Submission on the

Termination of Pregnancy Bill 2018

by Dr Rachel Carling-Jenkins MLC, Member for Western Metropolitan (Parliament of Victoria)

Introduction

I would like to thank the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee for the opportunity to provide input into the Termination of Pregnancy Bill 2018. In Victoria, we have had similar abortion legislation (with the exception of the safe access zones which was added fairly recently) for almost a decade. This gives those of us in Victoria a unique perspective on the legislation you are considering. My submission, which is backed up by extensive research, will go through particular clauses of the bill, and point to various aspects which are particularly unnecessary, based on misleading 'facts' and/or misguided. There are also aspects of your bill as drafted which are being considered for constitutional validity at this time.

I would welcome the opportunity to speak to the Committee if a suitable time can be arranged.

SCHEDULE 1: Definitions

I note that the Dictionary in Schedule 1 of the Bill provides that:

> ***termination*** means an intentional termination of a pregnancy in any way, including, for example, by—
>
> (a) administering a drug; or
>
> (b) using an instrument or other thing.

This definition does not seem fit for purpose as it could apply to the induction of a pregnancy with the intention of terminating it by delivering a live born child with no intention to end the life of the child (ie, a 'normal' birth using the assistance of, for example, administering a drug to induce labour or using forceps).

The Explanatory Notes state (p.1):

The phrase termination of pregnancy (termination) refers to a deliberately induced miscarriage by medical or surgical means (sometimes referred to as abortion). The choice of procedure depends on the gestation of the pregnancy, clinical indications including the risk of complications, the preferences of the woman and other relevant circumstances.

As the Bill is clearly intended to deal with intentionally ending the life of the unborn child it would be more fitting to use the term abortion. The only reason to avoid this term is the desire to pretend that "termination of pregnancy" does not involve the deliberate and intentional killing of an unborn child.

Except when quoting the terms of the Bill itself I will avoid euphemisms and refer to abortion.

CLAUSE 3: "REASONABLE AND SAFE ACCESS BY WOMEN TO" ABORTIONS

Clause 3 provides, firstly, that:

The purposes of this Act are—

(a) to enable reasonable and safe access by women to terminations;

Reasonable access to abortion

What is reasonable access to abortion?

Reasonable means "*as much as is appropriate or fair*".

Abortion is, by definition, the intentional ending of the life of an unborn child.

Modern science tells us much about the unborn child.

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The science of fetology has dramatically improved our understanding of unborn human life. It is no longer possible in the age of 4-D ultrasound and in utero fetal surgery to hold that the fetus is just a bunch of cells or anything other than "one of us", that is a human being.

These are just some facts about the unborn child revealed by recent scientific developments:

- "*Cardiac motion can be visualized using ultrasonography from as early as 26–32 days after conception, and certain aspects of embryonic heart function have been studied using Doppler ultrasonography from 6 weeks of gestation*."[i] At 6 weeks the mean heart rate is 117 beats per minute. At 10 weeks the mean heart rate is 171 beats per minute.[ii]

- A motor response can first be seen as a whole body movement away from a stimulus and observed on ultrasound from as early as 7.5 weeks' gestational age. The area around the mouth is the first part of the body to respond to touch at approximately 8 weeks, but by 14 weeks most of the body is responsive to touch.[iii]

- By 15 weeks gestation the human fetus has fully developed and functioning taste buds.[iv]

- "*Starting from the 14th week of gestation twin foetuses plan and execute movements specifically aimed at the co-twin. These findings force us to predate the emergence of social behaviour: when the context enables it, as in the case of twin foetuses, other-directed actions are not only possible but predominant over self-directed*".[v]

Any consideration of what is "reasonable access" to abortion must take into account the reality that abortion ends the life of an innocent human being. An approach to the law which makes the unborn child invisible is neither reasonable nor justifiable.

Safe access to abortion

Abortion is associated with adverse outcomes for women's mental health

There is a substantial body of research indicating an increased risk of mental health problems following an abortion. Not all the specific risk factors have been identified but some of the research

has controlled for factors including pre-existing mental health problems and the unwantedness of the pregnancy and found that abortion is an independent risk factor for increased mental health problems.

Longitudinal studies in New Zealand have found a general association of abortion with subsequent mental health problems. In 2006 David Fergusson and colleagues using data from the longitudinal Christchurch Health and Development Study reported that women who had an abortion before age 25 had 1.49-1.72 times the risk of experiencing mental health problems than women who had not got pregnant or who had become pregnant and not had an abortion. Those having an abortion had elevated rates of depression, anxiety, suicidal behaviours and substance use disorders.[vi]

In 2008 Fergusson and colleagues reported that exposure to abortion was associated by age 30 with a 1.3 relative risk of mental health problems while carrying an unwanted pregnancy to term was not a risk factor for mental health problems. This study effectively ruled out earlier suggestions that the adverse mental health risks seen in women who had abortion were associated with unwanted pregnancy itself rather than with the abortion.[vii]

In 2009 Fergusson and colleagues reported that over 85% of women who had an abortion reported at least one negative reaction to the abortion (sorrow, sadness, guilt, grief/loss, regret, disappointment) with 34.6% of women who had an abortion reporting five or six of these negative reactions. For those women with moderate negative reactions (1-3) to abortion this was associated with a 1.43 relative risk of subsequent mental health problems compared to women who did not have an abortion. For those with stronger negative reactions (4-6) the relative risk of subsequent mental health problems was 1.64-1.81. Fergusson concludes that for this population (women under 30) abortion is responsible for approximately 5% of all mental health problems.[viii]

Coleman and her colleagues found on the basis of an US national comorbidity survey that abortion was "*related to an increased risk for a variety of mental health problems (panic attacks, panic disorder, agoraphobia, PTSD, bipolar disorder, major depression with and without hierarchy), and substance abuse disorders*" and that it accounted for between "*4.3% and 16.6% of the incidence of these disorders*".[ix]

A 2011 meta-analysis by Coleman of 22 studies found that "*women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion. The strongest subgroup estimates of increased risk occurred when abortion was compared with term pregnancy and when the outcomes pertained to substance use and suicidal behaviour*."[x]

In particular the meta-analysis indicated a population attributable risk percentage as follows for various adverse mental health outcomes of abortion:

Anxiety	8.1
Depression	8.5
Alcohol use	10.7
Marijuana use	26.5
All suicidal behaviours	20.9
Suicide	34.9.

A 2016 US study using data from the National Longitudinal Study of Adolescent to Adult Health confirmed previous findings from Norway and New Zealand that, unlike other pregnancy outcomes, abortion is consistently associated with a moderate increase in risk (45%) of mental health disorders during late adolescence and early adulthood.[xi]

This study was particularly significant in providing "*some of the strongest evidence to date that the association of abortion with subsequent mental distress is not merely contingent but is indeed causal*".

An abortion law which took full account of this finding, far from facilitating ready access to abortion virtually on request, would instead prohibit abortion as deadly to the unborn child and of no benefit to women.

Abortion increases maternal mortality

Abortion has been found in population wide studies in Finland, California and Denmark to be associated with an increased risk of mortality, in particular a dramatically increased risk of suicide.

A paper published in 2005 in the *European Journal of Public Health* found that, compared with women who have not been pregnant in the prior year, deaths from suicide, accidents and homicide were 248% higher in the year following an abortion, according to a 13-year study (1987-2000) of the entire population of women in Finland.

The study also found that a majority of the extra deaths among women who had abortions were due to suicide. The suicide rate among women who had abortions was six times higher than that of women who had given birth in the prior year and double that of women who had miscarriages.[xii]

A more recent study of Finnish data from 2001 to 2012 found that while mortality rates, including suicide rates, had decreased for all categories, women were still twice as likely to commit suicide within one year of an abortion compared to women who had not been pregnant and 6.6 times as likely to commit suicide within one year of an abortion as women who had completed a pregnancy.[xiii]

Researchers examining death records linked to medical payments for birth and abortion for 173,000 California women found that aborting women were 62 percent more likely to die than delivering women over the eight year period examined. That study also found that the increase risk of death was most prominent from suicides and accidents, with a 154 percent higher risk of death from suicide and an 82 percent higher risk of death from accidental injuries.[xiv]

A study using Danish registry records was published on 1 September 2012 in the Medical Science Monitor. The study examined the records for 463,473 women who had their first pregnancy between 1980 and 2004, of whom 2,238 died. It compared the rate of deaths of women at various time intervals after their first pregnancy for women who had pregnancies ending in early abortion, late abortion, miscarriage requiring hospital treatment and childbirth. After adjusting the raw data for year of birth and age at first pregnancy the following statistically significant results were found.

In the first 180 days after the pregnancy ended women who had an early abortion were more than twice as likely to die as women who had a live birth. This increased risk persisted up until at least ten years after the pregnancy ended with women who had abortions having a 40% higher risk of dying within 10 years than women who had a live birth.

Women who had an abortion later than 12 weeks of pregnancy were over four times more likely to die within 180 days than women who had a live birth and almost two and a half times likely to die within 10 years.[xv]

A second study using Danish registry records was published online in the *European Journal of Public Health*. In this Danish population-based study, records of 1,001,266 women born between 1962 and were examined to identify associations between patterns of pregnancy resolution and mortality rates across 25 years. Increased risks of death were 45%, 114% and 191% for 1, 2 and 3 abortions, respectively, compared with no abortions after controlling for other reproductive outcomes and last pregnancy age.[xvi]

Registry based studies such as these two Danish studies and the early studies from Finland and California are important in gaining an accurate picture of comparative maternal mortality following induced abortion and childbirth.

The claim that abortion is safer for women than childbirth is usually based on limited data with many deaths following abortions not identified as such. This claim cannot be sustained in the light of the registry studies which consistently demonstrate that induced abortion, and even more so late induced abortions or repeat abortions, significantly increase the risk of maternal death.

An abortion law which aimed to keep women safe would prohibit all abortion.

CLAUSE 3: "THE CONDUCT OF REGISTERED HEALTH PRACTITIONERS IN RELATION TO"ABORTIONS

Clause 3 provides, secondly, that:

> *The purposes of this Act are—*
>
> > *(b) to regulate the conduct of registered health practitioners in relation to terminations.*

Abortion is not merely another medical procedure

Treating abortion as merely another medical procedure is misleading. Pregnancy as such is not a disease.

Abortion simply on the request of the woman is only a medical procedure in the same sense as executing a prisoner by lethal injection by a doctor at the request of the state is a medical procedure. That is to say, it is a procedure performed by a doctor using medical knowledge but not for any identifiable medical purpose. Abortion performed simply on request is not aimed at achieving health but simply at ending pregnancy through terminating the life of the unborn child.

The law should deal with the conduct of registered health practitioners in relation to abortion by prohibiting them from performing an abortion or participating in the performance of an abortion.

Abortion, properly understood, is never required for the preservation of the mother's life

Cancer treatment to preserve a mother's life even if that treatment may pose a risk to the health, or even the life, of her unborn child is not abortion.

Nor is the early induction of labour for conditions such as severe eclampsia provided (i) there is no direct assault on the unborn child intended to kill it and (ii) on delivery the child be given the same treatment, including resuscitation, as would be given to any child delivered at the same gestational age.

Neither of these scenarios is accurately defined as abortion, which always includes an intention to end the life of the unborn child, or at least recklessness about causing its death.

The Dublin Declaration on Maternal Healthcare signed by over 100 medical professionals, including 245 obstetricians and gynaecologists expresses this approach succinctly:

> *As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman.*
>
> *We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child.*
>
> *We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.*[xvii]

CLAUSE 5: "TERMINATION BY MEDICAL PRACTITIONER AT NOT MORE THAN 22 WEEKS"

Clause 5 would provide that:

A medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant.

Page 17 of the Explanatory Notes explains:

This adopts an 'on request' approach up to the gestational limit of 22 weeks. Under this approach there are no legislative grounds or consultation with another medical practitioner requirements. The lawfulness of the termination is determined by the same principles as those that apply to health matters generally, for example consent.

This 'on request' approach allows abortion for any reason including sex selection and eugenic abortions designed to eliminate a child who has, or may have, an unwanted characteristic or disability.

Abortions for sex selection

In July 2018, research into male-biased sex ratios in migrant populations in Victoria was published in the International Journal of Epidemiology[1].

Disturbingly, it found evidence of distorted sex ratios at birth for children of mothers born in China and India. There are nearly 1,000 missing girls in Victoria due to sex selection before birth in the Indian, Chinese and South East Asian migrant communities between 1999 and 2015.

In the five year period from 2011 to 2015, there were on average 32 girls each year missing from Indian-born mothers and 22 girls each year missing from Chinese-born mothers.

The researchers point to abortion following the identification of the sex of the unborn child as female as the primary mechanism by which the cultural preference for a male child is given effect.

Allowing abortion on request allows abortion for sex selection, including sex selection based on a cultural preference for male children.

Abortion as a eugenic measure

The United Nations Committee on the Rights of Persons with Disabilities provided comment on draft General Comment No 36 of the Human Rights Committee on article 6 of the International Covenant on Civil and Political Rights.

The Human Rights Committee proposed a specific measure favouring abortion "when the foetus suffers from fatal impairment".

The CRPD Committee commented that "*Laws which explicitly allow for abortion on grounds of impairment violate the Convention on the Rights of Persons with Disabilities (Art,. 4,5,8). Even if the condition is considered fatal, there is still a decision made on the basis of impairment. Often it cannot be said if an impairment is fatal. Experience shows that assessments on impairment conditions are often false. Even if it is not false, the assessment perpetuates notions of stereotyping disability as incompatible with a good life*."[xviii]

Attempts to deny the eugenic nature of laws permitting abortion precisely for disability are specious and without any plausible foundation. We will never treat people with disability with the equal respect which is their due if we endorse laws which explicitly allow for them to be excluded from a chance at life after birth – even if that may be a very short life.

Clause 5 would permit abortion for eugenic reasons in contravention of the rights of persons with disabilities to be treated with equal respect both before and after birth.

CLAUSE 6: "TERMINATION BY MEDICAL PRACTITIONER AFTER 22 WEEKS"

The so-called "additional requirements" are effectively meaningless.

[1] Kristina Edvardsson et al, "Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015" *International Journal of Epidemiology*, [redacted]

The range of circumstances to be considered is so broad that it is hard to imagine a scenario where a doctor who personally believed in abortion on request up to full term could be faulted if he or she claims to "consider that, in all the circumstances, the termination should be performed".

Finding a second doctor to agree would not be difficult.

Abortion at 22 weeks or later has additional harms

The act of abortion – the intentional causing of the death of a child before birth – is equally wrong at any stage of gestation.

However, modern abortion laws have rightly taken note of recent scientific findings both on the developing capacity of the unborn child to feel pain and the increasing rate of survival of very premature babies to explicitly prohibit late term abortions even where – as in the United States – an outdated, forty five year old decision by the Supreme Court currently prevents legislatures from banning all abortions.

Pain-Capable Unborn Child Protection Act

On 3 October 2017 the United States House of Representatives passed the *Pain-Capable Unborn Child Protection Act* by 237 to 189 votes. (The Bill stalled in the Senate on 29 January 2018, despite having majority support, after failing in a 51-46 vote to get the 60 votes need for cloture.)

This Bill is of particular interest as its sets out the Congressional findings about the unborn child's capacity to feel pain which are derived from extensive inquiries considering the available expert evidence.

Section 2 of the Bill reads[xix]:

> *Congress finds and declares the following:*
>
> *(1) Pain receptors (nociceptors) are present throughout the unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks after fertilization.*
>
> *(2) By 8 weeks after fertilization, the unborn child reacts to touch. After 20 weeks, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling.*
>
> *(3) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.*
>
> *(4) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life.*
>
> *(5) For the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli*

are applied without such anesthesia. In the United States, surgery of this type is being performed by 20 weeks after fertilization and earlier in specialized units affiliated with children's hospitals.

(6) The position, asserted by some physicians, that the unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and analysis, especially since 2007, provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

(7) Substantial evidence indicates that children born missing the bulk of the cerebral cortex, those with hydranencephaly, nevertheless experience pain.

(8) In adult humans and in animals, stimulation or ablation of the cerebral cortex does not alter pain perception, while stimulation or ablation of the thalamus does.

(9) Substantial evidence indicates that structures used for pain processing in early development differ from those of adults, using different neural elements available at specific times during development, such as the subcortical plate, to fulfill the role of pain processing.

(10) The position, asserted by some commentators, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from engaging in vigorous movement in reaction to invasive surgery.

(11) Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain at least by 20 weeks after fertilization, if not earlier.

(12) It is the purpose of the Congress to assert a compelling governmental interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain.

Twenty of the fifty US States have passed similar laws.

A law permitting abortion after 22 weeks is a law permitting the killing of children who can feel pain. It is a cruel law as well as an unjust law.

Decreasing age of viability

In November 2017 the journal *Pediatrics* published a case report on "*a female infant resuscitated after delivery at 21 weeks' 4 days' gestation and 410 g birth weight*" possibly the most premature known survivor to date.[xx]

According to the case report this little baby girl "*had multiple risk factors for adverse outcome, including prolonged mechanical ventilation, bronchopulmonary dysplasia, and threshold retinopathy of prematurity*."

However, she "*achieved discharge from the hospital on low-flow oxygen at 39 weeks' 4 days' gestation and 2519 g*."

By "*24 months' and 8 days' chronological age, she achieved cognitive, motor, and language Bayley III scores of 90, 89, and 88, equivalent to 105, 100, and 103 at 20 months 2 days corrected age*."

The authors conclude "*It is known that active intervention policies at 22 weeks' gestation improves the outcome for those infants and it may be reasonable to infer that these benefits would extend, if to a lesser degree, into the 21st week. Ultimately, such limited data exist at this gestational age that the time may have arrived for obstetrical centers to begin systematically reporting fetal outcomes in the 21st week.*"

The decreasing age of viability is relevant to the consideration of modern abortion laws insofar as any abortion permitted after viability directly destroys the life of an unborn child who could, in effect, have been delivered alive and still survive. It is difficult to see any rational basis for permitting a woman to agree to a deadly assault on her viable unborn child while treating as murder any deadly assault on a child of the same gestational age who has already been delivered alive.

A law permitting abortion of any child after 22 weeks is a law allowing the killing of a child who could potentially be safely delivered, and if given appropriate medical care, survive and flourish.

CLAUSE 6: "EMERGENCY ABORTION AFTER 22 WEEKS"

As discussed above, abortion – understood to include an intention to end the life of an unborn child or a direct and deadly assault on an unborn child – is never necessary to save the mother's life.

In a life-threatening emergency after 22 weeks of pregnancy, an unborn child may should be delivered by induction or Caesarean section as medically indicated to be give the best chance for saving the life of both patients – the mother and her unborn child.

It is unnecessarily stressing for a pregnant woman in these circumstances to describe such an action as an abortion or "termination of pregnancy".

There is no need for this provision whatsoever.

CLAUSE 8: "REGISTERED HEALTH PRACTITIONER WITH CONSCIENTIOUS OBJECTION"

The proposal in the Bill to require a health practitioner with a conscientious objection to abortion refer a woman requesting an abortion or advice on an abortion, or transfer her care to another health practitioner who "can provide the requested service" and has no such objection or to a health service provider where the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the" abortion is neither necessary or reasonable.

It is not necessary because no referral is needed under this Bill for an abortion.

"Refer" in normal medical practice is used in relation to referrals to a specialist, either by a GP or by a specialist in another field of medicine. In Australian law there are very specific requirements for referrals under the *Health Insurance Act 1973* and the *Health Insurance Regulations 1975.* It is potentially confusing to be introducing some different meaning of "refer" for the purposes of this Bill.

A woman who is told by a health practitioner that he or she has a conscientious objection to performing an abortion can readily seek another practitioner.

It is unreasonable to expect a health practitioner who has a conscientious objection to abortion to choose which abortionist or abortion facility to "refer" a woman to for the purpose of obtaining an abortion. Normally a health practitioner refers a patient in order for the patient to obtain specialist professional care to improve the patient's health.

In the case of abortion, a health practitioner with a conscientious objection to abortion is likely to genuinely believe that he or she has two patients to which a duty of care is owed - the pregnant woman and her unborn child. The only outcome of abortion for the second patient – the unborn child – is death. And, assuming the health practitioner is familiar with the medical literature on abortion and its adverse impacts on women's mental health and on maternal mortality, the outcome for the woman may also be poor, or even deadly. Why should the law impose a duty on a health practitioner to refer his two patients to a health practitioner who would bring about an outcome detrimental to the life and health of those patients?

For the same reasons outlined above in relation to emergencies under Clause 6 there is no need for any reference to emergencies in this Clause.

PART 4: "SAFE ACCESS ZONES"

On 24 November 2015 I spoke against the Public Health and Wellbeing Amendment (Safe Access Zones) Bill 2015, which, sadly, later passed and has become law in Victoria.

I said in part:

This bill's purpose is to provide — and I quote from the bill – "safe access zones around premises at which abortions are provided". I wish to dispute this wording. This bill is not really about safe access zones, for these zones are not safe. They are not safe for women and they are not safe for the pre-born children they carry into but not out of the premises.

First I need to lay some necessary groundwork or foundational comments to my contribution. Women, I believe, are victims of the abortion industry. While the ads that these clinics put out may say that abortions are low risk, they fail to create a full picture of the impacts — the physical impacts, the emotional impacts, the scars and the grief. Abortion trauma, sometimes referred to as post-abortion grief, frequently destroys relationships, shatters families both present and future and leads to crippling emotional strain. Abortion is not a solution to a problem, only a symptom of one.

This bill ignores the realities of the dangers of abortion. This bill seeks to make it a crime for any pro-life communication within a radius of 150 metres of an abortion clinic. Much of the debate around this bill has centred on the controversial clinic in East Melbourne. However, we are voting on a law tonight which will place no-go zones around all Victorian abortion clinics, public hospitals and private hospitals where abortions are performed and possibly even doctors' clinics.

Earlier this year I assisted the government to repeal Victoria's move-on laws as an unfair restriction on free speech. I supported the Summary Offences Amendment (Move-on Laws) Bill 2015 based on the principles of freedom of speech, freedom of association, freedom of assembly and basically the equality of all humans. [These principles are] integral to guaranteeing the conditions for a public discourse that will progress us towards a civil society. Freedoms are a right, a responsibility and a risk. Freedoms are at the heart of human dignity and the common good, principles which I am committed to upholding and which I do not see within this bill.

At the time that the move-on laws were repealed the Attorney-General, Martin Pakula, stated: 'Victoria doesn't need Bjelke-Petersen-style laws designed to silence dissent and outlaw peaceful protests'. What a fickle and short-sighted government — because this is exactly what this bill is about. So it is okay to be a union protester loudly proclaiming your objections to unfair or unsafe work practices, but hold a prayer vigil outside an abortion clinic and not only will you be moved on but you will be hit with a fine or threatened with imprisonment of up to 12 months.

This bill, in my opinion, aggressively, unnecessarily and disproportionately targets free speech and political communication on a contested subject which is protected under our constitution.

There are two more facts around this case which I feel necessary to bring once again to the attention of this house, albeit briefly. Firstly, there is the 2001 case where a security guard was shot and killed. This was a tragedy — a tragedy which would not have been avoided if this law was in place. The man who undertook this crime stole a gun, cycled to Melbourne, lived as a hermit and shot the guard. He acted alone. He acted contrary to pro-life values. He was a lone wolf, if you will. Legislation, tragically, will never be able to stop such a determined and misguided individual.

Secondly, I would like to point out that in the case of Fertility Control Clinic v. Melbourne City Council earlier this year the lawyers for the Fertility Control Clinic did not plead the facts in this case. I would dispute that the result of this case is a trigger for such a bill as this. There was no finding of harassment or intimidation. Furthermore, there was no proof that existing laws do not protect women from harassment and intimidation.

This bill is a disproportionate response to a misleading story, fabricated for the advantage of the abortion industry. The true effect of this bill, if not amended, will be to make peaceful protest, prayer, support workers and counsellors illegal in the vicinity of abortion clinics.

So I turn now to the false narrative underlying this bill. This bill and the commentary around this bill has been based on a gross misunderstanding at best, vicious and deliberate lies at worst. I am now going to quote extensively from work prepared by the Helpers of God's Precious Infants and directed to Minister Hennessy, where they set out the false accusations against the work that they currently do. They also point out the false and misleading information supplied in relation to this bill. Basically they believe that the bill's premise is based on a misconception and not on reality, and I would agree with this. We have been told that this bill is designed to support women's reproductive health choices. However, this is how the Helpers responded:

In fact, this bill is designed to get rid of us from outside the abortion business. It fails to support a woman's right to choose to give birth to her baby. We pointed out this flaw in our submission to the DHHS, but you have overlooked this in presenting the bill to the Parliament.

The extensive consultation process did not actually listen to these groups. Another claim made in the presentation of this bill is that it will enable staff to access their workplace without being verbally abused, obstructed or threatened. The Helpers stated:

In fact, staff are not verbally abused, obstructed or threatened by us —

the Helpers —

as we pointed out in our submission. Once again, you have ignored our evidence and misled Parliament by making false and malicious claims about us.

Furthermore, the Helpers have been accused of criminal conduct, to which they respond:

In fact, no Helper has ever been found guilty of any criminal offence outside an abortion centre. This is in spite of our actions being photographed, filmed, witnessed by security guards and members of the general public and MCC officers and police. In over 20 years of what you describe to Parliament as daily harassment, the abortion business has failed to provide a single piece of physical evidence to substantiate any claim against us. On the other hand, abortion business staff and security guards have committed numerous offences against us: assault (as proven in court), theft, vandalism, kicking … making obscene comments to us, et cetera. We have many of these incidents on video, as you would expect. You have misled Parliament by failing to mention the offensive and sometimes criminal behaviour of staff of the abortion business and by falsely implying that our behaviour is criminal.

There has also been a claim that while the Helpers may genuinely believe they are helping women, they are actually intimidating and causing anxiety to them. The Parliament has been given the impression that the Helpers are not helping anyone and are ignorant of the alleged harm that they are allegedly causing. They write:

In fact, it is mothers themselves who have told us that they are grateful for our help. You failed to mention this to Parliament, even though it formed a large part of our submission. You have also failed to acknowledge the good work we have done, as proved by the testimonies of those whom we have helped. The bill does not provide for any private or government organisation to fill the gap that would be left in the absence of the services that we now provide.

In discussion around the bill there has been a lot of reference to the 2011 study of the Victorian abortion business. They write:

… you did not mention to Parliament that this is the Fertility Control Clinic.

… that this survey is not peer-reviewed and was not published in any professional journal. As such, its reliability is questionable.

There have been claims made that the bill will strike an appropriate balance. The Helpers write:

In fact, you have completely ignored our submission of 42 pages; you have not addressed any of the issues we raised in that submission and you have not informed Parliament of your failure to do so. We point out that the charter requires that in any conflict of rights, policymakers will adopt the least restrictive approach to balancing those rights. It is hard for us to imagine a more restrictive approach than the one you have taken. By failing to address our submission and failing to address this requirement of the charter, you have misled Parliament as to the effect of the bill.

Far from being about privacy, this bill is about isolation — the isolation of women from information about options. The bill fails to understand the nature of the work of the Helpers as advocates, not protesters.

I wish to acknowledge that this debate is being observed tonight by members of the Helpers as well as by at least one mother and her daughter, who were rescued by the Helpers outside an abortion clinic. I also wish to acknowledge the photo sent this morning to all members of this place of a healthy baby girl saved by her mother with the assistance of the Helpers, sent by Ben O'Brien on behalf of the Helpers of God's Precious Infants. It was in our inbox this morning.

As I have mentioned before in the house, there is a human face to this debate — a debate about whether facts are being drowned out in favour of a well-crafted but rather misleading story. In a state where there is no mandatory counselling, no need for a GP referral for an abortion, no need to provide information about holistic health care alternatives and no need for a woman to be informed about the options available to her, such as pregnancy support, many women speak about turning up at an abortion centre without fully thinking through their decision. In the absence of any other avenue for promoting choice, the people outside abortion clinics are often the only ones providing an alternative — a real choice.

Earlier this year the Herald Sun published a letter headed 'Protesters helped me'. It says in part:
I approached an abortion clinic, about five years ago.

I was 12 weeks pregnant. The pregnancy was unexpected and I made an appointment at the clinic …

… I was gently approached by an older lady who gave me a brochure. Her only words were, 'Do you really want to do this?'. I said, 'No'.

People speak negatively about 'the protesters' at the front of abortion clinics, but these lovely people saved me and my baby.

…

I ask members of Parliament to vote against this bill so that women like me can have real choice.

This afternoon I had the privilege of meeting the author of this letter and her four-year-old daughter. She described to me the care and support she received and continues to receive from this group of committed individuals. I cannot understand how anyone can suggest that the birth and life of this healthy little girl should have been prevented.

If emotive arguments do not work for you, I will return to being an academic once more. In 2012 the journal Contraception published an article by Foster et al. headed 'Effect of abortion protesters on women's emotional response to abortion'. The authors did this because little was known about women's experiences with and reactions to protesters and how protesters affect women's emotional responses to abortion. They interviewed almost 1000 women seeking abortions between 2008 and 2010. Most facilities that they went to reported a regular protester presence. One-third identified protesters as being aggressive towards their patients. Nearly half of the women interviewed said that they had seen protesters. The conclusion in this report is that while protesters may upset some women seeking abortion services, there are no lasting effects. It states:
… exposure to protesters does not seem to have an effect on women's emotions about the abortion one week later.

This peer-reviewed article has been ignored in the preparation of this bill in favour of abortion clinic-sponsored research and in favour of the opinion of those who profit from this industry.

This law is simply not reasonable; 150 metres is a disproportionate response. The penalties are disproportionate responses; 120 penalty units or up to 12 months imprisonment is quite a punishment for praying the rosary, displaying a poster on church grounds or holding an open-air discussion group. I look forward to this bill being considered in the committee stage where I can explore some of the concerns that I have outlined and hopefully provide some assurances for those who presently feel they are the victims of a targeted attack on their religious and political freedoms.[xxi]

While some of the details in this speech are particular to Victoria the general argument against so-called safe access zones applies equally to Part 4 of this proposed law for Queensland.

Additionally, the constitutional validity of similar provisions in Victorian and Tasmanian law is currently the subject of a High Court case which is still under way. It would be constitutionally irresponsible for the Queensland Parliament to enact similar provisions before the High Court has determined this question.

In particular I note that it is designed Clasue 15 (1) (c) to punish speech and other conduct that "would be reasonably likely to deter a person" from undergoing an abortion.

This is an extraordinary provision. It seeks to penalise all such speech and conduct, even if it is expressed in a friendly, peaceful manner and is factual in content if it is reasonably likely to "deter" a woman from undergoing an abortion.

Unlike the law in Victoria the provision doesn't even require the conduct to be likely to cause any distress or similar negative emotional response. Indeed even if a woman received the communication readily and joyfully, or with relief and gratitude, the offence could still be made out if she decided not to proceed with the abortion.

This is perverse.

There are many women – and their children (who would otherwise be dead) – who are grateful that someone offered them a practical alternative to abortion right outside an abortion facility. The State has absolutely no good grounds for preventing such communications offering help to women in crisis.

CONCLUSION

A modern abortion law should take full cognisance of the science showing the unborn child as "one of us", that is a human being.

Abortion should, in every case, be treated as an unlawful assault that destroys the life of the child before its birth under section 313 (2) of the Criminal Code.

Section 282 of the Code should be understood not as permitting abortion (which always includes an intention to end the life of the unborn child) but as allowing surgical operations and medical procedures which respect both mother and child as individual patients while accepting that in some circumstances the life of the unborn child cannot be saved.

Late term abortions (after 20 weeks) or abortions performed for eugenics reasons involve additional wrongs and are particularly repugnant to justice.

Rather than prohibiting free speech in favour of life-affirming solutions to crisis pregnancies the Queensland government should do more to ensure that any woman faced with particular challenges by her pregnancy is offered such genuine solutions to these challenges.

The Termination of Pregnancy Bill 2018 should itself be terminated and not proceed into law.

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