Submission to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquiry re *Termination of Pregnancy Bill 2018*

From – Dr Carol Portmann MBBS FRANZCOG CMFM

Credentials -

Maternal Fetal Medicine (QUFW – private provider of obstetric gynae ultrasound and prenatal diagnosis, Spring Hill and Southport) P/T
Marie Stopes Australia (private provider of abortion and contraception Bowen Hills clinic) P/T
Previously – Obstetrician and Maternal Fetal Medicine specialist RBWH

Experienced provider of medical and surgical termination of pregnancy, late termination of pregnancy, selective termination in multiple pregnancy.

SUBMISSION

I support the bill in its entirety. I have provided an online submission with responses to each part of the bill. In this submission I wish to clarify those areas that have been raised as significant concern in the public and political arena.

RESPONSE TO THE LATE TERMINTION OF PREGNANCY ARGUMENTS.

Recently some individuals have raised highly emotive arguments suggesting that the change in abortion legislation in Queensland would result in women having late termination of pregnancy within minutes prior to the baby being born. These individuals are using highly emotive language such as “murder”, and “for any reason”.
These arguments are not factual, and do not consider the mothers’ situation, the process that doctors use to assess requests for termination of pregnancy, nor the health fraternities moral and ethical guidelines.
There are some very rare circumstances where very late termination of pregnancy may be considered an option for extremely serious fetal situations where there is very poor quality and quantity of life outcomes. In these cases, the fetal and maternal circumstances are carefully examined by a number of doctors and ethics committee before any decision would be made. Change in legislation would streamline this process but not remove it. The process takes time and involves a number of individuals consulting with the parents before any decision would be made.
Suggesting that a person can present requesting termination of pregnancy days before her expected due date and receive a termination without any due process just because of

legislative change is a complete falsehood and demonstrates a lack of understanding of the process.

Let us look at the facts. There are a very limited number of doctors who are trained to provide the physical procedure that is required for very late termination of pregnancy (feticide). The procedure would need to occur in a clinical setting with high end ultrasound equipment (major tertiary hospitals or clinics). Currently these doctors reside in South East Queensland and Townsville.

These doctors would not consider the procedure without due process and involvement of the hospital that the person would deliver at. Assessment of the baby and the person's situation by doctors/health care workers relevant for that situation would be part of that due process. This would be the same if being performed for maternal psychosocial indications and request. At all times, maternal wellbeing is the priority and Doctors will continue to uphold this.
Change in legislation would allow individuals to be properly referred and assessed in a timely and sensitive manner, but by no means result in "murder minutes before birth".

Concerns that a private clinic would utilize change in legislation to provide very late termination of pregnancy is also unsubstantiated. The procedure (feticide) is technically much more challenging in later gestations and very few private providers would be capable of it. The few cases (in comparison to <22 weeks gestation) make widespread training or upskilling of doctors a difficult concept. After the procedure is performed, the baby must be delivered and this must be done at a hospital/birthing unit who would have to be active participants in the process. The cost of setting up, credentialing and staffing a private clinic that also provides very late termination of pregnancy would be prohibitive and financially unviable.

RESPONSE TO GENDER SELECTION CONCERNS

Knowledge of gender of a pregnancy requires a formal ultrasound at a gestation over 12weeks (more accurately over 15 weeks) or a blood test that costs $400 (no medicare rebate). This blood test is performed after 10 weeks, and results take approximately one week, thus the earliest a gender result is available is 11 weeks.

90% of terminations of pregnancy are performed under 11 weeks ie well before gender can be assessed. Terminations of pregnancy over 12 weeks, and specifically over 15 weeks are considerably more expensive and of slightly increased medical risk.

Gender selection for anything other than medical conditions is not supported by the NHMRC (National Health and Medical Research Council) – this was mostly in reference to artificial reproductive technologies. Doctors in principal abide by this recommendation in regards to abortion as well.

Anecdotally, I have no recollection of any client specifically stating that gender was the sole reason for the termination of pregnancy. Of course, I cannot exclude this. It is also not typical for clients to ask the gender of the baby and use this in their decision making.

Overall, change in legislation will not alter the above facts and there is no reason to suspect a sudden rush in pregnant persons presenting for termination of pregnancy based on gender alone, nor that doctors would consider this a suitable indication on its own.

RESPONSE TO "TERMINATION IS ALREADY AVAILABLE IF NEEDED"

Termination of pregnancy is available to women

- With financial means
- Geographically placed near a clinic or supportive hospital
- With social supports to provide transport, after care, child care
- No medical concerns preventing private termination
- who have a sympathetic GP (or other health care worker) that knows where, how and who to refer to

Pregnant persons in the greatest need of support are the least likely to find it.
Pregnant persons with medical issues including obesity cannot access private terminations, but are often not able to have their circumstances considered at public hospitals.
Pregnant persons cannot access public hospital care even with reasonable indications, because typically they are told "we don't do that here" and refused assessment by health care staff.
Pregnant persons are at the whims and mercy of the opinions and view points of medical receptionists, nurses, doctors, medical administrators.
Access to and provision of care is haphazard, inequitable and based on whether there are supportive avenues at the district hospital and that the pregnant person finds them.

Change in legislation will change the above and can only do so for the better.

As long as abortion, the pregnant persons who request it and the health care providers are considered abhorrent and illegal, the care provided to pregnant persons will fall short. They may not receive adequate counselling, protection from violence, social and financial supports, drug rehabilitation, medical opinions or care. A change in legislation may well see a change in attitude to allow the kind of care pregnant persons deserve to receive regardless of their choices in their pregnancy. The potential increase in terminations as a result of improved access, may well be balanced by a reduction as people are able to receive sympathetic support that may allow them to seek alternative options.

The *Termination of Pregnancy Bill 2018* should be adopted in its entirety and not significantly modified as this is in the best interest of reproductive health care in Queensland.

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