health Act 1993 (ACT), s 82(1)-(2).
29 Greasley, above n 15, 7.
30 See, eg Explanatory Memorandum, Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013; Rebecca Lobo, ‘Socially Repugnant or the Standard of Care’ (2014) 60 (3) Canadian Family Practice 212, 212.
As required by the legislation, in August 2015, the Secretary of State published their assessment on social sex selection abortion.\(^{31}\) Ultimately they were unable to draw definite conclusions in the short time available, but noted that discrimination in favour of sons and against daughters was a deep-seated problem in some cultures. A commitment to further research was made, with the promotion of gender equality thought to be the most effective long-term solution.\(^{32}\)

In comparing the rationale for abortion based on disability as against gender, Lobo suggests little difference between the two in cultures where burden and suffering are not just limited to the disabled.\(^{33}\) She suggests society can either redress the reasons why the person’s gender or disability is a burden or allow for unrestricted access to abortion with no consideration of motivation.\(^{34}\)

Given federal laws ban discrimination for both gender and disability, denying entry into society based on disability but not for gender, demonstrates a lack of consistency in principles.\(^{35}\) As argued earlier in this thesis, the segregation of the fetus that may be destroyed into sub categories dependant on attributes such as gestational age or the presence of disability is already evidenced in a number of jurisdictions. Accordingly, this thesis agrees that gender becomes just another attribute upon which the worth of the fetus can be measured.

Doctors in Victoria and Tasmania who are offended at a request for social sex selection abortion would appear to have no alternative but to assist the pregnant woman to achieve this end by referring her on to someone who does not object to performing such an abortion. Accordingly, the State’s interest in permitting pregnant women liberal access to abortion suggests maternal autonomy prevails over other ethical concerns of the community such as social sex selection abortion.


\(^{32}\) Ibid 13.

\(^{33}\) Lobo, above n 30, 213-5. She notes the probability of violence and sexual assault, unequal status in employment, the need for a family to raise a dowry for marriage and an inability to inherit land or wealth as examples of the burdens that females can contend with in certain cultures.

\(^{34}\) Ibid, above n 30, 216.

It would be impossible to know if social sex selection abortion was occurring in Victoria and Tasmania given a pregnant woman is not required to stipulate the reasons the abortion is sought when it is performed prior to the upper gestational time limit. Currently before the Senate is the Health Insurance Amendment (Medicare Funding for Certain Types of Abortions) Bill 2013 which seeks to disallow government funding of social sex selection abortion. The Bill makes an exception for abortion on the basis of a gender specific disorder.

The second reading speech for the Bill noted:

Sex-selection abortions do happen in this country. That they happen is of deep moral abhorrence. It is something we should not tolerate under any circumstances. That a child will be destroyed if it is not of the desired gender is obscene. In an era when we claim equality for women and men, it is even more scandalous. Human beings are valued for their dignity as human persons. If having a boy to carry on the family name is out-moded then so too should we shun the pressure for our children to be complimentary bookends. Sex-selection abortion is a further means of entrenching sexual prejudice and devaluing the human person.

Predictably, there was vigorous opposition to the Bill based not on disagreement that social sex selection abortion was a concern for the community, but rather a suspicion that it was a tactic to suppress abortion. Senator Lee Rhiannon stated:

It is actually the latest ugly tactic of those who want to limit women's sexual reproductive rights. For many, their aim is to ban women's right to choose abortion. Quite seriously, the Bill is unnecessary and it is vexatious. It is about whipping up unfounded fear in the community by stigmatising women who seek abortion.

Of course, as has been demonstrated in this thesis, Australian women do not have an unfettered right to choose abortion except in Victoria and Tasmania up to a certain gestational age of the fetus. The Bill has not progressed beyond the Second Reading debate. Although this thesis agrees with the concern regarding social sex selection, the Bill is an impractical solution given the disparate state of abortion laws in Australia.

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36 Explanatory Memorandum, Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013.
37 Commonwealth, Parliamentary Debates, Senate, 19 March 2013, 2037 (John Madigan).
38 Commonwealth, Parliamentary Debates, Senate, 27 June 2013, 4349 (Lee Rhiannon).
In 2013 in Britain, the Director of Public Prosecutions chose not to prosecute two doctors who had offered and agreed to perform abortions based solely on gender, specifically the female gender. The position of the British Medical Association was that although normally it is unethical to perform abortion based on the grounds of fetal gender alone, the pregnant woman’s views about the effect of the gender on her situation and on her existing children could be a legal and ethical justification for abortion (in other words, it could meet the United Kingdom requirement for maternal health concerns).  

Davis and Douglas agree that there may be severe social and psychological pressures on a pregnant woman in a sex-unbalanced family that lead her to seek social sex selection abortion. They argue that in certain cases, social sex selection abortion can be as necessary as other medical therapies. It is clearly available in Victoria and Tasmania so long as it is sought prior to the upper gestational age thresholds.

For late term abortions in Victoria and Tasmania, and for the remaining states, where maternal health concerns prevail, the availability of a social sex selection abortion would seem to depend upon the ethics of the doctors involved and whether they see social sex selection abortion as a legitimate mental health concern or a social concern that makes abortion appropriate in all the circumstances.

7.6 Summary

In the preceding Chapters, this thesis has demonstrated the diversity of abortion law in Australia, with five different gestational age limits, and varying integrating requirements regarding maternal health concerns as well as fetal disability provisions. At first glance, abortion law is a confusing mess. It seems an impossible task to reconcile the disparity amongst the jurisdictions in order to achieve national consistency.

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41 Ibid.
This thesis notes the comments made in 1996 by the Model Criminal Committee, a Committee set up to unify criminal law in Australia.\textsuperscript{42} Almost 20 years ago, in its discussion paper on ‘Non-Fatal Offences Against the Person’ they noted that the political process in Australia had been unable to deal with the issue of abortion for a century and in their opinion, that was unlikely to change. To date, that prediction remains solid. Faunce has observed that given the inconsistent state of abortion laws in Australia and the lack of individual human rights under the Australian Constitution, there is no guarantee that the abortion issue will not come before the High Court of Australia in the near future.\textsuperscript{43}

Given that abortion laws are based in legal positivism, the disparate approach between the jurisdictions should not technically matter. However this thesis agrees with comments made by De Costa et al that concern by some parts of the medical profession regarding lack of guidelines in legislation and lack of case law examples suggest a need for clearer guidelines.\textsuperscript{44} The problem remains though as to how to prescribe the circumstances that justify a doctor forming the belief that an abortion is appropriate given the lack of consensus in the community as to the moral value of the fetus and when it is right or wrong to destroy it.

Legalising abortion on demand replaces the individual views of doctors and judges with that of the State.\textsuperscript{45} Arguably, it elevates abortion to a right that then requires the State to provide doctors willing to perform the act. As a consequence, it would appear to eliminate the basis for a doctor to object to the act by holding a different moral view,\textsuperscript{46} or at least require such a view to be subjugated to the woman’s right to an abortion. Such an outcome highlights the significant consequences of the positive law legislating on moral issues.\textsuperscript{47}

\textsuperscript{42} Model Criminal Code Officers Committee, Discussion Paper: Chapter 5 – Non Fatal Offences Against the Persons, 1996, Standing Committee of Attorneys General, APGS.
\textsuperscript{45} Oreb, above n 18, 268.
\textsuperscript{47} Oreb, above 18.
Abortion on demand and other liberal abortion laws that place emphasis on maternal health concerns characterise abortion as a women's health issue and de-emphasise the ethical aspect that it destroys human life. Whilst a pregnant woman’s decision to undergo abortion may not interfere with the general community’s ability to express a contrary view about the act, there is no getting away from the fact that abortion either by surgical procedure or by medical treatment (self administered abortifacient drugs) requires the assistance of health care professionals.

Their capacity to express objection to abortion and refrain from participating in it may be threatened in an environment where debate about the morality of abortion has been shut down in favour of debate about the lawfulness of abortion. The lawfulness of abortion is based on an artificial rule that is incapable of authoritatively and persuasively addressing the issue of human personhood.\(^48\)

Against this background of having discussed the basis of abortion laws in Australia, this thesis now discusses the legal status of conscientious objection by medical practitioners to performing or participating in lawful abortion.

\(^{48}\) *R v Iby* (2005) 63 NSWLR 278 [63].
CHAPTER EIGHT

CONSCIENTIOUS OBJECTION BY DOCTORS TO ABORTION

8.1 Introduction

Whilst medical law follows the positivist model, it continues to be punctuated by the natural law tradition. The legal recognition of a doctor to conscientiously object to performing or participating in lawful abortion is one such area that finds its roots in the natural law, and is the final area of discussion in this thesis.

In Australia, the right of doctors to conscientiously object to abortion is recognised by five jurisdictions, subject to limitations. Of those, two states impose statutory duties on doctors who conscientiously object to abortion to refer a woman on to another doctor whom they know does not have a conscientious objection. Four states compel a doctor to perform and/or participate in an abortion in an emergency situation, notwithstanding their conscientious objection.

Conscientious objection to abortion forces the lawmaker to accommodate different perceptions of abortion and the fetus. The challenge for the lawmaker is to consider whether the divergent views on the value of the fetus and the morality of its destruction can be accommodated in the law to the satisfaction of both parties or whether it will simply rank one right above the other. This thesis argues that in jurisdictions that permit abortion on demand, doctors who object to participating in abortion on conscience grounds may be in danger of the State imposing on them its position on the moral value of the fetus, and requiring them to participate in destruction of the fetus.

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2 This is based on the connection between conscientious objection and the moral value of the fetus.
3 See Table 2, page 148.
4 Abortion Law Reform Act 2008 (Vic) s 8(2); Reproductive Health (Access to Terminations) Act 2013 (Tas) s 7(2).
5 Abortion Law Reform Act 2008 (Vic) s 8(3); Reproductive Health (Access to Terminations) Act 2013 (Tas) s 6(3); Criminal Law Consolidation Act 1935 (SA) s 82A(6).
In this Chapter this thesis considers international covenants as a source of authority for a right to conscientious objection and overseas cases where the court has been asked to rule on what it means to participate in an abortion and whether it conflicts with conscientious objection. It then analyses the laws recognising conscientious objection by doctors to abortion in Australia and concludes that it is an area where there is likely to be ongoing debate and concern that arises from the conflict between the abortion laws and conscientious objection.

8.2 *International Covenants*

Hart notes that in the positive tradition of law, the natural law and its focus on objective or moral truths springs from ‘deep and old confusions from which modern thought has triumphantly freed itself.’

Accordingly, it is not necessary for positive law to adhere to demands of morality, even though it often does. However where the law touches upon a moral issue, the question arises as to who has the authority to decide moral rights, set the hierarchy of rights, and restrain what the lawmaker can do.

This has been recognized in circumstances such as the Nuremberg laws arising from World War II, which held that the laws in Nazi Germany though validly made, violated human rights. The *Universal Declaration of Human Rights 1948* recognises in its preamble, a need for normative morals for all people of the world in order to avoid acts that have gone against the conscience of people. It speaks of objective, fundamental human rights for all members of the human family that are to be universally protected. Accordingly, it sets a standard for behaviour by which people should abide by in order to enjoy freedoms such as freedom of speech and belief.

Covenants that flow from this original source instrument include the *International Covenant on Civil and Political Rights of 1966* and the *Convention on the Rights of the Child of 1990*. In these documents there is acknowledgement of the unborn child. Article 6 of the *International Covenant on Civil and Political Rights* prescribes

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8 Ibid 185-6.
10 Ibid Articles 18-19.
that every human being has the inherent right to life that shall be protected by the law. It goes on in subsection 5 to note that sentence of death shall not be carried out on a pregnant woman.

Additionally, the *Convention on the Rights of the Child* notes that the child, by reason of his or her physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.\(^\text{13}\) Although dated, none of the instruments sanctioned by the United Nations refer to a right of a pregnant woman to abortion.

Article 18(1) of the *International Covenant on Civil and Political Rights* specifically acknowledges that everyone shall have the right to freedom of thought, conscience and religion with no one being subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice. Interestingly, it goes on to provide that freedom to manifest one’s religion or beliefs may be subject to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedom of others. Accordingly, freedom of conscience is not an absolute right and it may be overridden.\(^\text{14}\)

As has been argued in this thesis, women in Australia have what can best be described as a conditional right to access abortion. In these circumstances, how does such a conditional right co-exist with other conditional rights? If there is no common morality in a society and all its laws are relative, when will one right override other associated rights and who has authorised this?

The *International Covenant on Civil and Political Rights* is not directly enforceable in Australia; however its provisions support a number of domestic laws which confer enforceable rights on individuals. In Victoria and the Australian Capital Territory, where Human Rights Charters exist, the Convention can be used by a plaintiff or defendant who invokes those jurisdictions’ Human Rights Charters.\(^\text{15}\) While the Convention cannot be used to overturn a law, a Court can issue a declaration of

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\(^{13}\) Ibid.

\(^{14}\) Sifris, above n 6, 905.

incompatibility which requires the relevant Attorney-General to respond in Parliament within a set time period.\textsuperscript{16}

Oreb notes that with regard to abortion and conscientious objection, the introduction of such Charters is a positive move that attempts to contain judicial discretion and individual views on morality by setting a context in which rights and notions of morality are perceived.\textsuperscript{17} However as noted above, the right to conscientious objection is subjugated to the laws of the State for broad reasons including the protection of public health.\textsuperscript{18} It sits awkwardly in the law where abortion law is framed solely as a women’s health issue, with no value given to the fetus. Accordingly it is the view of this thesis that International Charters are ill equipped to confirm either conscientious objection by doctors to abortion as an inviolate right or any right of a woman to abortion in any circumstances. In this area of law, the ordering of these rights is beholden to the morality of the lawmakers and their position on what the fetus is and whether it has any right to life or protection from destruction.

This thesis will now consider the conflict of rights between the right of a pregnant woman to have a lawful abortion and the right of health care professionals to refuse to participate in it. Several overseas decisions provide useful examples of practical circumstances where health care professionals considered their right to conscientious objection was breached, however in none of the cases was the health care professional successful.

\section{8.3 International Decisions}

Disputes about the infringement of a health professional’s right to conscientious objection to abortion have tended to focus on participation in abortion as opposed to performance of it. Specifically, indirect participation, as opposed to direct participation (such as assisting in the operating theatre) has been called into question. There are a number of international judgments that provide specific examples where courts have been required to determine whether indirect participation has intruded on conscientious objection. This thesis considers four that are on point.

\textsuperscript{18} International Covenant on Civil and Political Rights, above n 11, Article 18(3).
In *Greater Glasgow Health Board v Doogan and Anor*\(^{19}\) two midwives were co-ordinators of a labour ward and had formally lodged their conscientious objection to participating in abortion with their employer. The labour ward subsequently started to accept patients for abortion and the midwives claimed they were required to delegate, supervise and/or support other staff in participating in abortion or caring for patients having abortion. The midwives lodged a grievance with the hospital that was rejected. An appeal to the hospital’s board was also rejected and so the case came before the courts.

The Court of Appeal held that conscientious objection extends not only to the actual medical or surgical termination but to the whole process and that the right to conscientiously object is recognised, because the process of abortion is felt by many people to be morally repugnant.\(^{20}\) This was overturned on appeal where the Supreme Court held that the right to conscientiously object in section 4 of the *Abortion Act 1967* (UK) was not unfettered, but was subject to exceptions such as to save the mother’s life or prevent grave injury to her health. The particular wording of the provision permitted conscientious objection to participate in any treatment leading to abortion. A narrow meaning was taken to the phrase ‘to participate in’ and was held to be restricted to performing the tasks involved in the course of treatment, in a ‘hands on’ capacity.\(^{21}\)

This case is in line with the earlier decision of *Janaway v Salford Health Authority*\(^{22}\) where the House of Lords held that a receptionist typing a referral letter to a doctor to consult a patient regarding abortion was not participating in abortion. The term ‘participate’ was held to have its ordinary meaning, which referred to actually taking part in treatment administered in a hospital or other approved place.\(^{23}\)

Obviously, it is a matter for the lawmaker to decide whether they wish a narrow or broad construction of the term ‘participation’. As will be discussed in 8.4 below, two jurisdictions in Australia compel doctors who conscientiously object to abortion to refer the pregnant woman to another doctor whom they know does not have a

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\(^{19}\) [2014] UKSC 68.
\(^{20}\) [2013] CSIH 36.
\(^{21}\) [2014] UKSC 68 [37]-[38].
\(^{22}\) [1989] AC 537.
\(^{23}\) Ibid 1082.
conscientious objection to abortion. This raises questions of whether this will result in an abortion being performed; whether the referring doctor can be said to have participated in abortion indirectly; and whether indirect participation is covered by conscientious objection.

In *Pichon and Sajous v France* two French pharmacists claimed that their freedom of religion had been breached as a result of their conviction by French authorities for refusing to dispense oral contraception to three female customers. They appealed to the European Court of Human Rights. The Court held that the pharmacists could not give priority to their personal beliefs over their professional obligations where contraceptives are legal and could only be gained through prescription at a pharmacy.

In *Noesen v State, Dept of Regulation and Licensing* a Wisconsin woman, married with four children sought the morning-after pill at a local pharmacy. The pharmacist refused to fill the prescription and refused to transfer it to another pharmacist or to return the original prescription to the patient. The local Board reprimanded him for abusing his professional power by refusing to transfer the prescription to another pharmacy. He appealed this decision, but it was dismissed.

These two judgments highlight other ways in which health care professionals may feel they have participated in abortion. In these cases, the State’s sanctioning of a particular medical practice or treatment was the basis to refuse the health care professionals claim of conscience. This thesis contends that in so far as the law of a State tends towards the view that abortion is primarily about women’s health, and de-emphasises the destruction of human life, the application of a doctor’s right to conscientiously object to participating in abortion seems extremely limited.

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24 Abortion Law Reform Act 2008 (Vic) s 8; Reproductive Health (Access to Terminations) Act 2013 (Tas) s 7.
26 *Noesen v State, Dept of Regulation and Licensing*, 754 N W 2d 849 (WI 2008).
This small selection of international cases demonstrates the complexity of the issue. The courts will not immediately recognise a health care professional’s conscientious objection to abortion as absolving them from performing certain tasks. Rather, it requires a careful review of the health care professional’s work duties, measured against the infringement on the pregnant woman’s capacity to seek and obtain a lawful abortion in the particular country. This thesis now reviews the laws on conscientious objection in Australia.

8.4 Legislative Overview on Conscientious Objection

Table 2 below summarises the current relevant legislative provisions in Australia. Essentially, there is no statutory duty on a doctor by contract or statute to carry out an abortion in the Australian Capital Territory, the Northern Territory, South Australia, Western Australia, and Tasmania, although exceptions expressly exist with regard to an emergency situation in the Northern Territory, South Australia and Tasmania. New South Wales, Victoria and Queensland do not have specific legislation recognising conscientious objection by doctors to abortion.

In addition to legislation, or in lieu of it, professional standards can be found in the policies of various organisations such as the Australian Medical Association’s (‘AMA’) ‘Conscientious Objection’, and ‘Ethical Issues in Reproductive Medicine’, and the Royal Australian and New Zealand’s College of Obstetricians and Gynaecologist’s (‘RANZCOG’) ‘Code of Ethical Practice’.

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28 Health Act 1993 (ACT) ss 84-5.
29 Medical Services Act (NT) ss 11(6)-(7).
30 Criminal Law Consolidation Act 1935 (SA) s 82A(5).
31 Health Act 1911 (WA) s 334(2).
32 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 6(1).
Table 2 – Recognition and Limitations to Conscientious Objection to Abortion

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Act</th>
<th>Recognition of a doctor’s conscientious objection to participating in abortion</th>
<th>Duty to participate in an emergency situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Section 84(1) and (2), Health Act 1993</td>
<td>No duty to carry out or assist in abortion. A person is entitled to refuse to assist in or carry out an abortion</td>
<td>No</td>
</tr>
<tr>
<td>NSW</td>
<td>None</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>NT</td>
<td>Section 11(6), Medical Services Act</td>
<td>No duty to terminate or assist in terminating a woman’s pregnancy</td>
<td>No</td>
</tr>
<tr>
<td>QLD</td>
<td>None</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>VIC</td>
<td>Section 8(3), Abortion Law Reform Act 2008</td>
<td>Duty to perform an abortion in an emergency where necessary to preserve the life of the woman</td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>Sections 82A(5) and (6), Criminal Law Consolidation Act 1935</td>
<td>No duty to participate in abortion where person has a conscientious objection</td>
<td>Duty to participate in treatment necessary to save the life or to prevent grave injury to the physical or mental health of the woman</td>
</tr>
<tr>
<td>TAS</td>
<td>Sections 6(1) and (3), Reproductive Health (Access to Terminations) Act 2013</td>
<td>No duty to participate in an abortion where a person holds a conscientious objection</td>
<td>Despite any conscientious objection, there is a duty to perform an abortion in an emergency if it is necessary to save the life of the woman or to prevent serious physical injury</td>
</tr>
<tr>
<td>WA</td>
<td>Section 334(2), Health Act 1911</td>
<td>No duty to participate or perform an abortion</td>
<td>No</td>
</tr>
</tbody>
</table>

These documents are applicable nationally, despite the discordance in Australia’s abortion laws. This presents a challenging situation where the profession’s ethical position on various medical practices have no state boundaries, yet must be integrated into the differing legal norms of a jurisdiction. In addition, State health departments and individual hospitals or facilities may also have policy directives that articulate such duties.\textsuperscript{36}

The AMA defines conscientious objection as a refusal to provide or participate in a legally recognised treatment or procedure due to a conflict with the doctor’s personal beliefs and values. Its position is that no doctor should be compelled to act contrary to his or her moral convictions or religious beliefs except as required by law or in an emergency. The profession accepts, therefore, that conscientious objection is a limited right subject to the State’s authority to override it.

In regards to reproductive medicine, the AMA notes that a doctor may refuse to be clinically involved in the care of a patient seeking an abortion, but such a refusal should not impede the patient’s access to care. The AMA’s Position Statement on ‘Conscientious Objection’ states that indirect actions such as referring the patient to another doctor to provide the service is participation in the act. The main issue, therefore, is whether the lawmaker agrees that such participation infringes the doctor’s freedom of conscience and whether its laws are in line with the profession.

Parker notes that Codes of Conduct are owned by the profession and remain distinct from the law, but they are not above being inadequate. In some cases, where an aspect of self-regulation is enshrined in the law, the profession can end up surrendering that aspect of its conduct to external regulation. This appears to have occurred in Australia and will be discussed further below at 8.6.

There are few studies on the attitudes of Australians to abortion, and fewer still on the attitudes of doctors to conscientious objection to abortion. This is unfortunate given its self-evident relevance to the current debate. This thesis notes that a key issue is not just how many doctors have a conscientious objection to abortion, but how many support the right of their colleagues to be protected by conscientious objection.

37 Australian Medical Association Conscientious Objection, above n 33 [33].
38 Ibid [1].
39 Australian Medical Association, Ethical Issues in Reproductive Medicine, above n 34 [2.4.2].
40 Australian Medical Association Conscientious Objection, above n 33 [1].
41 Parker, above n 1, 449.
42 Ibid.
Internationally, a number of quantitative studies have been conducted on doctors or medical students and their attitudes to abortion. Strickland’s 2012 study of the attitudes of 1,437 medical students from universities in Cardiff, London and Leeds found that a third of participants would not perform an abortion for fetal disability after 24 weeks gestation, a third would not perform abortion for failed contraception after 24 weeks and a fifth would not perform abortion for a minor who was pregnant through rape.\(^{44}\) She concluded that although there were an increasing number of abortions taking place in the United Kingdom, fewer doctors were willing to perform them and if all the participants in the study acted on their conscience, it might be practically impossible to accommodate such doctors in the medical profession.\(^{45}\)

Niemin\(\text{en et al’s 2013 study of 548 first and last year medical and nursing students and professionals in Finland concluded that whilst only a minority would seek conscientious objection for themselves, one third to one half of respondents supported a doctor’s right to conscientious objection. A majority felt that conscientious objection would cause conflict in the workplace, with others needing to take over an unpleasant task.}\(^{46}\) The authors concluded that rational discussion on conscientious objection by health care workers requires professionals, politicians and the public to be made aware of the complexity of the issues involved. This included how to accommodate conscientious objection with lawful abortion and how to address the impact of conscientious objectors in the workplace, where discrimination and social conflicts might occur.\(^{47}\)

This thesis echoes this need for more research and more detailed discussion from people who will be affected by such legislation such as doctors. This Chapter will now focus on the legislation in Victoria, Tasmania and South Australia and its position on direct participation in an emergency and indirect participation by referral to another practitioner who has no conscientious objection.

\(^{44}\) Sophie Strickland, ‘Conscientious Objection in Medical Students: A Questionnaire Survey’ (2011) 38(1) Journal of Medical Ethics 22.
\(^{45}\) Ibid.
\(^{47}\) Ibid.
8.5 Abortion in Obstetric Emergency

Clearly, the medical profession’s representative bodies agree that conscientious objection is beholden to the law. With regard to emergency situations, it is not clear what constitutes this and whether it extends beyond a threat to the pregnant woman’s life. There are no reported instances in Australia where a doctor’s refusal to perform an abortion based on conscientious objection lead to the death or serious injury to a pregnant woman.

Much like maternal health concerns underpinning lawful abortion in New South Wales and Queensland, discussed in Chapter Four, such a term is capable of wide construction and application due to its subjectivity. Additionally, an emergency situation is characterised by immediacy and so by definition does not permit for time to explore the basis of the clinical judgment, much like maternal refusal of caesarean section discussed in Chapter Three (although in that scenario, there is a reversal of concern for the fetus over the pregnant woman).

In Victoria, there is a positive duty on the health practitioner in section 8(3) of the Act to perform an abortion on a pregnant woman when it is deemed necessary to save her life. The circumstances that would satisfy this scenario are not set out in the legislation, however Mendelson notes that it is likely this phrase will be interpreted to mean the physical and mental health of the pregnant woman as defined by Menhennit J in *R v Davidson*, discussed in Chapter Seven. This thesis agrees with this conclusion.

In Tasmania there is also a duty to perform an abortion where it is necessary to save the life of the woman or preserve her from serious physical injury. Again there are no guidelines in the legislation to assist with interpretation of what constitutes a serious physical injury deemed sufficient to override a doctor’s conscientious objection to abortion.

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48 Australian Medical Association, above n 33 [4]; RANZCOG, above n 34, 5.
51 *Reproductive Health (Access to Terminations) Act 2013 (Tas)* s 6(3).
In South Australia, there is a statutory duty to perform an abortion where it is necessary to preserve the life of the woman or to prevent grave injury to her physical or mental health.\(^{52}\) This tri-fold criterion that compels a doctor who conscientiously objects to abortion to perform or participate in abortion in South Australia appears to have the clearest and widest application amongst the three jurisdictions.

Ascertaining whether the harm to be averted actually existed to the level required and was capable of being known within time in order to perform the abortion, is a medical question and may be subject to a difference of opinion. The case of *Royal Women’s Hospital v Medical Practitioner’s Board*,\(^{53}\) referred to in Chapter Seven involving a Victorian woman threatening suicide if an abortion were not performed, is an example where a positive assessment was made by two doctors.

Should a pregnant woman be denied an abortion and succumb to injury, Mendelson notes there would appear to be a strong case for breach of statutory duty by the doctor in a civil claim for damages.\(^{54}\) She opines that in such cases, the only complete defence by the doctor would be proving that the breach was occasioned solely by the plaintiff’s conduct, with no contribution by the defendant doctor.\(^{55}\)

Accordingly, a tragedy is required in order to test the extent of circumstances that apply. As the incidence of emergency cases mandating direct participation on the conscientious objector seem rare, the more contentious area of dispute is that of requiring a doctor to participate in treatment leading to an abortion and working out whether the term ‘participate’ has a different meaning in practice and in the law.

According to the examples given in international law, referred to in section 8.3 above, actions judged to be ‘indirect’ participation as opposed to ‘direct’ participation, may not be a sufficient platform for the doctor to exercise conscientious objection. This thesis now considers how the law compels participation in abortion by conscientiously objecting doctors in these three jurisdictions.

\(^{52}\) *Criminal Law Consolidation Act 1935 (SA) s 82A(6).*
\(^{53}\) [2006] VSCA 85, 24[1].
\(^{54}\) Mendelson, above n 50, 665.
\(^{55}\) Ibid.
8.6 Participation in abortion

8.6 (a) South Australia

In South Australia, the legislation provides that the burden to prove conscientious objection rests with the person who wishes to rely on it.\(^{56}\) This is not the case in Victoria and Tasmania. Between 1988 and 1990 in South Australia, nurses refused to provide services for second trimester abortions for ‘social reasons’ on the basis of conscience. Pregnant women seeking abortion on those grounds were required to travel to Sydney or Melbourne to obtain abortion.

Cannold argues that the nurses’ conscientious objection was morally impermissible because it invaded the pregnant woman’s autonomy, put her health at risk (by having to travel interstate for abortion), and treated her unjustly.\(^ {57}\) Whilst she conceded that participation in late term abortion might cause stress to a health care professional that could outweigh the harm to the pregnant woman,\(^ {58}\) in her view, the health care professional would need to demonstrate that the objection against abortion, or abortion in the particular circumstances, was central to their self-definition.

In her opinion, the person must be willing to lose their job or even go to jail to prove the depth of their belief otherwise their conscientious objection is civil disobedience or a political act.\(^ {59}\) Otherwise, she concluded that morality requires such nurses to refrain from acts that are inconsiderate to the interests of others. In other words, a nurse can conscientiously object, but only where there is an assurance someone else will provide the care.

However in South Australia, the fetus of 28 weeks gestation has a special status in that it is considered a child capable of being born alive and its destruction is only permitted where the woman’s life is at risk.\(^ {60}\) Accordingly, if considering the jurisdiction’s abortion law and conscientious objection law together as a sensible

\(^{56}\) Criminal Code Consolidation Act 1935 (SA) s 82A(5).
\(^{57}\) Leslie Cannold, ‘Consequences for Patients of Health Care Professionals’ Conscientious Actions: The Ban on Abortion in South Australia’ (1994) 20 Journal of Medical Ethics 80, 81-2.
\(^{58}\) Ibid, 85.
\(^{59}\) Ibid.
\(^{60}\) Criminal Code Consolidation Act 1935 (SA) s 82A(8).
whole, this thesis suggests that Cannold’s argument may not hold for a very late term abortion, though it may do so at an earlier fetal gestational age.

This thesis now examines the situation in Victoria and Tasmania regarding the requirement of a doctor exercising a conscientious objection to abortion to refer the patient on to another doctor who does not hold the same objection, and considers how this position sits with the respective underlying abortion law.

8.6 (b) Victoria

Prior to the introduction of the Abortion Law Reform Act 2008, Victoria did not have any legislative provisions relating to conscience whereby a doctor could be excused from performing or assisting with an abortion. Now, section 8(1)(a) and (b) of the Act, whilst recognising that health practitioners may have a conscientious objection to performing or participating in an abortion, sets a positive duty on the part of such a doctor to declare their conscientious objection to the pregnant woman and to refer her on to another practitioner whom they know does not have a conscientious objection to abortion.

The Explanatory Memorandum to the Act clarified that the doctor was obliged to make enquiries or take other steps to inform himself or herself of the views of the doctor to whom the referral is made so as not to refer the woman to another doctor who may share a conscientious objection to abortion. However it may be difficult to classify a doctor as having a conscientious objection to performing or participating in an abortion per se. How exactly are doctors able to carry out this task of ascertaining the views of colleagues unless the referral is to a doctor or facility that performs abortions? Would this constitute indirect participation in abortion?

It is not clear whether the referral is to be made to a doctor who will perform abortion or merely to a doctor who will advise and present choices that include abortion. If it is the former, then as noted in 8.4 above, the AMA’s Position Statement on Conscientious Objection characterises referral to another doctor who will provide the service as an example of an indirect action that qualifies as ‘participation’ in a

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62 Strickland, above n 44.
procedure or treatment, and therefore an activity that the doctor may object to. This is a conflict between the law and the profession. Acknowledging this conflict, AMA Victoria advised doctors to fulfil their legal duty and avoid a conflict of interest by placing signs in their waiting rooms or on their website stating they are not available for advice or assistance with abortion.

Obviously a practical solution, it obviates the need to prepare a referral note and avoids concerns about moral complicity. However, this recommendation that doctors should ‘out’ themselves as being conscientious objectors to abortion so as to avoid the requirement to provide a referral to an abortion provider raises concerns about privacy. It sits well, though, with Cannold’s comments noted in 8.6(a) above, that a doctor who objects ought to go to great lengths to demonstrate this otherwise their refusal is an act of civil disobedience.

If however it requires a referral to a doctor who will not actually perform the abortion, then Ethicist Nicholas Tonti-Filippini makes the practical point that as abortion is widely available from a variety of community centres without referral, there is no need for the doctor to refer the woman on. Accordingly, in his view, women would not be excluded from accessing abortion if doctors exercised conscientious objection and withdrew from advising them.

This thesis takes the position that the opinion of those who object to being obliged to refer patients on is relevant to this discussion. Understanding whether they would consider referring the patient on to another person who does not perform the abortion might be a distinction that is acceptable. Further research is required.

The Professional Standards Panel of the Victorian Medical Board ruled on a complaint made by a doctor about the conduct of another doctor who conscientiously objected to abortion. The respondent doctor admitted that in practice, when approached by a woman seeking an abortion he would advise her of his

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63 Australian Medical Association Conscientious Objection, above n 33 [1].
65 Cannold, above n 57, 81-2.
66 Nicholas Tonti-Filippini, Bioethics, Motherhood, Embodied Love and Culture, (Cooper Consulting, 2013) 151.
67 Medical Board of Australia, Performance and Professional Standards Panel Hearing: Reasons, Hearing date 24 January 2013, reasons, 14 February 2013.
conscientious objection, refuse to provide a referral to another doctor but indicate that the patient should see another doctor to obtain the said referral.

This practice was found to be unprofessional conduct and in contravention of the requirements under section 8 of the Act. The Panel noted that the doctor’s conduct was not consistent with the expectations of the community and the contemporary environment. It concluded that the term ‘refer’ required that at a minimum, the doctor should send or direct that patient to another practitioner who did not have a conscientious objection to abortion or he was to otherwise facilitate access to such a practitioner.

Whilst this decision does not clarify the issues raised above regarding to whom precisely the referral needs to be made and whether that referral will directly result in abortion, it does suggest to this thesis that ‘indirect’ participation on the part of the doctor is not considered to be ‘participation’ sufficient to displace a woman’s right to a lawful abortion up to 24 weeks gestation.

In Victoria, abortion is permissible after 24 weeks where two doctors believe it is appropriate in all the circumstances. It is unclear whether the doctor’s view on the moral status of the fetus is a permissible circumstance or whether it is restricted to the health consequences to the pregnant woman. This is somewhat different to the South Australian situation where legislation defines the fetus at 28 weeks as a child capable of being born alive, and where the lawfulness of destruction at this time reflects this definition. In other words, the fetus in and of itself does not appear to be the focus of the provisions. It holds no special status that overrides other concerns.

This thesis argues that to disallow the doctor’s view on the moral value of the fetus as a relevant matter to consider for abortion after 24 weeks gestation, is a very worrying development in the law, as it is not only the State imposing its view that the fetus has no value, but it then directs the doctor to act in accordance with that view. It seems a distinct probability that in line with Victoria’s liberal abortion laws, the courts

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68 Abortion Law Reform Act 2008 (Vic) s 5(1)(a).
69 Criminal Code Consolidation Act 1935 (SA) s 82A(8).
will interpret ‘participation’ in a narrow sense, uphold the statutory duty to refer, and limit the doctor’s exercise of conscientious objection.\textsuperscript{70}

It is unfortunate that opponents of section 8 of the Act did not invoke the Charter of Human Rights and Responsibilities Act 2006 (Vic) and require the court to issue a statement of incompatibility which requires the Attorney-General to respond in Parliament.\textsuperscript{71} This would have provided a good vehicle within which to test these issues. No doubt a test case will arise in which these important issues can be ventilated. This thesis now considers the law in Tasmania.

\textbf{8.6 (c) Tasmania}

The Reproductive Health (Access to Terminations) Act 2013 (Tas) imposes a statutory duty on doctors who conscientiously object to participating in abortion by compelling them to, under threat of a fine, provide the pregnant woman with a list of providers from a prescribed list who do not have a conscientious objection.\textsuperscript{72} Sifris argues that there is a distinction here between Victoria’s obligation to refer because the Tasmanian provision does not require the referral to be to a doctor who will perform the abortion, rather it is simply to a doctor who does not have a conscientious objection.\textsuperscript{73}

In support of this interpretation, Sifris refers to the regulations, which note that the prescribed health services the doctor must refer to include: Family Planning Tasmania, Women’s Health Information Line, The Link Youth Health Service and Pulse Youth Health South.\textsuperscript{74} As argued above, this interpretation is an interesting one, but requires clear confirmation from the lawmaker and the views of the profession, especially doctors who conscientiously object.

\textsuperscript{70} See, Oreb, above n 17. Oreb notes that the doctor’s obligation to refer is evidence of the intent that abortion on demand up to 24 weeks gestation is an actionable right for all women.
\textsuperscript{71} Oreb, above n 17, 266-7.
\textsuperscript{72} Reproductive Health (Access to Termination) Act 2013 (Tas) s 7(2).
\textsuperscript{73} Sifris, above n 6, 913.
\textsuperscript{74} Reproductive Health (Access to Terminations) Regulations 2014 (Tas) s 4.
The purpose of the Act can be found in documents such as the Population Health Equity's Information Paper on the Reproductive Health (Access to Terminations) Bill (‘the Information Paper’) which states that the changes sought to recognise that unplanned pregnancies occur, acknowledge women as capable decision makers, recognise abortion as a safe, medical procedure that will not cause negative mental health outcomes and recognise community standards.\footnote{Population Health Equity, ‘Information Paper Relating to the Draft Reproductive Health (Access to Terminations) Bill’ Department of Health and Human Services, March 2013, 6-11.}

The Information Paper noted that the dividing line as to when abortion on demand ceases was picked on the basis of clinical practice and approaches in other jurisdictions.\footnote{Ibid 12.} There is a clear supposition in the Information Paper that abortion is nothing more than a woman’s health issue.\footnote{Ibid 10.} There is no acknowledgement of the variety of views regarding the moral value of the fetus or indeed the scientific advances in knowledge that may challenge the notion of personhood or the viability of the fetus at certain gestational ages.\footnote{See, eg, Talat Uppal et al, ‘The Legal Status of the Fetus in New South Wales’ (2012) 20 Journal of Law and Medicine 178, 183; Kristen Savell, ‘Life and Death Before Birth: 4D Ultrasound and the Shifting Frontiers of the Abortion Debate’ (2006) 15 Journal of Law and Medicine 103, 109.}

Explaining how the legislation would not deny a doctor or woman opposed to terminations the ability to live by their beliefs, the Information Paper curiously noted ‘Rather, the law will extend that right to all Tasmanian women. In that way, each individual woman is able to make the best decision for her, according to her beliefs and having regard to her individual circumstances.’\footnote{Above n 78, 12.} In other words, there was no recognition by the lawmaker that the Bill might take anything away from doctors. Instead, its focus was on giving something to women. However it is not clear how compelling a doctor to indirectly participate in abortion achieves a balance of rights from the doctor’s perspective. Guidance regarding what a referral involves can be found in the Second Reading Speech for the Bill wherein it was stated:

…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...
Accordingly, the lawmaker has decided that a referral note does not amount to participation in abortion. There is nothing much a doctor with a conscientious objection may do other than wait to be charged and then mount a challenge that the law is unjust and engage in a serious discussion about how participation to the degree required is a serious affront to their freedom of conscience regardless of the lawmaker’s decided stance on the value of the fetus. Oreb notes that there may be other, less restrictive ways, to achieve access to abortion such as maintaining a public register of abortionists or doctors who do not hold a conscientious objection. This is a useful suggestion as it obviates the need for a referral.

After 16 weeks gestation, the woman’s access to abortion is not absolute. However the matters doctors must take into consideration for an abortion sought at this time are not open ended. Specifically, two doctors must agree that continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy was terminated and in so doing they must take into account the current and future physical, psychological, economic and social circumstances of the person.

However unlike the Victorian legislation, there is no reference to a doctor considering ‘all the circumstances’. Accordingly, whether or not the legislation permits a doctor to decline abortion on the basis that they believe a fetus of a particular gestational age attains personhood or moral standing is unclear, but taking into the account the clear intent of the lawmaker to promote abortion as a woman’s health issue suggests the State is imposing a non-neutral view that the fetus has no value.

It is worth noting that the Tasmanian law has additional provisions that enhance a woman’s access to abortion. The act prohibits people protesting in relation to abortion to come within 150 metres of an abortion facility under pain of a fine up to 75

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80 Tasmania, Parliamentary Debates, Legislative Assembly, 16 April 2013 (Michelle O’Bryan).
81 Oreb, above n 17, 268.
82 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 5(2).
83 Abortion Law Reform Act 2008 (Vic) s 5(1)(a).
penalty units or imprisonment not exceeding 12 months or both. Without case law examples, it is difficult to say how these laws will work in practice. Two years on, there have been no court cases regarding a breach of these provisions.

It is also worth noting that in October 2015, the Australian Capital Territory enacted similar zones for persons protesting abortion in the Health (Patient Privacy) Act 2015. As at November 2015, Victorian Parliament commenced debate on the Public Health and Wellbeing (Safe Access Zones) Bill 2015 that also intends to enforce exclusion zones. Laws such as these raise issues about freedom of political communication and no doubt will result in a test case that touches upon the status of abortion laws and the value of the fetus in the law.

Calls for the reform of abortion laws nationally so there is effectively abortion on demand, as well as laws that limit the capacity for people to protest abortion, would seem to diminish the importance of conscientious objection. Where the State, through various laws, imposes its view on the community that the fetus has no inherent value that can override the consent of the pregnant woman to its destruction, there seems little basis for an opposing view based on morality to have a credible place in the debate.

8.7 **Summary**

In Australia, clarification of what the obligation to refer entails is critical to properly assessing whether balance has been struck. Sifris notes that compromise in this context means each party is not entirely content and that laws in Victoria and Tasmania have achieved balance. This thesis disagrees. The compromise required of doctors displays a lack of recognition for the position that abortion is immoral. Savulescu suggests that conscientious objection by doctors is wrong and immoral and should be illegal because doctors who are not prepared to offer lawful services that are beneficial to patients should not be doctors. As has been stated throughout this thesis, where a legal system’s laws are based on legal positivism, then morality

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84 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 9.
85 See Sifris, above n 6, 904.
86 Sifris, above n 6, 914.
is not a necessary ingredient to the validity of its laws. It is interesting that Savulescu takes a moral position on a legal issue and then attempts to bind others to it based on his morals. He seems to argue that a lawful practice is a moral practice and therefore denying access to it is immoral.

As George notes, the claim that moral laws are unjust is inescapably a moral claim so beware the ethical relativist. Savulescu ignores the fact that there is no clear, unfettered legal right to abortion in every circumstance. Where it is lawful it still requires medical oversight that rises above that of obtaining informed consent. To use the fact that abortion can be lawful to jettison conscientious objection seems a bold statement, particularly where the law in question has a confused position on what the fetus is and, therefore, whether it is morally right or wrong to destroy it.

The natural law concerns itself with identifying principles on which laws are based and the limits of the rule of law. The use of authority by lawmakers is defective, says Finnis, where rules are made by them not for the common good but for their own or their friends’ or party’s or faction’s advantage or out of malice against some group of people. Arguably, an unjust law is still a valid law. An issue however is whether a person’s conscience may be used as a basis to compel them not to follow a validly made law and if so, the consequences of that decision (such as Apartheid laws).

Finnis frames the question as: Given that a legal obligation presumptively entails a moral obligation, and that the legal system is by and large just, does a particular unjust law impose upon me any moral obligation to conform to it? Whether this question should be answered by the law and jurisprudence or better left to the fields of bioethics or politics is debatable.

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88 Hart, above n 7, 185-6.
90 John Finnis, Natural Law and Natural Rights (Oxford University Press, 2nd ed, 2011) 352.
91 Ibid 352.
92 Ibid 357.
Finnis argues that these issues are dealt with by judges every day when giving judgment set against the milieu of the sociology and political philosophy current at that time.\(^93\) Hart points to a sobering fact of life that

\[\ldots\] it is plain that neither the law nor the accepted morality of societies need extend their minimal protections and benefits to all within their scope, and often they have not done so… though a society to be viable must offer some of its members a system of mutual forbearances, it need not, unfortunately offer them to all.\(^94\)

The controversy over statutory duties on doctors who conscientiously object to performing or participating in an abortion highlights the complexity of the abortion debate in Australia. It reminds us that it is not just about a woman’s capacity to access health care and advice on abortion, it is also about community expectations of a need to strike a reasonable balance that also accommodates the rights of the doctor to exercise freedom of thought, conscience, religion and belief. This in turn encompasses a doctor’s opinion regarding what the fetus is.

Whitcomb notes that with the legalisation of abortion in many countries of the world, there is an ostensible social acceptance of the practice however a uniform willingness by doctors to perform abortion has not followed.\(^95\) Moreover, she argues that societal and professional pressure to provide abortion has given rise to an affirmative intolerance of conscientious objection in the medical profession with the view that those who conscientiously object to performing an abortion are somehow subversive and threaten abortion rights.\(^96\) She argues that the push for mandatory referral by doctors who conscientiously object forces a material co-operation on the part of the doctor and is an effective way for those who oppose conscientious objection to force affirmative co-operation on those doctors.\(^97\)

Australian laws provide doctors with a limited protection of their right. Liberal access to lawful abortion in Victoria and Tasmania further limits conscientious objection by elevating abortion to a right, when sought prior to the fetus reaching a particular

\(^93\) Ibid 352.
\(^94\) Hart, above n 7, 200-1.
\(^96\) Ibid.
\(^97\) Ibid.
gestational age. This thesis anticipates that doctors who conscientiously object to performing or participating in abortion in these States will likely be labelled as people with ‘fringe views’. This is based on the fact that their views as to the value of the fetus and the ethics of abortion are adverse to the trend in law reform in these States.

The medical profession would appear to support the position that when it comes to conscientious objection to lawful medical procedures or treatments, abortion represents a special category of case where the profession’s representative bodies are not willing to support a robust and broad interpretation of what acts constitute ‘participation’ in abortion. Additionally, as has been argued in previous Chapters, they are contending with different abortion laws throughout Australia that lack a common thread. Trying to accommodate a national response from the profession in these circumstances seems a very difficult task.

The debate will no doubt continue and culminate in a legal test case to assess the boundaries and perhaps validity of these laws in Australia. In the meantime, until the law is clarified in Australia, doctors who conscientiously object but practice in areas where they may be called upon to perform or participate in an abortion would be well advised to follow professional Codes of Conduct and open lines of communication with employers to ensure that a suitable compromise can be reached to accommodate their objections whilst not infringing women’s access to lawful procedures. Further research and study into what Australian doctors believe constitutes participation in abortion would obviously be helpful.
CHAPTER NINE

CONCLUSION

This thesis has examined the way in which the Australian law punishes or condones destruction of the fetus in the context of third party assaults against the pregnant woman; maternal duty of care to the fetus, abortion; and conscientious objection by doctors to abortion. It considered whether there is a common and consistent position in Australia on when it is lawful to destroy a fetus in order to test the hypothesis that the legal status of prenatal life in Australia is relative.

This thesis has demonstrated that the fetus has a relative status under Australian law by revealing an absence of unchanging principles that underpin the way in which the law perceives what the fetus is, what its value is, and when its destruction is lawful. This thesis highlights the disparate legal approach between the jurisdictions as to when and in what circumstances it is lawful to destroy a fetus and how the relevance of the physical attributes of the fetus to the commission of an offence, changes dependant on the specific law in question.

The capacity for the status of the fetus to be relative is made possible by maintenance of the born alive rule, which posits that only at birth does the (previously) unborn child become a legal person. With the maintenance of the born alive rule, one has a legal basis to ignore evolving scientific knowledge about the fetus, as well as philosophical reasoning about what a person is. This arbitrary approach to the definition of a legal person fits into the framework of legal positivism, where notions of morality or justice are not considered to be necessary requirements of valid law.

1 Crimes Act 1900 (NSW) s 20; Crimes Act 1900 (ACT) s 10; Criminal Code 1899 (Qld) s 292; Criminal Code Compilation Act 1913 (WA) s 269; Criminal Code Act 1983 (NT) ss 1C sc1(2)(a)-(c); R v Hutty [1953] VLR 338, 339.
In Chapter Two, this thesis demonstrated that where the fetus is destroyed as the result of a third party assault on a pregnant woman, the criminal law statutes in the Australian Capital Territory, New South Wales, Queensland, Tasmania and Victoria, expressly characterise the pregnant woman and the fetus as a single entity. Accordingly, as the fetus is not considered to be a legal person, it cannot be the victim of a crime and therefore any crime is characterised as one against the pregnant woman alone.

For this offence, the level of physical development of the fetus is irrelevant to whether a crime is committed. This is in contrast to the offence of child destruction, which operates in the Australian Capital Territory, the Northern Territory, Queensland and Western Australia. Here, it is a crime to destroy a fetus about to be born or capable of being born alive. Accordingly, the physical maturity of the fetus is a relevant consideration as to whether that particular crime has been committed.

The argument has been made that as child destruction is an offence rarely prosecuted today, it ought to be repealed and dealt with under laws regulating late term abortion. However, in the Australian Capital Territory and Queensland, there is no express prohibition on late term abortion, and in Western Australia, a late term abortion is permitted under certain circumstances. Accordingly, in these jurisdictions that maintain the offence of child destruction and permit late term abortion, there is a clash in logic from the perspective of the fetus, where its physical traits that were determinative of an offence being committed in one scenario (child destruction), suddenly become irrelevant in a different scenario (late term abortion).

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4 Crimes Act 1900 (NSW) ss 4, 42; R v King (2003) 63 NSWLR 278; Crimes Act 1900 (ACT) ss 43, 48A; Criminal Code 1899 (Qld) s 313(1); Crimes Act 1958 (Vic) s 15; Criminal Code 1924 (Tas) s 184A.
5 Crimes Act 1900 (ACT) s 42; Criminal Code 1988 (NT) s 170; Criminal Code 1899 (Qld) s 313(1); Criminal Code Compilation Act 1913 (WA) s 290.
7 Health Act 1993 (ACT) ss 80-83; Medical Services Act (NT) s 11(3); R v Bayliss (1986) 9 Qld Lawyer Reps 8.
8 Health Act 1911 (WA) s 334(7).
After considering third party assaults on the pregnant woman that destroy the fetus, this thesis then considered the general issue of materno-fetal conflict. Academic opinion can be sorted into three main approaches; the separate entity approach, the single entity approach and an in between approach. The third approach often called the ‘not one, but not two’ approach appears to find the most resonance in legal cases dealing with maternal behaviour that compromises the fetus. Whilst the law upholds the concept of maternal bodily autonomy over the life of the fetus, on occasion it has circumvented this to protect the fetus by finding a lack of legal capacity on the part of the pregnant woman that then curtails her behaviour.

These morally complex dilemmas are the precursor to the issue of abortion, where the pregnant woman specifically seeks to harm the fetus. Chapters Four, Five, Six and Seven of this thesis considered the regulation of abortion in Australia. It highlighted the disparate national approach to the circumstances that make abortion lawful. As summarised in Table 1 on page 75, in seven jurisdictions, the law expressly states in statutes or case law that the mother’s life or health has primacy over any right of the fetus to be born. In five jurisdictions, the gestational age of the fetus sits alongside maternal health concerns. In three jurisdictions, the presence of disability in the fetus can legitimise abortion, in conjunction with gestational age. In two jurisdictions, the consent of the pregnant woman to abortion is sufficient to legitimise abortion so long as the fetus is below a particular gestational age.

From a positive law perspective, as the law considers the physical realities of the fetus as only one of a number of factors relevant to the question of whether its destruction is lawful, multiple approaches are acceptable. The capacity for physical traits to decide whether an offence has been committed is determined by the particular law in question, with no rationale required as to why it was relevant in one set of circumstances but not in another.

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Accordingly, despite the muddled approach to the regulation of abortion in Australia, the laws that are made are still valid, positive laws. However, if the purpose of positive law is to regulate rights and obligations between people, achieve a measure of justice and be socially accepted by the community, then the State must ensure its laws achieve balance.

It is evident when considering abortion law reform in Australia over the last 25 years, that there has been increased access to lawful abortion and a de-emphasis on any notion of fetal legal rights. However, this thesis’ analysis of the laws in each jurisdiction demonstrates that we have not reached the point where it could be said that Australian law as a whole reflects abortion on demand. Limitations and legal oversight in one form or another continue to exist and a doctor's judgment as to the appropriateness of the abortion is still considered a necessary requirement in all jurisdictions.

This thesis has argued that continuing medical oversight for the appropriateness of abortion should be non-negotiable given it requires the assistance of the medical profession to achieve its end. However the most recent abortion law reform in Victoria and Tasmanian, discussed in Chapter Seven, created abortion on demand up to a certain gestational age.¹⁰ In so doing, it took away the power of medical oversight and elevated abortion in that context to a standard medical procedure.

This thesis takes the position that where the State imposes laws that equate abortion to a standard medical procedure, it runs the risk of creating a duty on doctors to provide abortion on request. Those doctors that oppose abortion could be at risk of becoming marginalised, with their views considered not worthy of being considered in public discourse because the law has deemed a fetus to have nil value. This thesis views this type of development as worrying. Doctors who conscientiously object would have no protection from State oppression.

¹⁰ Abortion Law Reform Act 2006 (Vic) s 4; Reproductive Health (Access to Terminations) Act 2013 (Tas) s 4.
The Tasmanian law has gone further in advancing the primacy of a woman's right to abortion by imposing more stringent obligations on doctors to co-operate materially in ensuring that abortion is achieved, notwithstanding their conscientious objection to participating in the act. The response of the medical profession in Victoria and Tasmania suggests that rather than insisting on a doctor's right to freedom of conscience and integrity of moral beliefs, they will try and find a way to avoid this conflict occurring.

The practical application of these laws, and the question of whether laws creating statutory duties on doctors to perform or participate in abortion are unjust and/or defective, await a suitable test case. This is an area worthy of further research.

Whether other jurisdictions can enact similar provisions limiting conscientious objection by doctors to abortion or creating statutory duties on them is less clear. This thesis contends that without clear laws creating abortion on demand, a jurisdiction probably cannot limit conscientious objection. In other words, where there is a requirement for doctors to be satisfied of maternal health concerns, a pregnant woman cannot demand an abortion from them. Accordingly, where the lawmaker wishes to advance the primacy of a woman’s right to bodily autonomy, law reform would need to formally remove medical oversight and with it, the doctor’s traditional gate keeper status.

Such conflicts of rights are the foreseeable result where relativism underpins the law. Where the touchstone principle of the law fails to deliver consistent legal results, it is difficult for the State to regulate with any moral authority, the rights and obligations of people affected by the laws it makes. Imposition by the State of a particular position such as the nil value of the fetus, would permit the lawmaker to regulate the behaviour of people affected by that law, such as doctors.

Having considered the laws in these four areas, and reflected on areas where there appear to be common purpose, this thesis now makes suggestions for amending the law to achieve consistency between jurisdictions. These suggestions are made on the following realistic, assumptions/limitations: Firstly, that it is unlikely lawmakers in

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11 Reproductive Health (Access to Terminations) Act 2013 (Tas) s 7(3).
Australia will overturn the born alive rule and bestow legal personhood on the fetus; and Secondly, that the practice of abortion is likely to continue.

The suggested amendments are; the repeal of child destruction laws in the Australian Capital Territory, Queensland and Western Australia; decriminalisation of abortion in Queensland, New South Wales and South Australia; lawful abortion where two doctors are satisfied that there is a proportionate justification for the abortion in accordance with their best judgment; deletion of reference to fetal disability; and recognition of a doctor’s right to conscientiously object to performance or participation in abortion without limitation. Penalties should remain severe for unlawful abortion.

The non-existence of prosecutions for child destruction highlights its lack of practical usefulness. Of most concern for this thesis is the rationale that the mature fetus is more deserving of legal recognition and protection than the less mature. This relies on an attribute of the fetus as the basis for the offence as opposed to any inherent value. It provides justification for other attributes of the fetus (such as disability) to be considered legitimate factors in assessing the lawfulness of destroying it.

The decriminalisation of abortion is not a particularly controversial suggestion for Australia given abortion law reform. However, the subsequent suggestion regarding how abortion should be regulated is the most challenging reform and ties into the related recommendations regarding fetal disability and conscientious objection.

The most significant reform would be whether to adopt the gradualist approach to the value of the fetus and agree on an upper time limit when abortion is unlawful or subject to strict guidelines. As discussed in Chapter Five, to do so would bring Australia into line with countries like the United States of America and the United Kingdom. On the other hand though, it imposes an arbitrary value on the fetus that does not accord with the way third party assaults on the pregnant woman are perceived in the law, and may also not accord with evolving scientific knowledge or philosophical arguments about the fetus.
Requiring two doctors to be satisfied that there is proportionate justification for abortion and permitting conscientious objection without limitation would be the trade-off for having no gestational age limitation. It permits a difference of moral and/or scientific opinion on the issue and does not dictate what the doctor must consider. This thesis takes the position that a militant, pro-abortion agenda that seeks to bind everyone to the view that the fetus is not a person and has no value, is not the answer to ‘good’ law, does not reflect a tolerant and respectful society, and does not acknowledge the variety of perspectives on personhood. Rather, it represents a tyranny that is unbecoming to the values this nation adheres to.

In regards to conscientious objection and the obligation of doctors to refer patients on to others who will perform abortion, the position of this thesis is that the doctor who conscientiously objects should accept that the State has deemed that abortion can be lawful in certain circumstances and therefore s/he ought not to actively prevent a woman from accessing it. However likewise, the pregnant woman should accept that the doctor who is asked to perform an abortion can either refuse outright on the basis of conscience or refuse on the basis of a valid concern that in the particular circumstances the abortion is not justified (assuming the particular law permits this). The doctor should not be forced to participate nor should their non-participation become a disciplinary issue.

This thesis concludes that the search for the truth about what the fetus is, what its value is, and why it is right, wrong or neutral to destroy it, cannot be found in the positive law with its commitment to the born alive rule. If our Australian legal system were to replace relativism with the natural law, then it would be highly doubtful that abortion laws and other laws legalising destruction of prenatal life would be lawful or at the very least would be much smaller in number with clear boundaries that would not change with the times or with technological advances. However as ethical relativism is fundamental in Australian society, where social practices expected by a section of the community involve the destruction of prenatal life, laws that reflect a strict moral position that the fetus is a human being and all human beings are persons, is very unlikely to be accepted by the community and hence by lawmakers.
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