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HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr JP Kelly MP
Mrs T Smith MP

Staff present:

Ms S Cawcutt (Research Director)

PUBLIC HEARING—INQUIRY INTO THE ABORTION LAW REFORM (WOMEN'S RIGHT TO CHOOSE) AMENDMENT BILL AND INTO LAWS GOVERNING TERMINATION OF PREGNANCY

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 15 July 2016

Cairns

PROOF

FRIDAY, 15 JULY 2016

Committee met at 1.38 pm

CHAIR: Good afternoon, ladies and gentlemen. Before we start, I request that mobile phones be turned off or switched to silent mode. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into laws governing termination of pregnancy and the Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 open. I acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are Mr Mark McArdle, the department chair and member for Caloundra; Mr Aaron Harper, the member for Thuringowa; Mr Sid Cramp, the member for Gaven; Mr Joe Kelly, the member for Greenslopes; and Mrs Tarnya Smith, the member for Mount Ommaney.

The committee's terms of reference require the committee to consider and report on aspects of the law regulating termination of pregnancy in Queensland. The terms of reference include examination of a bill introduced by the Independent member for Cairns, Mr Rob Pyne, which was referred to the committee on 10 May 2016. However, the committee's terms of reference are broader than the bill. The parliament has asked us to consider and report on aspects of the law, including existing practices in Queensland concerning termination of pregnancy; existing legal principles that govern termination in Queensland; the need to modernise and clarify the law without altering current clinical practice; legislative and regulatory arrangements elsewhere in Australia, including regulating terminations based on gestational periods; and provision of counselling and support services for women. Copies of the terms of reference are available from the inquiry secretary.

I will outline a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee that takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. Witnesses have previously been provided with a copy of schedule 3 of the Standing Orders, 'Instructions to committees regarding witnesses', and we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript to propose any necessary corrections. While parliamentary privilege applies to these proceedings, there is nothing preventing another agency from utilising public evidence forensically to seek to gather evidence parallel to that disclosed in the committee's inquiry. For any media present, I ask that you adhere to my directions as chair at all times. The committee's broadcast rules are available from the inquiry secretary.

I remind all those attending today that these proceedings are similar to parliament to the extent that the public cannot participate. Members of the public are reminded that the public may be admitted to or excluded from the hearing at the discretion of the committee. Please also note that this is a public hearing and you may be filmed or photographed. We will invite each witness to make a brief opening statement of no more than five minutes and then members will ask questions. I will allow up to 20 minutes for individual witnesses and we have a longer session with four medical professionals. I ask witnesses to focus on new information. If an earlier witness has made the same point you wanted to make, it would be helpful if you could offer us new information rather than repeating earlier evidence.

I now welcome our first witness. Dr Tim Coyle, who is here with his wife, Anne. Welcome. I invite you to make a brief opening statement.

COYLE, Dr Tim, Private capacity

Dr Coyle: Thank you. Good afternoon and welcome to Cairns. I am a general practitioner and I hold a diploma in obstetrics. I have been practising in Cairns for the past 36 years. I worked in the UK National Health Service in obstetrics and gynaecology for 18 months. I was a rural GP in Victoria for five years. I have been a qualified doctor for 45 years.

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The reference to existing abortion practices in Queensland and my written submission give references to the harmful effects of abortion. The postabortion syndrome, as it is known, has become a very serious community mental health problem in Australia and, indeed, in Queensland. There are numerous reports already, documented in my submission about the mental health effects and physical effects of abortion. I have some new information here, as well. A search of Medicare item number statistics shows that item No. 2701, the GP mental health plan, has a 50 per cent bias towards women, that is, 50 per cent more women than men are receiving GP mental health plans. A casual search will show about 15 organisations providing postabortion mental health support. AGA or Abortion Grief Australia is a postabortion support group in Western Australia that receives funding from the Western Australian state government for mental health care for what is now regarded in Western Australia as a serious problem. The AGA website shows numerous visits to download booklets and brochures about postabortion grief, postabortion syndrome, silent suffering and men and abortion trauma, as well.

There was a demonstrable ambivalence in women having abortions. I know of 10 cases of request for reversal in Queensland after starting a mifepristone abortion because of mind change by the mother. Most of these mothers have a successful reversal of the abortion process safely by a gynaecologist and another doctor who specialises in reversal. Patients are told by abortion providers and other doctors they consult that reversal is not possible. I do not believe that abortion providers have any experience of reversal, because, to use the words of Bill Shorten, reversal is not in their DNA. The point is that if the mothers had proper counselling they would not have been in this predicament of changing their minds.

Mothers entering abortion clinics for a booked abortion change their minds after being approached by an outsider and who simply ask, 'Do you really want this?' This was my experience in the UK National Health Service. In the UK National Health Service, preabortion counselling was absolutely nil. The British psychiatric journal has a study reporting a 61 per cent increased risk of suicide ideation and an 81 per cent increase in mental health problems postabortion. This is not surprising since at the heart of the matter is human life—a human life the parent is well aware of and has subconsciously bonded with, and this will continue to echo in the mother's heart indefinitely.

Studies by the Royal College of Obstetricians and Gynaecologists and others have shown that 97 per cent of abortions are done for nonserious reasons, termed as social, psychosocial or economic reasons. I have no doubt that the abortion providers will come before you with accounts of every dreadful ghastly complication of pregnancy that can be imagined. The usual modus operandi of abortion providers when they are attempting to liberalise abortion laws is to give the impression that abortions are done for these cases. On the contrary, most abortions are done on normal mothers with normal babies. I have no doubt that these figures are still more than accurate, based on my own observations over 46 years of practice. Abortions for serious reasons are covered in the existing interpretation of the Queensland law by Judge McGuire.

Finally, I have one common ground with Mr Pyne. I agree with Mr Pyne that section 225 of the Criminal Code should be deleted, but only that. I would like to propose amendments to the existing law that will bring about mandatory preabortion counselling and mandatory follow-up of the patient after the abortion to detect mental health problems. There should be mandatory preabortion counselling by an independent qualified councillor. There should be an amendment to the law to bring that about. Section 225 is the one that says any woman with the intent to procure her own miscarriage, either by taking a poisoned or noxious substance, could be liable to imprisonment for seven years. I agree with Mr Pyne that that section 225 could be deleted. However, the others we would like to see in place with an amendment to bring about mandatory preabortion counselling and postabortion follow-up for a period of at least three years, probably at best five years. Thank you.

CHAIR: Thank you, Dr Coyle, for your opening statements. You are currently practising?

Dr Coyle: Yes.

CHAIR: Do you see many women presenting to you, seeking a termination?

Dr Coyle: No, I do not. I suppose it is probably because my views are known and people know that if they come to me seeking an abortion I will be sending them to what we call Pregnancy Help. There is a Pregnancy Help organisation here in Cairns. They provide support and help. After a session with this kind of help before abortion, mothers often change their minds and find the support that they need.

CHAIR: Dr Coyle, you mentioned that proper counselling is required, inferring that most people are not receiving proper counselling. What are the reasons for that? Do you feel that they are not getting proper counselling when they visit a GP, as well?

PROOF

Dr Coyle: Yes. I feel it should be independent counselling by a qualified counsellor. Because of postabortion syndrome, which is causing this terrible mental health problem in the community, there are lots of what we call unwanted abortions, that is, women out there have had apportions who, in fact, have not wanted them but have been pushed into them by various pressures, which could have been resolved by counselling with an independent councillor. We found that with Pregnancy Help quite often we can resolve the pressures that are ongoing.

CHAIR: Would I be right in saying that you feel that the current legislative regime works, with the exclusion of section 225?

Dr Coyle: Yes. I think section 225 could be deleted. Yes, if there is a serious reason for an abortion, if the mother's health is at risk, that is covered by the existing law as interpreted by Judge McGuire.

CHAIR: That was my next question: in what circumstances do you think that a termination is warranted?

Dr Coyle: From my personal point of view, I think there could be resolution of the issues. My point of view is that if there are issues where the mother's life is at stake, that is covered by the existing law.

CHAIR: Dr Coyle, you made a statement that most terminations performed are not done because of serious risk or foetal abnormalities. The committee has heard statistics that there are in the order of 11,000 terminations a year of admitted patients. Do you feel that that is indicative of the current legislative regime working or not working?

Dr Coyle: I think there is certainly a liberal interpretation going on at the moment. If you want to look at the actual reasons for abortion, 97 per cent are done for convenience.

CHAIR: You said there is an interpretation issue of the law now as it stands; by whom?

Dr Coyle: It is a matter for the courts to sort it out. As a law is in place, I think there is need for some sort of regulation, yes, of abortion providers.

CHAIR: Because time is limited, I will pass to the deputy chair.

Mr McARDLE: Doctor, thank you very kindly for being here this afternoon and for your submission, as well. Doctor, at what point in time do you believe a foetus becomes self viable and then upon birth can sustain itself?

Dr Coyle: It is generally accepted that 24 weeks is the sort of age of viability. I believe in Japan they have had premature babies at 20 weeks surviving. It is generally accepted that 24 weeks is the age of viability.

Mr McARDLE: If we accept, on your argument, 24 weeks is when a foetus becomes viable, what do you say to the argument that until that point in time, and leaving aside disability post that time, a woman has the right to control her own body?

Dr Coyle: There are two people there, you see. Even though if the baby was born right then he or she might not necessarily survive because of prematurity—they are still developing—as far as I am concerned, that is a viable baby, a viable pregnancy. The baby only dies if somebody interferes with it.

Mr McARDLE: Would you agree that if a woman is carrying a foetus that has significant disability concerns a termination could occur in those circumstances?

Dr Coyle: I am not convinced that all disabilities require an abortion. Modern medicine has many skills for dealing with babies with disabilities.

Mr McARDLE: Is there a definition of 'disability' that you would say warrants consideration of a termination in all the circumstances?

Dr Coyle: No, not from my point of view. No, I am not aware of any definition myself.

Mr McARDLE: Would you say that if a woman conceives as a consequence of a rape that gives the woman the choice in those circumstances or a domestic violence situation where it is, in fact, rape but in a marital situation?

Dr Coyle: But it is still a human life. There are many mothers who have taken a baby to term who have been raped. They have been very happy and grateful afterwards that they did not actually have an abortion. I think abortion is the wrong solution for a social problem. There is a social problem, obviously, and there are other things. You need to resolve the problem and not just kill the baby to sort out the problem. If it is domestic violence, something has to be done about that; if there are rapes going on, something has to be done about that.

PROOF

Mr McARDLE: You made the comment that if a woman came to your practice seeking a termination, you would refer them on to a—I will use the word—pro-life organisation. Would you also recommend that, if they were determined to seek a termination, they seek a practitioner or a clinic that would proceed with that termination, providing the law was complied with?

Dr Coyle: No, I certainly would not recommend it because I know it would be bad for the mother. Abortion is always bad for the mother. There is a continuing sense of regret that never goes away. I would never recommend it. I would never recommend referral. There is another matter that I suppose will be brought up by others, which is conscientious objection by doctors and nurses to abortion.

Mr McARDLE: If in the final analysis the parliament did pass a law that required a doctor who held a personal belief that they could not perform a termination—and I accept that—to refer that patient to a doctor or a clinic that would, would you see that as a violation of your values?

Dr Coyle: Yes, I would. Certainly it would be testing the law in that case.

Mr McARDLE: On page 2 of your submission, there is an article headed 'The physical complications of abortion'. It runs for a number of pages.

Dr Coyle: Yes.

Mr McARDLE: At the end of it, you refer to many references. Forgive me, but is that your article or is it written by an author and you have placed that it into the text of your document?

Dr Coyle: No, the references are obtained from an article on abortion.

Mr McARDLE: Did you write the article, doctor, or is the article by someone else?

Dr Coyle: That is another article. It is an article on just that, with associative references, yes.

Mr McARDLE: Could you give a citation for that article, please?

Dr Coyle: I could, but not right now, I am afraid.

Mr McARDLE: Thank you, doctor. I appreciate your time and trouble.

Mr KELLY: Dr Coyle, thank you for your submission and for appearing today. I am going to pick up on that article, as well. You have identified a range of physical impacts of surgical abortion and, I assume, mental health impacts of all abortions. I have gone through the references in the article that you have put in your submission. For the most part, those references are for one-off articles that are 30 to 40 years old. I also read the Australian and New Zealand College of Obstetricians and Gynaecologists termination of pregnancy resource for health professionals. They cite a lot of data, as well. Effectively, on most of the issues that you raise, they reach a different conclusion; almost a completely opposite conclusion. I have gone through the references of their paper as well. All of those papers are what we call a systematic review. You would understand what that is?

Dr Coyle: Yes.

Mr KELLY: Those have much more recent publication dates and much bigger sample spaces. What can you tell me about the validity of the data that you are using to backup your argument?

Dr Coyle: People have done their studies and found their conclusions, and I think it will keep going on.

Mr KELLY: But from a research perspective, we do not look at one article, or one research, and say, 'That's the answer;' we look at a whole series of studies if we are going to engage in true research; is that correct?

Dr Coyle: I think you will find that some people will say that studies are flawed, especially ones they do not agree with. That is not uncommon, actually.

Mr KELLY: You are making a statement about ectopic pregnancy. I think you say that abortion is strongly associated with ectopic pregnancy—I cannot find the exact wording—and then make a statement that there is absolutely no link. As somebody who understands research, I lean more towards their paper than your paper, because that is based on one article from 40 years ago as opposed to theirs, which is based on—I forget the number—but it was something like 80,000 outcomes across multiple studies. What would your guidance be to me terms of which data I should use as my basis for decision-making in this committee process?

Dr Coyle: I would be inclined to go for the one that tends to show the increased incidence of ectopic pregnancy, actually. If an article is more recent, maybe because of antibiotics, or infections post abortion that had some effect, perhaps—

PROOF

Mr KELLY: That is true for an article written in 1972, which is why when you start to look at a problem again you look at all the most recent information; is that right?

Dr Coyle: Not necessarily. I think it is a good idea to look at the whole picture.

Mr KELLY: I just want to quickly ask you about counselling. You obviously hold strong views on counselling. We have heard a significant amount of evidence from other people who have practised in this field in various ways that a very high percentage of women who present to a medical officer requesting an abortion have already made up their minds. If we look at this from a public health perspective—and I assume that your objective is that you would like to reduce the number of terminations—if we are going to design a program around that, if our counselling is mandated at the point of talking to a doctor, have we not missed the boat? Is that not too late?

Dr Coyle: I think the point is that they have not made up their mind because of the ambivalence that is visible. Women outside abortion clinics change their minds. Women who have taken the abortion pill have changed their minds after taking one dose. How can you say that they have made up their mind when the doctor sends them off for an abortion and, if there has not been adequate counselling, how would we now how their mind is?

Mr KELLY: We have heard evidence over the last few days of a culture of stigmatisation and secrecy. The statistics available are, quite frankly, shocking and poor. If we maintain abortion within the Criminal Code, how great is our capacity to collect the data that we need to provide the counselling that you seem to think we need to collect the data that you seem to think we need to collect in an environment where people may be reluctant to provide that data against the backdrop of potential criminal charges?

Dr Coyle: I think there is already data to show that there is a significant problem with post-abortion depression and so on. I think there is already sufficient data about post-abortion syndrome and depression post abortion. There is a lot of it. Why are 15 groups providing post-abortion support in that way if there is not a problem? Of course there is a problem. It is very obvious. That is why the least we could do is mandatory counselling by an independent councillor. I do not think that a doctor is really appropriate; I think it should be by an independent counsellor who has qualifications in counselling.

Mrs SMITH: Thank you for your presentation this afternoon. I have only a couple of brief questions, Dr Coyle. One is that you made mention that the abortion clinics need to be regulated. Can you point to any safeguards in the bill of the member for Cairns as to where, or how, that would occur? Has that been considered?

Dr Coyle: As I said, I would like to see some sort of mandatory counselling introduced before and follow-up, too, actually. I do not think that the patients are followed up for long at all—if at all, in fact. It can take five to 10 years sometimes for symptoms to fully develop. Charlotte Dawson, that media personality who committed suicide last year, in her autobiography said that her depression started after her abortion—again, about which she was ambivalent. That is just an example.

Mrs SMITH: Dr Coyle, would it surprise you to know that over the past 10 years there have been 125,000 abortions in Queensland? In speaking to the experts over the last couple of days, there also is a statistic that says that, in decriminalising it, we would not see a reduction in any way. Would you like to make any comment on that?

Dr Coyle: Yes, I think it is generally agreed, as far as I am concerned, that, if all the criminal codes are removed—all of them—then are going to see a huge surge in abortions. Actually, if you search item No. 4, Mifepristone dispensing, you will see that there were 3,500 with Mifepristone done in Queensland in the 2014-15 period time period. Presumably, most of that was for abortions. That is quite a lot, actually.

Mrs SMITH: Sorry?

Dr Coyle: It is the Mifepristone. It is the abortion pill.

Mrs SMITH: The evidence suggested that, whether you decriminalise it or still have it in the code, it does not make any difference to the number of people seeking the abortions.

Dr Coyle: All right.

Mrs SMITH: That is where I would ask if you had a comment on that.

Dr Coyle: All right. I would not agree with that. I think there would be an increase. It is certainly bad enough already. Perhaps with better counselling and mandatory counselling, we might see a decrease.

PROOF

Mr HARPER: Thank you, Dr Coyle, for your submission and comments today. It is a morally and ethically challenging bill, I am sure, for a number of people who have divergent views. Ours is to find a balance. I am trying to find a balance. After reading your submission, can I give you a scenario? A 29-year-old married woman in her second trimester—16 weeks—gets a scan with her husband present. It was a planned pregnancy. There are defects that cannot be repaired identified. That married couple go off and over the next few weeks make a decision. Do you believe a woman should have the choice—that child has no success of living—of aborting in that scenario, given that it is a husband and wife who have made that decision, morally? What position would you hold? Do you think that they would have the right to choice?

Dr Coyle: I think you would have to be absolutely specific about the actual condition that the baby has. There are a lot of conditions that can be managed medically and skilfully. Just writing the baby off straightaway—there are a lot of things going on here. I have had ultrasounds reported showing allegedly low ear levels and so on and the mother could have gone off and had an abortion. They have repeated the ultrasound in two weeks and it had been perfectly normal. You have to be careful, I think, about the interpretation of ultrasounds.

Mr HARPER: No doubt with advancing technology and medical interventions, a couple of weeks later it is confirmed by a second test.

Dr Coyle: Yes.

Mr HARPER: Do they have the right to choose in your mind? Should they have the right? It offers a moral question, I think.

Dr Coyle: All right. Yes, from my point of view, I think if the mother continues the pregnancy she would be much better off and much happier in the end, but from the point of view of the law as it stands, Judge McGuire's interpretation does cover for situations like—

Mr HARPER: That is where the mother is at risk. This is the baby at risk.

Dr Coyle: Yes. The law does cover it for that, but from my point of view I can think of many reasons the mother should continue. From the law point of view, from the parliamentary point of view, if a person has an abortion for that reason, Judge McGuire's ruling does cover that.

Mr HARPER: You mentioned that abortion rates would go up. Our parliamentary research to date shows that the Victorian model past 2008 showed no increase. On what basis do you give that evidence?

Dr Coyle: I think the late-term abortions in Victoria have been quite high. I cannot give you the link. I cannot give you the actual figure for them, but they have been quite high, actually.

Mr HARPER: Can you take that on notice if you want to provide any further evidence?

Dr Coyle: Yes, it was quite disturbing, actually, the late abortions that have been done in Victoria.

Mr HARPER: Thank you.

Mr CRAMP: Thank you, doctor, for coming in today. I am going to touch on your comments around counselling pre and post termination. It is something that I have questioned other witnesses prior to this. I have to say that I do not agree with the statement that we miss the boat if we approach a woman who is seeking to have a termination through counselling to ensure that this is the correct decision for her. I also noted the age of some of the information that you are relying on in your document. Based on that, do you think that there is a need for some more recent studies around the question? I ask that in the context that, if we were to do that, should we change the laws prior to looking at all of that data? One thing that has concerned me is that I note that Australia does not have a lot of data around terminations to rely on. A lot of witnesses have brought forward information from the United States or from Canada. Are there grounds for further examination of this issue in Australia before we alter the laws and we could get some new sets of data after that?

Dr Coyle: I do not think that we should delete the law and pass this bill as it stands just for the sake of obtaining data. I do not think that is warranted. I think the abortion rate will increase, actually, if all the sections are removed completely as the bill stands.

Mr CRAMP: Okay. If we were to look at counselling—and you mentioned mandatory counselling, and a lot of your notes relate to post termination—who is best placed to set such requirements? Would it be mandatory under a regulator such as the state government or do you think it could be as a set of guidelines by the AMA or another peak body?

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Dr Coyle: I think it should be a bigger requirement that the abortion provider provides a referral, if you like, to a counsellor. There are qualified counsellors available—and the same with post abortion, too. They should provide a referral to such a person. You can get qualified psychologist counsellors, but there are qualified counsellors in their own right, who I think would be able to address all the issues that are going on.

Mr CRAMP: I understand that, but who would set that requirement? Do you think that the AMA, or the Australian college of psychologists or psychiatry can set that? If we were to look at changing this legislation, should it be definitely wrapped up in that legislative change as a mandatory requirement?

Dr Coyle: I suppose there would have to be some sort of accredited counsellors available and then there would have some sort of mandatory requirement to refer.

Mr CRAMP: Okay. So by the regulator? By the state government?

Dr Coyle: Yes, I think that it would be reasonable, yes.

Mr CRAMP: I was seeking your opinion on that. That is good.

Dr Coyle: Yes. I think that is reasonable.

CHAIR: Thank you very much. On behalf of the committee, can I thank you, Dr Coyle, and Anne, and wish you both well. Thank you for the submission that you made to the inquiry and for requesting to come and give us your evidence today.

Dr Coyle: Thanks.

CHAIR: I ask for quiet in the public gallery, or you will have to leave the room. I take this opportunity also to acknowledge our parliamentary colleague Rob Pyne, the member for Cairns. I would have done so in my opening statement, but I believe you entered the room just after I spoke.

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CARETTE, Dr Michael, Private capacity

DE COSTA, Professor Caroline, Private capacity

HYLAND, Dr Paul, Private capacity

McNAMEE, Dr Heather, Private capacity

CHAIR: I invite Dr McNamee to make an opening statement of no more than five minutes, then we will proceed to each of your opening statements and then I will open it up to the committee for questions.

Dr McNamee: First of all I would like to offer a right of reply to some of Dr Coyle's comments.

CHAIR: That is okay if it is part of your opening statement.

Dr McNamee: It is. I believe it would have been more honest for Dr Coyle to present himself as the president of Cherish Life Queensland, a practising Catholic and a conscientious objector to termination. Unfortunately, I feel he struggles to separate that role from his role as a medical professional. Our professional body clearly states that we need to have a separation between our personal beliefs—

CHAIR: I am sorry, Dr McNamee, but I think it would be better if you moved on to your opening statement rather than commenting on other people who are participating.

Dr McNamee: In terms of the terms of reference, reference No. 1, existing practices, I will not spend much time on this. I would refer the committee to Carol Portmann's submission and also to the therapeutic termination of pregnancy guidelines written by Queensland Health. It really gives a very wideranging and clear guide to the current practice in Queensland which is similar to many countries in the world where, and I quote from the guidelines—

> The decision to provide a termination of pregnancy is made in partnership with the woman (and her family, where appropriate) and her health care professional.

Nobody else has a right to interfere with that situation. The law, of course, interferes with the ability for the woman to make a free choice, and I am sure you are all aware and have heard repeatedly about the case of the girl Q. We had a similar case in Cairns a year or two ago that I was personally involved in. We had a 12-year-old Aboriginal girl who was pregnant and sought termination in the public system. She was supported by her mother and a professional councillor and was obstructed from that termination by exactly the same processes as Q. Queensland Health wished to take that case to the Supreme Court. We are very fortunate in Cairns in that we have excellent abortion services, which is unusual for Queensland. My colleague, Dr Michael Carette, in the end offered a private termination to that girl. The only way we could do it in a timely manner was by funding from Children by Choice, because although Queensland Health through the sexual health clinic does fund private terminations, we could not access those funds because the lawyers of Queensland Health were obstructing us.

Dr Carette did not do anything illegal. He and Professor de Costa assessed the girl as being Gillet competent; therefore she met the letter of the law and she had the right to make that decision without the interference of the court. The fact that Queensland Health attempted to take her to the Supreme Court in exactly the same way as the girl Q is the immediate harm that the current law is causing in clinical practice. It does not harm middle class people in Sydney, who can go off to their local clinic, pay $500 and get their termination: it harms our dispossessed, our young and our vulnerable. The law has created a two-tier system in Queensland where the rich can access termination easily and the poor cannot. This cannot be allowed to continue.

Public doctors use the law as an excuse for not offering termination services. I did my gynaecology in the UK, where termination takes place in every public gynaecology clinic. I was horrified to come to Cairns and find out that is not true here. The law is obstructing practice; it is obstructing access to the vulnerable. There is no evidence from Victoria, as have you stated, that the number of terminations will increase if we decriminalise abortion. Equal access will improve and we will not have delays where girls like Q end up with a later termination which is more medically complicated and more emotionally distressing than she could have had if Queensland Health had not involved lawyers.

Every day in my practice I see the harm that the law does. I offer medical termination and women ask me on a weekly basis, 'Is this legal?' That is an extremely difficult thing to explain to a woman in an emotional setting. My only response can be, 'At the moment it is legally illegal' and that

we are protected by case law, but a lot of women in Cairns are aware of the case where a woman was prosecuted. I do find it a little bit hypocritical that Dr Coyle feels section 225 should be removed and yet I, as the provider of the termination to that woman, could still be prosecuted.

We have counselling already. So that you know any conflict of interest, I was on the management committee of Children by Choice for five years. It is a Queensland state government funded independent counselling service and we use it widely in our practice, both in the public and private setting, for women to access counselling. I have been to their offices and I can tell you they have just as many pictures of babies up on the walls as they have letters from women saying, 'Thank you for helping me to make the decision that was right for my family to access a termination.' They offer parenting, they offer adoption and they offer termination. They are truly independent. They are already in place. We use them widely. They are government funded. We do not need any law to tell us to use them or to offer them to our women. The law does not need to be involved. The law is not involved in any other counselling that takes place in medical practice. We as doctors care for our patients. We care for their wellbeing. We want them to make the right decision. We do not need the law to tell us when a woman needs to be counselled. As one of you stated, the majority of women approaching a clinic have already made their decision and they have had their counselling with their partner, with their friends, with their family and sometimes with the pastors of their churches, and they have made their decision already.

Prof. de Costa: Thank you for your invitation to speak to you this afternoon. I am a specialist obstetrician gynaecologist, a Fellow of the Royal Australian and New Zealand College of Obstetricians, a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Royal College of Surgeons of Glasgow. I have been in specialist practice now for 35 years, first of all in Sydney and then in Cairns for 22 years.

Abortion has always been integral to the care of women I have been looking after, both surgical and medical abortion and early and late. I first learned how to perform abortion on the National Health Service, as Dr McNamee also experienced. Part of that training involved speaking to women first of all and indeed counselling them, working out why they were requesting abortion, explaining the procedure and what they needed to take into account in making their decisions.

I have been Professor of Obstetrics and Gynaecology at James Cook University here since 2004, and in that time I have conducted extensive research into contraception and abortion practice and services and abortion law in Queensland and the rest of Australia. This research has been both in my own university department and with colleagues from the sexual health clinic and with colleagues from UQ, including Professor Heather Douglas, who I know spoke to you on Wednesday, and from the University of Sydney. In the past 12 years we have produced 16 peer-reviewed papers in such journals as *The Lancet*, the *Medical Journal of Australia* and *O&G Magazine,* which is the Australian college's journal of which I am now the editor-in-chief.

When I sat in the spectators' gallery in Brisbane I noted that members were keen to hear about Australian research and data, and there is a great deal and it is recent. There is no need to rely on outdated American statistics. I would be happy to answer questions from the committee on two matters which I thought were not completely answered on Tuesday: one on the failure rates of contraception in Australia; and the second on whether women actually use abortion for contraception in Australia. I would be happy to do that in the question time. I would also appreciate a bit of time to enlarge on the description of the management of foetuses in that critical time between 23 and 26 weeks, which you explored a bit with Professor Kimble. I feel I might have a little bit more to add to that, and I have already started that in my written submission, which I understand you have read.

I think the most important point I would like to get across to you is that the current law does not reflect the reality of modern medicine and modern abortion practice and the views of the majority of Australians with regard to a woman's right to make her own choices about her reproductive health. The continued existence of the law makes many doctors reluctant and indeed fearful of becoming involved, although my experience is that most GPs want to be able to refer women requesting termination to safe, accessible abortion. We also conducted a study of all the fellows and trainees of the Royal Australian and New Zealand College of Obstetrics and Gynaecology in 2010. This was published in the *Medical Journal of Australia* in 2010, and about half the fellows and trainees replied to this questionnaire. Those who did not tended to come from areas of our speciality where abortion was not an issue, such as menopausal women or oncology. Of the 750 who did reply, 85 per cent said that they not only did not have opposition to the practice of abortion; they actively welcomed changing the law. This was with regard to the Victorian law.

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I have also conducted research with Heather Douglas on how abortion providers in Queensland and New South Wales feel that the law—which of course is the same in New South Wales as it is in Queensland—impacts on their work. We conducted in-depth interviews with 15 Queensland providers, and all of them stated that they tailored their patient notes to fit in with the law. For example, where a diagnosis of severe foetal abnormality was made they would imply that the diagnosis had severely impacted on the woman's mental health; whereas the woman was perfectly intelligent and able to understand the diagnosis and to make an informed decision for herself, which women in Victoria, Tasmania, Western Australian largely, South Australia and the ACT are now able to do.

When I say that doctors are fearful, I do not exaggerate. Those who oppose decriminalisation can be very threatening. For the past 12 years since my email address and my place of work are publicly available I have received a continuous stream of hate mail, all of it anonymous and all of it based on the religious beliefs of the senders. I have been subject to harassment from a stalker here in Cairns, and for a while I received police protection. Doctors in rural and remote areas of the state in particular do not want to be singled out by such people. When they live in small communities, often with their families, they do not want to be singled out as being supportive or providing abortion.

All three of us here from Cairns would like to comment on the recent Q case, which now makes our ability to provide abortion for very young women aged 14 and under much more uncertain. It was already uncertain; it is more uncertain now. There are more than 100 and possibly nearer 200 young women of this age, that is, under 14, presenting with pregnancy each year. These figures I have are from Children by Choice. The Q judgement would imply that we need to seek judicial authority to proceed to termination for them. Dr Carette, Dr McNamee and I were all involved in this case. There was great consternation amongst health administrators, and it was solved by myself and Dr Carette consulting with the young woman and her parents. She was clearly Gillet competent. She was able to consent to her termination, which she duly did. It was performed without incident and she and her family were happy with the outcome. I have been involved in several such cases, and I believe there are many such cases in Queensland in the private sector each year. That is all I have to say at present. I would be happy to answer questions.

Dr Carette: My presence here as a witness rests on my long experience in the field of the abortion profession so I know it works, I know how it works and how it happens. The anti-abortion lobby actually knows very little. Relying mostly on American extreme propaganda, they have constructed the myth of a wicked abortion-promoting industry doing irreparable harm to women. This view, backed up by spurious data and gruesome videos, suits their preconceptions and is reinforced by their fellow practitioners and the priests. On the other hand, after close to 10,000 cases I know exactly what happens; others can only rely on hearsay and fantasies. I also pioneered the use of Mifepristone in Australia, although in recent years that technique has been taken over by others.

Of my 8,600 surgical cases, two I had admitted to the public hospital for overnight observation. They were discharged the following morning fit and well. Since I relinquished my public hospital appointment I have an arrangement with the Cairns hospital so that they will admit any patient of mine who needs in-hospital care for a serious complication. They have had no occasion to let me know of any such case.

Relevant to the sad case of Q, the young lass in Gladstone, I can report that in the last few years I have terminated the pregnancies of 32 girls under the age of 16 down to and including the age of 12. Poor Q was seen by a small army of doctors, gynaecologists, paediatricians, clinical psychologists and social workers. A Supreme Court judge decided that all these experts—and not least the girl herself and her mother—were not qualified to provide consent for her procedure. Luckily, he was qualified and so he said she could have it done. We are fortunate to be controlled by such men.

This part of Queensland is well-served. Most patients who feel the need to have their pregnancy terminated go to the Sexual Health Service, a unit of the Cairns hospital. If a medical abortion is decided on this is provided. Dr McNamee and Dr Hyland can tell you more about this field. If a surgical abortion is thought best they are referred to me. Numbers would be in the region of 750 per year all combined.

The anti-choice lobby would have you believe that abortion providers are in it for financial gain. Let me tell you that any doctor looking for the most stressful, least glamorous, most repetitive and least lucrative career path would become an abortion provider. Like any gynaecologist, I see women at their request and after referral from another doctor. The patient and I discuss the problem, and I will do my best to treat it by whatever means is appropriate without deference to either the police or

the church. Patients come to me asking to have their pregnancy terminated. The anti-choice lobby would have you believe that some doctors promote abortion. As far as promoting is concerned, the only thing within my power, should I wish to exercise it, would be to talk her out of it.

Concerning the dangers of abortion, if I may present this conflict in a different light. It is a truth so plain to my colleagues and me that we have got used to it and we do not think about it much anymore, but there might be those among the public or even on this committee who do not understand what is really going on. The Catholic Church believes that abortion is a sin. To be precise, it is a grave evil. Groups like Right to Life exist to try and stop it happening. They decided long ago that the best tactics are scare tactics. They deliberately make abortion out to be dangerous and if they have to distort or even make up the evidence, well, it is in a good cause. They have concluded—probably correctly—that fear of illness or death is more likely to deter a woman than to tell her she is sinning, which would have absolutely no effect whatsoever. In terms of the dangers of abortion, this is as near as I can get you to the nub of the problem.

Counselling is something the anti-choice lobby is most keen on, only to them—as you may have guessed—it means persuading her to change her mind. Most patients do not need, nor welcome, significant input from a doctor. Occasionally—just occasionally—I may detect a flaw in a patient's decision-making and when I do so, I say so. This may lead to a change of heart. If it does, I consider this a considerable victory. We inquire about domestic violence, we test for any sexually transmitted diseases, we council about safe sex and we talk about contraception. I am personally gratified that fully two-thirds of my patients leave hospital with ongoing contraception already in place. Any patient who comes for a second visit or worse I regard as a failure.

Let me say in conclusion that any organisation which outlaws effective contraception has disqualified itself from the abortion debate.

Dr Hyland: Thank you indeed for inviting me to this committee's inquiry. I am a specialist obstetrician and gynaecologist with over 40 years experience. I am a Fellow of the Royal College of Obstetricians and Gynaecologists, a Fellow of the Royal Australian College of Obstetricians and Gynaecologists and a Fellow of the Royal College of Surgeons. In addition to gynaecology I have established and administered seven day surgery centres for over 15 years in New South Wales and Tasmania, where we provide the sole termination facility in that state.

Last year I formed the Tabbot Foundation to provide medical abortion services for pregnancies under 63 days using telemedicine—that is, by telephone consultation—after which the required medications are provided by mail to all regions, rural and remote, giving continued support by a gynaecologist and follow-up with nurses. This is an Australian-wide service currently operating in all states with the exception of South Australia and the Northern Territory. Queensland women make up about 15 per cent of the 1,000 registrations that we have taken over the last nine months since we commenced in October 2015.

Medical abortion is the increasingly preferred method of pregnancy termination in most of the developed world: almost 100 per cent in Norway; 85 per cent in Sweden and Scotland; and 50 per cent in England. In the USA it was announced two weeks ago that it is now 46 per cent, which is double what it was three years ago. This trend is undeniable and it will continue in this country, where it stands now at about 30 per cent. Surgical numbers will fall to a level such that, as in the USA, surgical centres will close or amalgamate. We also expect the approved gestation will increase to 10 weeks from nine following the FDA approval in the USA, further reducing surgical numbers. Current international trends indicate that all terminations over 14 weeks will be performed medically in a designated facility.

Medical abortion means affordability. Our fees are half or almost a quarter of those that other medical or surgical termination providers charge. Medical abortion means accessibility without the need for attending a designated surgical facility, especially because of the provision by mail, to many areas where no service currently exists. Our service avoids the harassment and intimidation of patients and staff without the need for exclusion zones. We had expert legal advice so that we could provide our service under the existing Queensland legislation, and we expect to continue to provide this service regardless of any changes that may result from this inquiry.

In both Queensland and New South Wales we were advised to provide psychological consultation routinely to comply with relevant legislation in those states. Most first-trimester terminations in every state of Australia are performed on demand and for psychological reasons. In following this policy we have noticed that those patients who do have counselling seem to have clarity for their reason and are comfortable with their decision.

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CHAIR: I thank each of you for your opening statements. We will open it up now for the committee to ask questions which they may direct to a particular doctor. I would like to start with a brief comment. I certainly appreciate that views are quite divisive and there are strong views both for and against. I think many Queenslanders would fit somewhere in between. I appreciate views are nuanced. If I could start first with Dr McNamee. What is the cause of most requests when women present to you seeking a termination?

Dr McNamee: Failure of contraception or a failure to use effective contraception. If you look at why they are choosing to terminate, there is any reason you could come up with. We see women ranging from the age of 12 to the age of late forties; we see women who are married with children; we see children who are married without children; we see women who have been raped and women who are the victims of incest. I think the personal circumstances are vast. The common thread, of course, is that they have not had effective contraception.

Part of my work is educating doctors about the use of long-acting contraceptives. We now have implantable contraceptives—the ones that Dr Carette is talking about that he tries to ensure women have after their procedures—which have failure rates of around one per cent. The minority of Australian women use those devices, and part of my education—I go around the state educating doctors—is to try and encourage them to offer these methods more commonly and to move away from methods such as the pill or condoms, which are notoriously unreliable.

CHAIR: What is the failure rate of the pill or condoms?

Dr McNamee: It depends whether you look at the scientific failure or the real world failure. The scientific failure is very low. If you took the pill absolutely perfectly—so you always took it on time, you never had vomiting, you never had diarrhoea and you never had any other medications—the failure rate of the actual method is extremely low at less than one per cent, but in the real world we see a failure rate well above that. Professor De Costa showed me a figure of about nine per cent, but I have seen it quoted even higher than that. If you look at the failure rate of contraception in the most fertile, so the under 25s—I have worked for a youth service for many years and deal a lot with chaotic young women—there are studies which show that the difference between an implantable contraceptive, such as the implant in their arm, and taking the pill is that they may be 20 times more likely to fall pregnant on the pill. Young women are notoriously poor at taking the pill.

Everybody at this table wishes to reduce rates of termination. As Dr Carette says, we are not all making millions of dollars out of it. We realise it is a distressing thing for a woman to go through, and we all would prefer that they had effective contraception and did not need our services. Australia is second in the western world with its termination rate second only to America, and one of the key reasons is because of the lack of uptake of long-acting, reliable contraceptives. That is where we need to be focusing our prevention methods. I am involved in a committee that is trying to improve the uptake of those methods all over Australia, let alone in Queensland. We have the methods now to reduce termination rates, and that is where we need to be putting our energies.

CHAIR: Dr McNamee, you mentioned the failure rate of the pill. Do you also have the predicted failure rate of prophylactics?

Dr McNamee: There was a study of condom use where stable couples relied on condoms for contraception, and if they had any problems like a slipped condom or a broken condom they withdrew from the study so that we were actually looking at the failure rate of the condom itself. The failure rate was about 18 per cent. That is surprisingly high. I work in HIV medicine as well as in contraception and termination. I think the problem with condoms is that because they are 99 per cent effective at stopping HIV, which is a fantastic thing, people have developed this idea about them being more reliable than they really are. When I tell my young women that failure rate they are often horrified that it is so high, yet you see many a woman who does not recall a condom accident, condom failure or not using a condom and who still presents pregnant.

CHAIR: At what stage of the decision-making process do you often find women present to you?

Dr Carette: They present after the decision has been made. Women do not often want to discuss choices with a doctor. The doctor tries not to take this personally, but the woman will discuss it with her partner, with her family, with her siblings or with the woman next door. I think the doctor comes about No. 5 in the pecking order as to who they wish to ask for advice. That is the way it is. The answer to your question in brief is that nine out of 10 have already decided exactly what they have to do before they come in through my door.

CHAIR: Do you find that many are aware of the current legislation, or is that something that you then tell them?

Dr Carette: Oh, no, they have no idea. I do not have to deal with it often. I only deal with it if a patient says, 'Is this legal?' It depends who you ask and it depends what you mean by 'legal'. I do not want to get involved in this depth with my patients because we might be there all day. It is not very often that they know what the law is. Very, very rarely.

CHAIR: It has been mentioned to me and also in testimony that ambivalence is something of significant concern when women are making the decision. How do we ensure that there is unbiased counselling or support or information provided to women—and I mean bias from either side, because both have been cited as an issue—to make sure that, if they are to make a decision under a regime where they can make that decision, it is one that they feel they have been able to do in an informed way.

Dr Carette: We are trained in non-directive counselling. In other words, the purpose of counselling is to get your patient to express vocally how she feels about her situation, what she feels the up sides and down sides may be of continuing the pregnancy, and likewise what she feels are the up sides and down sides of not continuing the pregnancy. If you let the patient explore her own feelings and communicate her feelings to you, she will learn better what it is that she wants to do and what she has to do. This is completely non-directive, and that is the technique I am sure we all use.

CHAIR: When you say 'we', do you feel doctors should be responsible for providing that, Dr McNamee?

Dr McNamee: I see women at a different stage of the process because I am a GP, so I see them when they have just done the pregnancy test—sometimes the night before, sometimes that morning. A lot of women know the minute they see the second stripe what they are likely to do because most of us as women are planning our families and planning our lives. I have two children. I never wanted more than two children. I was very careful not to fall pregnant after I had had my second child because I did not wish another child and nor did I wish an abortion. I think women are constantly planning their lives and thinking ahead in consultation with their partners, if they have one, as to what their life plan is, so when they see that second stripe a lot of women immediately know how they feel about it. I often say to them, 'How did you feel when you saw the positive pregnancy test?' A lot of them will say, 'Horrified.' 'Shocked.' 'I burst into tears.' Ambivalence is not common, and if we detect ambivalence we delay. When women come to me I ask them, 'Where are you at in the process?' I ask them, 'When did you find out you were pregnant?' because I need to know how long they have had to consider it. If they did the test that morning, obviously we are not going to make a decision that day. I ask them how far along their decision process they are. I ask them who they talked to. If they have only talked to their partners I am not very happy. I prefer them to talk to other people in their lives: their mothers, their sisters, their friends. We put a lot of effort into ensuring that the woman is coming to the correct decision. The last thing any of us want is to harm a woman. The last thing any of us want is to offer a termination to someone who later regrets it.

If you look at the latest data, a lot of it is from the States. One of the problems with looking at abortion in Australia is that the lack of item number makes it difficult to really study it. The studies from the States have shown that 99 per cent of women choosing termination do not regret it. It is impossible to make that 100 per cent. When women make these decisions I sometimes say to them, 'It is unlikely you are going to be 100 per cent sure you are making the right decision. You have to weigh up your current family situation, your current relationship, your current financial setting, your work, the kids you have at the moment, what you want in your life and make the best decision that you can today.'

CHAIR: Dr McNamee, what was the time horizon of that study?

Dr McNamee: There was a follow-up at three years. They followed women up after termination and did psychological assessments on them over the three-year period asking them about negative emotions, and it was extremely rare to find any serious negative effects. What damages women is not having the right to choose and not having the freedom to choose. I was born in Ireland, which has a terrible history around the management of pregnancy, particularly unplanned pregnancy. Those of us who were brought up in that setting knew of women who were forced to make decisions one way or another, and that is what we need to avoid. The current law is interfering with women's free choice.

Prof. de Costa: I agree totally with what Dr Carette and Dr McNamee have said. They are referring very much to early abortion. I have considerable experience as an obstetrician with later abortion and with caring for women who have a not necessarily planned, but certainly a wanted pregnancy and who then go through the screening and testing which is available to all Australian women and unfortunately get a diagnosis of a severe abnormality. This requires a very different

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approach. You need first of all to explain the diagnosis to the woman, and usually her partner and often other family members and often her general practitioner. You may need to have several consultations with her because it is very difficult to take this diagnosis in when you first hear it. Most women assume that the test is going to come back and it will be very positive. You then need time to explain what the actual diagnosis means. There are some extremely severe abnormalities of the neurological system, of the brain, of the heart and of the kidneys—there could be absent kidneys and so on—all of which are essentially lethal. The foetus can continue to grow in utero because the mother is providing a blood supply with nutrients and oxygen, but once the baby is delivered it is on its own and it cannot survive. The various intricacies of the diagnosis and what it means have to be explained first of all and then the possibility of termination explored with the couple.

These things take time, and these diagnoses are often made after 16 weeks and approaching 20 weeks. If termination is being thought of by this couple, and particularly by the woman, there is a tremendous stress that the law imposes by making abortion only assessable in a few places in Queensland. If the woman passes 20 weeks and still has not really got a definite diagnosis, this can often happen with cardiac abnormalities. It is hard sometimes to see on ultrasound exactly what the abnormality is. There are some cardiac abnormalities which may be corrected by surgery and some which cannot, so there needs to be several sessions. The woman needs to be certainly offered professional counselling or speaking to a social worker, but she also needs to be helped through this by her obstetricians and also by paediatricians.

CHAIR: Professor de Costa, if we accept the argument for the moment that the current legislation should be reformed, in your opinion where does the law have a part to play with regard to the termination of pregnancy?

Prof. de Costa: I think that a termination must be performed by a registered medical practitioner.

CHAIR: And that is the extent?

Prof. de Costa: Yes. There are already very adequate health regulations where around medicine is practised and who practises it. As doctors we are required to be registered. First of all, we have to get through medical school, get a degree, get appropriate specialist training, have appropriate experience and we need to be registered every year. We must have continuing education which must be confirmed to AHPRA, who register us. Every institution we work in must be accredited by Queensland Health, and there are very stringent regulations about what you can do in regard to simply taking out tonsils. Abortion is covered by this quite adequately as it is. Day surgeries are regulated at the two clinics which provide abortion.

CHAIR: Professor de Costa, your submission referred to Queensland Health guidelines that should be followed regarding therapeutic terminations, and you just referred to those then, but does having restrictions or guidelines enshrined in law not provide additional and greater protections to doctors, women and the public interest? I suppose I am referring now to gestation.

Prof. de Costa: I think what we have is adequate because we work within these institutions and we work within our own professions.

CHAIR: Absolutely you are right. You work under those guidelines for many medical procedures, but this is a medical procedure that does involve an additional consideration, being another life. Does that not change the position? When you look at the other jurisdictions most have a gestational restriction in the legislation, but you feel that is not necessary?

Prof. de Costa: Certainly my college is of the opinion that there should be no upper limit and they give very good reasons, which are that there are rare cases where the diagnosis is not made until after 24 weeks. It just typically provides another level of bureaucracy for people to go through if you are going to have to jump that kind of hurdle. If there is to be an upper limit which will then perhaps, as in Tasmania and Victoria, be followed by the need to have two doctors to make the decision, then 24 weeks should be the lowest.

CHAIR: You do not feel that a gestational limit is warranted?

Prof. de Costa: No. I think that we can act professionally and appropriately for the care of our women without it.

CHAIR: What is the margin of error for estimating gestation?

Prof. de Costa: About five days. If it is measured at six weeks, it is plus or minus just a few days. As the foetus grows it becomes lighter and lighter because, as you know, babies can be perfectly healthy weighing 2.5 kilograms or four kilograms, so they grow according to their genetic makeup.

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CHAIR: I found a particularly interesting article entitled *Australian attitudes to early and late abortion* by Lachlan J de Crespigny, Dominic J Wilkinson, Thomas Douglas, Mark Textor and Julian Savulescu dated 2010 which I am sure you are very aware of. I found this study interesting because it is one of the only ones that I have ever found that differentiates between Australian attitudes to abortion depending on different terms. I know a figure often cited by both sides is that about 80 per cent of people support or oppose, but this talked about 87 per cent of respondents indicating that abortion should be lawful in at least some circumstances. That significantly dropped down to less than half, 48 per cent, for the third trimester unless they understood the reasons for it. When you see statistics like that, would any of you acknowledge that the public are uncomfortable with having legislation like that now proposed, as there is no safety net around what is an uncomfortable question for the public. I appreciate your professionalism in talking about doctors and how well trained you are.

Prof. de Costa: Third-trimester abortion is virtually unknown in Australia.

CHAIR: I acknowledge it is very low, but it is not non-existent. I am asking more from a community attitude point of view.

Prof. de Costa: I think the general public would be right, and I think doctors would agree that you would be very cautious about third-trimester abortion. In fact, I do not even know how you would perform third-trimester abortion: it is normal birth.

CHAIR: You do not think that building some restrictions into responding to community—

Prof. de Costa: I am perfectly happy to agree with the college that 24 weeks is an appropriate gestation to take, provided that you do not make it dependent on a panel of doctors or other people saying yes or no at 24 weeks. Two doctors should be sufficient, as has been decreed in Victoria and Tasmania.

Dr McNamee: I think we need to distinguish between the Criminal Code and the Health Act. Within the Health Act you can regulate things such as gestation. We do not need this in the Criminal Code.

CHAIR: Sorry, all of these questions were premised on the argument that we need to reform the law. Would you not think that these things should be built in, given that currently there is no proposal to have any restriction?

Dr McNamee: I think between our registration as doctors and the guidelines of the colleges that we work within there are layers upon layer of regulation. When the occasional doctor is a maverick or does something completely outside of those guidelines, there will be action taken. When doctors act irresponsibly or beyond what is considered normal practice, then occasionally the Criminal Code is used. For instance, doctors that have gone around and killed patients have been prosecuted for murder. The Criminal Code is there for the occasional doctor who may be psychotic or behaving outside of the normal practice, but we are dealing with life and death every day in our work as doctors and the layers of legislation and restriction we have already are sufficient. We do not need any additional layers. Certainly, the college of gynaecologists I think are the people who are best placed to advise whether they feel there needs to be any higher level and they have said not.

Mr McARDLE: Dr Hyland, you said in your submission that your service circumvents the humiliation of attending a local clinic. You then make the comment in the next paragraph that most women who come to your clinic are unaware that there is a Criminal Code that oversees abortion plus the common law. What generates the humiliation? What do you say causes the humiliation? It is not the Criminal Code, because most do not know about that. Is it the way society views abortion generally speaking?

Dr Hyland: We get humiliation, intimidation, obstruction and abuse at all levels of management of pregnancy termination—from making an appointment with a general practitioner, with a general practitioner refusing to refer a patient, as you have heard, to pathology providers who are taking blood from a patient in order to do a test before the medical abortion who comment, 'Isn't it lovely? You're having a baby,' to ultrasonographers who are doing an ultrasound scan saying, 'Look at this,' when we specifically ask them not to show them.

Mr McARDLE: Would you agree with me it is not the Criminal Code; it is the social situation because you make the comment in your paper?

Dr Hyland: Absolutely. Most of our patients, as Ms Linard asked, are unaware that abortion is illegal, especially the younger age group. They think it is freely available. They do not recognise the risks that medical practitioners take.

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Mr McARDLE: Dr Carette, you made a similar comment that—paraphrasing if I may—overwhelmingly those who come to your service are not aware of the Criminal Code intervention in this arena.

Dr Carette: They will not be aware of the niceties and the intricacies of the Criminal Code in its various sections 224, 225, 226, 282 and all the other things confuse and confound the situation. They are not aware. It is an interesting point, Mr McArdle, that with regard to the young Cairns girl who was prosecuted—charged by the police—in 2009 she was aware that it was illegal and the reason why she sent to Europe to get her abortifacient medications was because she thought she would have to because it is not legal in Queensland. There is that amount of ignorance, as Dr Hyland said, particularly amongst the younger generation. They have no idea.

Mr McARDLE: Can I rephrase the question this way: the fact that the Criminal Code exists in this state and the common law that flows from it has no impact as to why a woman approaches your services because they are simply unaware of the impact. If we accept that and if we then amend the Criminal Code, logically you would not expect to see an increase in numbers. However, those who are coming through now have little, if no, knowledge of the Criminal Code.

Dr Carette: This is absolutely correct. There would be no increase in the number of abortions at all. You will not prevent unplanned pregnancy—you cannot do that—and you will not increase the abortion rate by decriminalising abortion because the situation could not change. I would have to say that for the last two decades the abortion laws as they stand have probably not prevented one abortion nor punished one offender.

Mr McARDLE: Dr Hyland, you also made the comment that many GPs are unclear of the law in the jurisdiction in which they practice combined with the fear of being targeted by antichoice groups under the heading of the Tabbot Foundation website. Changing the law is not going to change the antichoice group approach, is it, because their basic tenant is that abortion should not be allowed under any circumstances?

Dr Hyland: Absolutely correct. The way it works is that the referring general practitioner believes that the abortion will be provided. There is no reference to the Criminal Code or the legislation. The patient is referred for pregnancy termination. It is only the obstructive general practitioner, whom we have heard of, that obstructs and intimidates and harasses the patient. Unfortunately it happens in the medical profession.

Mr McARDLE: Moving to the question of the right to object—that is, a doctor's right to object—I posed to the prior witness that if the parliament moved to legislate that if a doctor holds a view on conscience that they cannot perform a termination do you think it is important that that doctor have an obligation, however, to a patient who is seeking termination to refer them to a doctor who would consider that as an option?

Dr Carette: The Queensland Health regulations—Queensland Health advice—is that any doctor in a public hospital who is approached by a patient requesting abortion and if that doctor has a conscientious objection to abortion they have two duties: one is not to say anything derogatory to that patient or denigrate that patient and the second is to expedite their referral to a colleague who has no such objections.

Mr McARDLE: I make the comment, Doctor, that today we have heard evidence that that would challenge the values of a particular doctor. Although I accept the commentary, is it important that that is enshrined in some manner to ensure it does take place?

Dr McNamee: It is already enshrined in AHPRA's regulation and there is a section in the AHPRA regulation around conscientious objection. It states very clearly that if the doctor has a personal or a conscientious objection to termination they do not need to be involved in the provision of that termination. It also makes quite clear that they must offer an alternate healthcare professional in a timely manner, and that can be as simple as having some cards on your desk for the family planning clinic or the Sexual Health Clinic or for my clinic, and AHPRA is very clear on that point. I know in Victoria that that was enshrined in law and it may surprise you to hear that I do not actually agree with putting it in as a law or a Criminal Code. I do not think doctors need be prosecuted for not following AHPRA's regulations. I think they need discipline by AHPRA, warning by AHPRA or notes made on their registration on the website by AHPRA that they have broken AHPRA's regulations and AHPRA has plenty of ways of disciplining us and encouraging us to live up to our responsibilities. I have unfortunately, like Dr Hyland, experienced many GPs in this town who have abused many patients, been outright rude to my patients and have done things like stormed out of the room and chucked the chart back at the receptionist and not even speak to the patient, let alone offer alternate care, and those women have made complaints to AHPRA and some of those doctors have been disciplined.

PROOF

Prof. De Costa: I believe our first duty is to the patient and in this situation referral must be effective. It does not need to be to a known abortion provider, but it must be to somebody who can provide the three options—the woman having the baby and keeping the baby, adoption or abortion.

Mr McARDLE: How is that best achieved, Doctor?

Prof. De Costa: By such a service as Children by Choice, by Family Planning Queensland and by the counselling that is attached to public and sometimes private clinics but public hospitals certainly.

Mr McARDLE: Professor de Costa, you made comment about a study that was done a little while ago, and I think the expert appeared before us on Wednesday afternoon. Fifteen Queensland doctors were interviewed and the expert said—if I misquote please let me know—that they often 'reframed' the testimony or the evidence. When you read the report filed by the expert, it in fact uses the word doctors 'invent' the circumstances to qualify for the mental health proportion of the requirement. I said at that time that that worried me because, as you identify here quite clearly in your submission, there are very clear guidelines, and whether we accept them or not is perhaps beside the point at this juncture. That is the way the law stands in this state. Do you agree with that statement that there are doctors that either reframe or invent circumstances that qualify for the mental health proportion of the requirement for termination to occur?

Prof. De Costa: Yes, I do.

Mr McARDLE: Do you—

Prof. De Costa: Reframe is perhaps the better word than invent.

Mr McARDLE: I am only quoting the document—they are not my words—and I think the expert witness was meaning the former, not the latter, but may have been carried away with the issue. You believe that does happen and that would potentially lead to a breach of the law as it stands at the moment. That is my estimation. Do you agree with that?

Prof. De Costa: I think it could lead to a breach of the law because, yes, it is done with the patient in mind.

Mr McARDLE: That is something—

Prof. De Costa: That we would like to be removed from our—

Mr McARDLE: That was not the question I was going to ask. I will not ask the question that I am thinking of, for obvious reasons I suspect. That is not complying with the current law though, is it?

Prof. De Costa: No.

Mr McARDLE: No.

Prof. De Costa: That was really the point of the study.

Mr McARDLE: Yes. With regard to the issue raised by Dr Hyland of the website, I think it is 120 hits you have a month and you have a telephone service with 850 in eight months. People have actually later terminated their pregnancy over that period of time, and that is about 1,250 per 12 months if you extrapolate that figure out. Those figures are not recorded anywhere are they, except in your own—

Dr Hyland: Now we have reached 1,000, we are in the process of publication in collaboration with other forces.

Mr McARDLE: Would you say that the use of that technology in that you are not required to attend the surgery is going to skew the figures of terminations as time goes by because, looking at the amelioration aspect, women will more likely than not approach termination by going through the web or telephone service, so a drop in terminations over time may be skewed by modern technology with regard to accessing termination services?

Dr Hyland: We believe we have the gold standard. We are talking about the first 10 weeks. It is nine at present but, let us face it, it is going to be 10. Most terminations, as you asked before, are done before 10 weeks or at 10 weeks. There are a few where it is done between 10 and 13.6. Generally you cut off at 14 in a freestanding clinic. Those mid-trimester abortions now are best managed medically in a facility. The figures are undeniable; the trend is that way. Sure, the surgical numbers are going to drop as the medical numbers increase—so much so that clinics will close, as is happening in the United States now. I actually believe the termination numbers in Australia may actually slightly increase, because we are providing a service now in areas which were not previously provided.

PROOF

Mr McARDLE: My point is this, though. At this point in time there are certainly clinics that are required to report each year to the Chief Health Officer. I do not think any of your practices are required to fulfil that step?

Dr Hyland: Correct.

Mr McARDLE: If women then access the web for various reasons, the reporting of terminations from clinics could decrease over time as well, could they not?

Dr Hyland: From surgical clinics, the numbers will drop.

Mr McARDLE: Yes, that is right.

Dr Hyland: There is a record of the number of people who are having a medical abortion. We are reaching rural and remote communities where it was previously not available. These women were having unwanted pregnancies. Now they will be able to get that service.

Prof. De Costa: I am in no doubt that there is quite a large black market in these drugs and there has been for a considerable time before these drugs were available. Methotrexate, which is freely available in Australia, was used. I have been contacted every time I have been involved in this by more than 20 doctors who have told me they have been using these drugs and by doctors who have been contacted by women who have used them. They are easily obtained from overseas. The only reason we had the Cairns prosecution was a series of coincidences.

Mr McARDLE: Taking the way the law stands at the moment and the requirement to meet either the physical or mental safety or wellbeing of the woman, whether we like it or not, what steps do you take in your practices to satisfy either of those requirements?

Dr Carette: It is established that a woman's health and wellbeing includes her emotional and psychological health and wellbeing as well. Generally speaking, I would say from my practice, if a woman tells me in good faith that she is not coping, she cannot cope with proceeding with this pregnancy because of the emotional, psychological, family, social pressures then she qualifies as a legal abortion.

Dr Hyland: We have in Queensland a qualified psychologist who consults with the patients so that we can comply with the law. We felt it was necessary because of the ease now that we have made this service accessible.

Mr McARDLE: By telephone or online?

Dr Hyland: All our services are by telephone.

Dr McNamee: I think the slightly ridiculous thing about the law is that for my patients, for whom I offer medical terminations up to nine weeks, the woman just needs to tell me that she has thought it through thoroughly and she does not wish to have another child and being forced to have another child would cause her immense psychosocial distress—which is a no-brainer if you do not want another kid, and you have decided that, and someone is going to try to force you to continue with the pregnancy that you have not planned to have.

My patients are better covered by the law than obstetricians' patients who may find that they have a baby with no brain and are offered the choice that they can either continue the pregnancy to term, but all their neighbours and friends will be patting them on the belly and asking when they are due and they know the baby is going to die within hours of being born or they can be offered a more humane option which is to deliver early so they do not have to go through those months of torture and public pregnancy.

Those pregnancy are the ones least covered by the law because a woman is making a rational decision that she does not wish to carry a baby that is doomed to die and does not want to talk about the expected birth of this baby in public for months to come. She is making a rational decision based on the lack of ability of the baby to live. Those are the very cases that would be most open to prosecution because there is no paragraph in the law to cover the management of severe foetal abnormality. The law threatens those decisions more than it threatens the decision of one of my patients who comes in and says, 'I have two kids. I don't want a third one.'

Mr KELLY: Thank you for your submissions and for appearing today. Professor de Costa, if a young research student approached you and said they have a single study from 40 years ago or a systematic review involving hundreds of thousands of combined results, what would your advice be to that student in terms of which would be the better set of data to use?

Prof. De Costa: For the purposes of finding out the actual evidence for something it would be the systematic review. That is our highest level of evidence in the practice of medicine. A systematic review is a way of analysing all the studies known and ranking them as to how robust they are and how well they have been conducted.

PROOF

Mr KELLY: You have all said that you would like to see a reduction in abortions. I think most health professionals would. If we approach this issue from a public health perspective, how difficult is it to develop public health programs in the absence of sound data?

Prof. De Costa: Impossible. You have to have something to know what you are going to correct.

Mr KELLY: Do you feel that the current situation of having the abortion laws within the Criminal Code contribute to the poor data that we have on abortion in Queensland?

Prof. De Costa: Yes, they do. It is not only Queensland but it is virtually all other states apart from South Australia and, more recently, Western Australia. Abortion is not reported, either medical or surgical. You need to know what you are dealing with before you can come up with a solution.

Mr KELLY: Just recently we heard—I think you mentioned you were in the gallery—statistics for the last 12 months for overnight admissions to public hospitals. There were 295 abortion. I believe approximately 120 were late-term abortions, which would be about the number I would expect. Overnight admissions into the private sector were, I think, 10,700. That is a quite a significant difference. Have you any thoughts on why there is such a vast difference in terms of services being offered in the public and the private sector?

Prof. De Costa: I do not think they were overnight admissions, they would be day surgery.

Mr KELLY: My understanding is that they were overnight admissions they were referring to.

Prof. De Costa: I do not think any of the day surgeries keep patients overnight. That is one of the reasons they practice the way they do. It would be the number of terminations. The law, the attitudes of doctors, the attitudes of the church percolate through to society. They have pushed abortion into a grey area. It was always there. It did not benefit women when it was promulgated in 1899. Up until the 1970s women died regularly from self-induced or unsafe abortion. Since the 1970s, fortunately, that was improved, but abortion has stayed in that grey area partly because it is the law.

Mr KELLY: Dr Carette, you have mentioned the case of Q. Thank you for bringing that up. It has been mentioned by many people who have made submissions. I note that it has been incorporated into the Queensland Health clinical guidelines. How does the private member's bill address your concerns related to this case? If we simply remove these three items from the Criminal Code and one from the transport operations code, will that alter or have any impact on the issues related to the case of Q?

Dr Carette: As Professor de Costa was saying, the fact that the law is there serves as an excellent excuse for some public hospitals and public doctors to wash their hands of the whole issue. If the law were repealed they would lose a perfectly good excuse. I think it would make a different in that regard.

As far as 12-year-old girls having surgery is concerned, the Queensland Health guidelines are quite happy with girls under 16 making their own decisions. I think there are plenty of provisions in the requirements for informed consent that would protect children that young even if the law were repealed.

Mr KELLY: The guidelines suggest that for non-Gillick women under a certain age you have to seek judicial oversight of their decision. Does the removal of these three items from the Criminal Code deal with that issue?

Dr Carette: To be honest I am not exactly sure. We would not treat a patient under age who we did not consider to be Gillick competent because that would be a mistake in law. We would have to go by the parents' recommendation. The whole point of Gillick competence is that it frees the young patient from the directions of her parents.

Mr KELLY: Professor de Costa, you gave a really good comparison of the approach to this issue in various state jurisdictions. You note in your submission that in Tasmania, Victoria and the ACT that abortion has been decriminalised and is regulated like all other health procedures under the various health acts. I am interested in this. At the point of decriminalisation was it necessary to add additional regulations to the health acts? Was that done at the time, subsequently or at all?

Prof. De Costa: Certainly in the Tasmanian situation, which I was involved with, they did it at the same time. They have had their cut-off point at 16. Beyond 16 weeks you need to have the opinion of two doctors—one of whom is a gynaecologist and below 16 weeks you need the opinion of one doctor and the consent of the woman. There is conscientious objection in the health regulations as well and in the Health Act of Queensland.

PROOF

Mr KELLY: During the hearings and based on my reading of other jurisdictions, there is a range of issues that have been dealt with or suggested that we deal with. I know you talked about conscientious objection under the AHPRA code. There has been things like gestational limits, safe access to clinics, equitable access to abortion services, reporting and data collection. That is a long list. Are these matters dealt with in current health acts in Queensland or would we need to add regulations to deal with those issues?

Prof. De Costa: Some of them are dealt with in the therapeutic guidelines. Conscientious objection is. Obviously 24 weeks is not. There was no gestation period in the Criminal Code. Access zones are not dealt with.

Mr KELLY: When you say that conscientious objection is dealt with in the guidelines, is that the Queensland Health clinical guidelines?

Prof. De Costa: Yes.

Mr KELLY: Are they enforceable at law? If I am a GP and suggest that I have a conscientious objection and seek to influence the decision that women will make regarding their pregnancy, would those guidelines be enforceable at law or the AHPRA ones?

Prof. De Costa: I am not sure they would be enforceable at law, but you could certainly make a complaint to the Queensland Medical Board or to AHPRA.

Mr CRAMP: Dr Hyland your service interested me when I first read about it. We were speaking to the previous witness about the psychological effects. We have heard from both sides of the argument with regard to whether there are any psychological effects. I note in your submission that you consult with the patients, pre and post abortion. Do you have any psychological follow-up with the patients? My concern is around the telephone consultation as opposed to face-to-face consultation and the level of support given to those patients.

Dr Hyland: We actually believe we get a better rapport with the patient over the phone because there is no direct confrontation. Our nurse is the one who discharges the patient at about 14 days and she does a discharge summary. She looks at her in terms of satisfaction and total cost. We do not do a psychological assessment afterwards. We are looking currently to see for patients who have psychological consultation in New South Wales and Queensland as against no consultation in Tasmania or Victoria or Western Australia whether there is any difference in their degree of comfort in taking that position.

Mr CRAMP: Do you think there should be some follow-up in regards to your service at a longer period from a psychological point of view to make sure that these women are coping?

Dr Hyland: After 15 years experience in surgical procedures, I do not think that it is a common occurrence and I do not see that there would be any difference with a medical procedure.

Mr CRAMP: You note in your report—and a few people have noted it—the exclusion zones around a physical premise, and I note that your service does it. Your service—

Dr Hyland: Avoids it.

Mr CRAMP: Yes, avoids it totally. For the actual physical premise, do you think exclusion zones should be included or enshrined in any legislation that is changed?

Dr Hyland: Yes. Indeed, in our surgical facility in Hobart and Launceston—

Mr CRAMP: I did note that; due to the exclusion zone it is minimised.

Dr Hyland: Yes. I made a submission to government which they accepted against the local AMA advice that it was not necessary, but we occasionally had a group of Christian Brethren who were harassing and intimidating our patients. There has been one protester who has been arrested since that exclusion zone came into place.

Mr CRAMP: I take it this is your reference to the Australian doctor at the end of your submission?

Dr Hyland: Yes.

Mr CRAMP: I note that when you talk about your failure rate you mention incomplete abortion. Can you explain to me what an incomplete abortion is? With reference to the Australian doctor, three have failed and eight were incomplete. Can you take me through some of the physical outcomes of that terminology?

Dr Hyland: Those statistics are not correct, because they were written by a journalist and they were not validated by me. They were done when we were up to 600 or 800—I cannot remember—and the report was done a few weeks later. In terms of a failure rate—and that means an ongoing viable pregnancy—I think we have had three.

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Mr CRAMP: What happens to those women when it fails?

Dr Hyland: That is a very good question. In Tasmania where we have a surgical facility then we can manage that. In Western Australia we refer the patient to the Stanley hospital because she was 10 weeks by the time we discovered that. They did an ultrasound and they said, 'This is viable. We're not doing it,' until I reminded them that if she has an abnormality as a result of the medications that we have given her they could be medically liable. They contacted the patient again and changed their decision.

Mr CRAMP: Were all these patients still willing at this stage to go through with termination or was there any—

Dr Hyland: Absolutely.

Mr CRAMP: I am interested in two comments that were made. We are talking about open advice. Dr McNamee, you said that you are trained to provide open, non-directional advice, but you said that when you spoke to a patient you advised them that they could have the baby and have people pat their tummy or they could take the more humane route and terminate a baby that is doomed to die. I am a lay person; I am not a doctor. Dr Hyland, you also said that people even in the medical profession still intimidate your patients including showing them scans of their unborn foetus or child, whichever side of the argument you sit on.

Dr Hyland: Sadly.

Mr CRAMP: I am taking a very objective view to this. I wonder, first of all, Dr Hyland, how is that intimidation if a medically trained specialist shows a patient their unborn child or foetus? My understanding of psychology and a person's mindset is that just because they make a decision today does not mean they are going to stick with that decision next week. How is that intimidation on the behalf of that specialist? I will refer to you, Dr McNamee, after that if you like.

Dr Hyland: I must say that it has not happened with a medical specialist, a radiographer or diagnostic imaging; it is from their staff who have other values.

Mr CRAMP: How is it intimidation regardless?

Dr Hyland: We specifically request that the patient is not shown the ultrasound scan. They have made a difficult decision already and they do not need to compound it with seeing a live baby, nor do they need to compound it by knowing they have two or three. They have come along for a pregnancy termination and it is redundant to tell them they have twins: 'Which one do you want to have terminated?' They have already made that complex decision and reached it. It is not frivolous. Why make it more complex for them?

Mr CRAMP: I take your point, but I also argue that as human beings we change our mind based on new information every day. In fact, I live that dream in this job. I still say to you that that, to the best of my knowledge—and I have a lawyer sitting near me—would not be classed as intimidation or any form of bullying. Has the patient specifically signed any waiver to say they do not wish to see, and you noted yourself, an unborn child?

Dr Hyland: No they haven't, but on the other hand one could suggest that what you are suggesting may lead to post-traumatic stress.

Mr CRAMP: Would it lead them to change their mind?

Dr Hyland: It will give them more conflict undoubtedly, don't you think?

Mr CRAMP: Conflict is not always a bad thing. It was not a judgement call on you. I am just trying to hear both sides of the argument and they were a few statements. Dr McNamee, would you like to add to that, because you commented that they were doomed to die. With all due respect, I listen to both sides. I have not heard a lot of statements that were objective. I have heard a lot of opinions. Could you explain to me how that is objective?

Dr McNamee: I want to distinguish that, when I was talking about the woman making the decision to remain pregnant until nine months with a baby, for instance, with a severe brain abnormality not compatible with life, many women in my experience will take the decision that they would rather birth that baby at maybe 24 to 25 weeks, wrap it up in a blanket and hold it while it expires than continue to carry it to 40 weeks because of the social, visible nature of pregnancy. Pregnancy is of course a positive and wonderful thing when it is wanted and the baby is healthy, but it is very difficult for a woman to have a lot of people know that she has a baby that passes away.

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That is a very private thing. To distinguish between that scenario, which is a very rare scenario, thankfully, and extremely tragic and I think all of us could relate to a couple grappling with that decision versus my patients who are in extremely early pregnancy. Sometimes there is not even a foetal pole when we offer the medication for termination. There is a gestational sack and a yolk sack and we cannot even see a foetus.

I think the point Dr Hyland is making, as I have also experienced, is radiographers who despite my writing on the form 'unplanned pregnancy' which really means this woman is undecided about the future of the pregnancy—and I always discuss with the woman when they go to the scan that, if you do not wish to see the image, instruct the radiographer that your plan is to have a termination and you do not wish to have that image in your mind. If you wish to see the image, have a look at the image—whatever you want to do. What I object to, and I am sure Dr Hyland is referring to, is we do have radiographers who are also conscientious objectors. There does not seem to be any regulation around their behaviour in the ultrasound room. I have certainly had them point out the heart beat and point out features of the foetus, and the woman has expressly asked not to see the image. I have had a woman recently who made a complaint against a radiology practice because of that. She had stated that she did not wish to see the image and the image was forced upon her.

I know in America some states have brought in regulations where women are forced to see the image, and I would agree with Dr Hyland that the whole point of this is we want to have our women as psychologically healthy as possible and have a society where every child who is born is truly wanted and welcomed. We must not intimidate the woman or try to change the woman's mind but let the woman go through this process in the way that is best for them.

Prof. de Costa: Can I make one point? It is essential for a woman undergoing abortion, particularly a medical abortion, to have an ultrasound so that the doctor is aware that the pregnancy is in the uterus and not an ectopic pregnancy and is of the gestation stated, because medical abortion at home can only be performed after nine weeks.

Mr CRAMP: Dr De Costa, I am trying to understand the processes involved. In the end this is far from a clean issue; it is a surgical issue. Explain to me in section 2 of your report what happens when a baby is suctioned?

Prof de Costa: The woman is under a general anaesthetic, so she is asleep. There is a vaginal approach through the cervix to the uterus where the pregnancy is. The cervix is dilated—that is, stretched—so that that approach can be made and she is unaware of this because she is asleep. Suction is provided through a tube—you may have seen suction in emergency departments perhaps—for the mouth to keep secretions away from the lungs. It has a fairly sharp ending on that plastic tube which helps to remove the pregnancy so it is sucked out and into a bottle and sent for the pathologist to look at and to confirm that there was a pregnancy there.

Mr CRAMP: So I can understand the argument Dr Hyland is talking about between nine and 10 weeks, at nine and 10 weeks what form does that foetus take? Is it just an egg and a sack, as was noted before, or is there a formed foetus?

Prof. de Costa: It is about 1½ centimetres long.

Mr CRAMP: What does it look like? Does it look like a 1½ centimetre baby or an egg and a sack?

Prof. de Costa: Often it is very hard to distinguish the foetus at that stage. There is liquor—amniotic fluid—quite a lot of placenta tissue, membranes and a certain amount of blood clot.

Mr HARPER: It is ironic I think that before us we have medical professionals who combined outweigh the actual law that is before us of 117 years. I will let you do the maths, but what I am saying is that you do bring significant years of experience in your area and I appreciate the views that you have brought today. Professor de Costa, I am interested in your work with the Victorian Law Reform Commission, which last went through this in 2007-08. Then it went on to the Victoria royal commission for a year. You gave expert advice or evidence in that process. If Queensland went down a similar pathway, would it be duplicating that enormous body or work? We have heard from ethicists, academics and the legal profession, but I would like to hear your viewpoint please.

Prof. de Costa: I think the document used by the Victorian Law Reform Commission is excellent. It went into great detail as to what happened in Victoria, what happened elsewhere, what happened overseas and came back with recommendations about what should happen in Victoria. It was subsequently voted on by parliament and introduced, and is now the practice in Victoria. I think the 24-week gestation limit with two doctors after that appears to be working well. Abortion numbers have not overall gone up for Victorian women. The fact that there are more late abortions in Victoria—

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I think it is about 180 a year—is because there is abortion tourism from Western Australia, Queensland, New South Wales, South Australia and the Northern Territory to the one private facility that will perform some abortions after 24 weeks, and it is usually only within a couple of weeks of the 24 weeks.

Mr HARPER: I did not hear from the gentlemen earlier—just your viewpoints. I think we heard from you, Dr McNamee, on the 24-week gestational period that is in the terms of reference. Can I just get your viewpoints, please, gentlemen?

Dr Carette: The anti-abortion lobby place great store on late-term abortions. It is good publicity for their cause. Late-term abortions are traumatic, they are confronting and they are emotive. What you must realise is that one per cent of all abortions are performed in the second half of pregnancy and four per cent of all abortions are performed outside the first three months. It is a rarity, it is done by expert doctors in big hospitals with plenty of experience and you really have to disregard the big fuss, I think, that is made about it on emotional grounds by those who oppose it.

Dr Hyland: I think you should understand that most pregnancy terminations are done in the first trimester, up to 14 weeks, and most of those are for psychological reasons. I do not know that psychological reasons would ever be the reason a late-term abortion would be performed. Then it is performed by serious foetal abnormalities which are often incompatible with life or for serious maternal illness. It is a different kettle of fish we are talking about. It is not a woman who wakes up one morning at 33 weeks and thinks, 'I've had enough of this. I want it terminated.' That never happens.

Mrs SMITH: In the last 20 years—you said it yourself, Doctor—there have been no charges to doctors or patients. We have understood, I guess, that most patients are not even aware of the laws. We do not see an increase or a decrease through decriminalising or criminalising abortions. Also, there has not been, I guess, enough data collected around abortion's impact, the effect and a whole range of other things. Why, then, do we need to change if on all of those bases—and in your own words you said that in the last 20 years no patient or doctor has been charged—

Dr Carette: Well, I—

Mrs SMITH: I have quickly summarised, but I have to just ask that question.

Dr Carette: No-one has been successfully prosecuted. No abortion has been prevented. No offender has been punished. The problem is: there was a charge six years ago and no-one knows when the next random charge might come. It is worrying, because it is there. It is bullying. It is a threat. It hangs over one's head that it may happen again any time. It is that, plus the reason that doctors and patients do not know what is legal and what is illegal. That in itself is a reason for repealing the laws. There is another reason. As the law as it stands sits, there as an insult to all those women who bitterly reject the fact that the law courts can assume control over their reproductive rights.

Mrs SMITH: Ten years ago we would never in our imagination have thought we could do the services, I guess, that you are providing now through technology, through medicine and research and science. In that regard, I ask you: is there not now a greater possibility that we will end up having unqualified people coming into this realm, be it through the distribution of drugs et cetera, so therefore there would be more of an onus on us—more than ever now—to actually have legal protections? If we are now going through your particular service through the internet or through telephone services and there is not even face to face, is there not a possibility we could open that up to a market of unqualified or illegal practitioners?

Dr Hyland: Tanya Plibersek put this on the PBS so that it is readily available now. If it is not prescribed by a certified medical practitioner then it costs something like $370. Why pay $370 when you can go to a doctor who is certified in doing it to get the drug and get it properly dispensed and then managed? It will not happen.

Mrs SMITH: I then come back to Dr de Costa. You made references to say that this all should come under the Health Services Act and gave an example of when you have to take tonsils out. I think the one thing we may need to give consideration to is that there are a lot of people who believe that once a child is conceived, or throughout those periods from 12 weeks through to 24 weeks—the heart beats and the child is developing—there is a child involved and it has then moved away from the mother. We have heard those discussions. Comparing it to taking tonsils out is not comparing apples with apples.

Prof. de Costa: I certainly do not mean to be flippant in that. I respect those views of people who believe life begins at conception. I see life as a continuum. The ovum is a live cell, as is the sperm. I have 45 years of medical practice looking after women during pregnancy, whether they

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choose to continue it or not, and I respect their views. The conclusion I have come to is that the foetus becomes a person when the mother decides that that is so. I also speak as a mother of six children. I know what it is to be pregnant and to have children. Women who are older perhaps delay making that decision—and I have done it myself because I had two of my children in my forties. I have had an amniocentesis and I could not think about the foetus as being a child until I knew that I did not have to make a decision about termination. For some women of course this will happen, too, when they see the blue line. As Dr McNamee has made clear, for many women that is not the case. We respect the views of the people you refer to. We do not say that they have to have abortions. We are not pro abortion; we are simply pro choice and we are for removing as many legal barriers as we can to women making those choices.

Mrs SMITH: With regard to the AMA and their position on compulsory referral, I referred to the paper provided by Father Frank Brennan. The AMA go on to say that compulsory referral by a conscientious objector is actually an infringement on doctors' human rights by interfering with a doctor's right to freedom of thought, consciousness and belief. Therefore, they were very critical of the position down in Victoria of putting that into the legislation regarding the rights and responsibilities with compulsory referrals. That was the AMA. Do you have any comments on that?

Dr McNamee: I do not actually know that that is the AMA's position.

Mrs SMITH: I can show you the paper, if you like.

Dr McNamee: The AMA have recognised the right to conscientious objection. As I have said previously, I actually agree with the fact that that should not be a criminal act for a doctor. I think if a doctor has conscientious objection they have a responsibility to offer the patient another doctor. The simplest way that happens in real life is that a conscientious objection doctor would pass the patient on to another doctor in their surgery who may have a more open opinion and may be able to offer the woman all options. That is as simple as a doctor needs to do. What a doctor cannot do is throw the woman out of their surgery—that has certainly been done before—abuse the woman, call her evil, tell her that she is a murderer, try to talk her out of the situation. That is abusing your patient. I think I have the AMA statement here—AMA Queensland.

Mrs SMITH: This must be Victoria. Dr Travis, president, AMA Victoria, actually stated, 'Unwarranted because it departs from the existing AMA code of ethics'. Then Dr Travis, president, AMA Victoria, goes on to state—

> The bill infringes the rights of doctors with a conscientious objection by inserting an active compulsion for a doctor to refer to another doctor who does not have a conscientious objection.

Dr McNamee: I am afraid that is life. This is a secular society and a woman has a right to have all options discussed with her. They are not saying that you have to refer to an abortion service; you just have to refer to another doctor who is not a conscientious objector. That is enshrined in the therapeutic termination of pregnancy guidelines for Queensland Health. In the first paragraph of 'Who will deal with a woman presenting with an unplanned pregnancy' it says that a doctor who is not a conscientious objector is to see that woman. In my country, Ireland, abortion is still illegal. Doctors who feel that strongly that they cannot practise in a secular society, where women have a right to consider all options as a thinking, intelligent adult, should perhaps move to the Republic of Ireland.

Prof. de Costa: I have the submission to your inquiry of the AMA Queensland of 30 June this year. They say that conscientious objectors should not use their objection to impede access to treatments that are legal or would impede the patient's access to care, although they respect the right of medical practitioners to hold different views. We are up to date, in June 2016 and in Queensland.

Mrs SMITH: I was referring to a Dr Travis, president of the AMA in Victoria, and his comments.

Prof. de Costa: I understand.

Mrs SMITH: Again, there are differing views. They were their comments with the objection of putting it into the actual legislation.

Prof. de Costa: I think that was the Tasmanian legislation.

Mrs SMITH: No, definitely Victorian. I guess my last comments would be that as a committee we need to, of course, weigh up the legal aspect of it. At the end of the day, we have to weigh up the community's expectations and the views of the community. Overwhelmingly, all of the submissions I have gone through have opposed any changes to this law. You made the statement earlier, Dr McNamee, when you first came in, about the previous presenter, that he was Cherish Life and he was Catholic. Well, there are many people out in the community who hold those views and, based on our submissions, the number of views are overwhelming. We do have to give all of that great consideration and be respectful of that.

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Dr McNamee: I understand that, but if you look at the statistics for Australia I think you find that only 10 per cent of the community, on surveys, say that they are committed to any religion and practise any religion. Between 80 and 90 per cent of Australians consider themselves secular. Eighty per cent of Australians consider a woman has a right to terminate a pregnancy. Therefore, just because the anti-choice lobby is very organised, has a lot of money and has organisations that they can easily drive people forward to put submissions in, such as churches—those of us in the pro-choice campaign do not have churches. We do not have meeting places. It is very difficult to get people motivated to do something such as put a submission in to a parliamentary inquiry.

I think you have to remember that you are seeing a skewed view of the population. You need to look at the population surveys on attitudes within Queensland to termination. We did a lot of work around this when the Cairns case hit the courts, because people were horrified that it was happening. We were in the streets of Cairns getting petitions signed and speaking to the general public. People were horrified. We had Catholics come up to us and say, 'I would never have a termination. I don't agree with termination, but I don't think that young woman should be prosecuted.'

I would ask you all to realise that the anti-choice movement is a very powerful movement. They have shocked doctors in America. They have done all sorts of things that our side—our reasonable, secular side—will not do and the submissions that you have received are not a reflection of the general Queensland feeling.

Mrs SMITH: I would finally say that it is sad reflection on our society when we have 12-year-olds being pregnant. I am not talking about rape or incest; I am saying that, with 12-year-olds falling pregnant, we end up with that other situation. That is my final comment.

Dr McNamee: I absolutely agree with you. I work a lot with teenagers. I have had to put contraception into 12-year-olds. People are horrified that I have had to do that, but these girls are on the streets. They are having sex. They are at risk. At least if we stop them getting pregnant we stop them facing this decision and facing the chance of dying in childbirth, which is greatly increased at the age of 12 compared to the age of 20.

The problem with society is that puberty is getting younger and younger. We as a society are not doing anything to react to that. When I was a teenager, the average age of first period was 15. It is now 12. We have girls getting periods at 10 and being fertile by 12. I totally agree with you. I am absolutely horrified to think of a pregnant 12-year-old. Again, it is through good sex education and good contraception provision that we are trying to reduce those numbers.

CHAIR: Thank you. Our time for this session has expired. Thank you, Dr McNamee, Professor Caroline de Costa, Dr Carette, and Dr Hyland for your submissions, for your opening statements and for being willing to answer all our questions. Thank you.

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SHUMACK, Ms Lyn, Private capacity

CHAIR: Lyn, welcome. Would you like to make an opening statement and then we will ask questions?

Ms Shumack: I would, thank you. Thanks so much for the opportunity to provide evidence to this committee. Allow me to introduce myself. I am a psychologist with 30 years of clinical experience specialised, but qualified in both clinical and forensic psychology, which means that I am an expert not only in psychological diagnosis but also in how the law impacts on mental health and vice versa. I provide consultancy services to many organisations and government departments acting as an expert witness, or assessor for court matters across a wide range of jurisdictions—in local, district and federal courts. I am, therefore, best able to assist this committee on matters relating to my field of expertise which, of course, includes evidence based psychology and the quality of psychological research. I am an Australian Psychological Society trained and accredited pregnancy counsellor and currently provide psychological interviews for Queensland and New South Wales women seeking abortion through the Tabbot Foundation in order to comply with the legal requirements in those jurisdictions. These women are routinely screened for psychological distress, risk of domestic violence and coercion and offered contact details for professional counselling and support, because we aim for best practice when it comes to duty of care.

I have two matters that I want to address regarding your terms of reference. Firstly, on existing medical practice, I would like to make three points. Firstly, almost all abortions in Australia are done during the first 14 weeks of gestation and, importantly, almost all of those—and I think Dr Hyland also made this point—are performed for psychological reasons. It is only in later pregnancy that the more serious medical conditions such as congenital foetal abnormalities or severe maternal illnesses occur and, consequently, become significant reasons for seeking an abortion.

Secondly, it must be acknowledged that current medical practice in all states of Australia is really abortion on demand. The few obstructions to this are from doctors who may harass, intimidate or fail to appropriately refer a woman seeking an abortion or from protesters outside centres who do much the same in an effort to psychologically traumatise and shame women into not going ahead.

Thirdly, in Queensland, a mental health reason is made to fit the law by being determined a serious danger to the woman's mental health, but for every patient their situation is serious enough for them. Under the present case law, serious danger can only be correctly judged by the court. Instead, it is curiously left to the judgement of a medical practitioner or, in some cases, an unqualified counsellor or nurse to decide what is, in fact, serious. It is patently inappropriate that they are required to make a decision whether a particular case satisfies what is, in effect, case law and, therefore, the province of legal, not health practitioners.

On counselling and support services, I notice that there has been a lot of comment about mandatory counselling. Almost without exception, the women I speak to have already made a firm decision to seek medical abortion. Very few express the wish to follow with further consultation. In addition, there is virtually no credible research on the effects of counselling on a woman's decision-making capacity when seeking a pregnancy termination. Most women are intelligent, capable people who can make these decisions for themselves. Neither is there much research available on later psychological adjustment. Any claim that there is certainly rather dubious. I am specifically talking here about Australia, with specific regard to medical abortion. It is our intention to do such research and we are collecting that data at the moment, but it is too early days for us to help you with that, I am sorry, but our data collection process is in train. I will say, however, that our feedback clearly indicates that those women who were interviewed by our psychologists overwhelmingly expressed the view that they thought it extremely helpful for two reasons: it allowed them to further articulate and clarify their reasons; and reassured them that they had all the medical, nursing and psychological support that they required.

Psychological support does benefit patients. We know that from years of research, but women do not need another layer of obstruction or regulation. We must not assume that they do not thoroughly consider every aspect of their physical, mental, social, or financial situation, or that, in making their decision, they do not consult widely with family and friends. For that reason, I would suggest that any consideration of counselling should be optional. That is all that I have to say on that matter.

I do, however, have some information about that citation that, I think, Dr Tim Coyle did not have, because I noticed—and being a forensic psychologist I cannot help myself; I check the references that people put in their submissions so I can help him with that citation. I put in the first two lines of his submission into Google and it came up as a submission made by a guy called David

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Reardon, who apparently has a copyright on that information. He is an American electrical engineer and anti-abortion activist. If you google him, he is the founder of the Elliot Institute, an anti-abortion advocacy group and author of a number of articles and books on abortion and mental health. The *New York Times Magazine* editor, Emily Bazelon, described him as a pro life movement and described the growth of post-abortion counselling ministries around the United States as part of an effort by the pro life movement to outlaw abortion by stressing its purported psychological effects. I am glad I am here to help you with that.

CHAIR: Could you repeat the surname?

Ms Shumack: David C Reardon.

CHAIR: Thank you very much. Does that conclude your opening statement?

Ms Shumack: Yes.

CHAIR: Lyn, I am sorry, just to clarify, you regularly see patients as part of your operations as a clinical psychologist?

Ms Shumack: Yes.

CHAIR: What are some of the key factors that can cause some further degree of stress or cognitive dissonance when women are making decisions? I am talking about the stigma one. What are some of those elements that make the decision harder? I do not imagine any woman finds the decision easy.

Ms Shumack: When they are balancing a number of different factors. The really stressful thing for most women is when those factors conflict with each other when they have equal weight on things, because they do not know which way to turn at that point. Of course, that is a very stressful—incapacitating and immobilising really as well as psychologically. The other thing, of course, is where they feel that they are influenced by other people's attitudes and values and there is a fair amount of coercion going on and that conflicts with what they are feeling in their own hearts. Those things increase significantly the stress of the situation that they are making a decision about.

CHAIR: Of course, views are quite polarised. We have seen that in the debate. We can see that people have very strong views. I know that some of our doctors reported earlier that women tend to come to their consultation with a clear decision made in their own minds, but there are others who may not and feel far more conflicted. What are some of the things that makes their journey easier to arrive at a position that they can live with so that we do not have some of the issues that we have heard about with ongoing depression or issues later?

Ms Shumack: They need to have as much information as possible and good-quality information so that they can take a balanced view of what is going on and weigh up all the factors. When I ask them questions about what have they considered in making their decision—I will say to them, 'Do you make up your mind based on your own physical health in the future? Or your mental health? Your stress level? Your social or economic situation? Your family situation? Your social situation? Your financial capacity? They almost always—over 90 per cent of them—will say to me, 'It's all of those things.' They are thinking about all of those things. There is an awful lot to consider. As I heard the doctors say, their patients think about it for a little while, because there is just so much to take on and they have to talk to other people about that.

The difficult thing for them really is often the relationship that they are in, the quality of the relationship that they are in. In particular, I have been interested in this article that I have with me today, which is talking about the incidence of not only domestic violence with their partner but also the quality of the relationship that they had. In here it talks directly about that. This is a study done by the University of California, San Francisco in May 2013. It is written by a woman called Foster and it is out of Advancing New Standards in Reproductive Health and it is called 'The effects of abortion on women's romantic relationships and risk for intimate partner violence'. It found that one-third of the women reported that the reason they wanted to terminate their pregnancy had to do with the man involved in the pregnancy. That is very consistent with the statistics that we are getting at the moment with the 1,000 that we have done with the Tabbot Foundation. They list the reasons: poor relationships; partner is unable, or unwilling to support the baby; partner has characteristics that make them undesirable to have a baby with; partner does not want to have a baby; partner is abusive; or respondent does not want to be a single mother.

Given that there is a big problem in our society being highlighted in the media in recent months and years with domestic violence, I think it is cogent that that study provides that information for this committee, because you have to consider there are many more reasons that women have pregnancy

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terminations than you would normally think of. You would not normally think that one-third of them say it is because they consider their partner unsuitable. That might be a partner they have been married to for a very long time.

CHAIR: How does our current legislative environment or that proposed by the bill before the committee change those elements of partners and concerns and issues that are happening in that regard?

Ms Shumack: I do not know that it does. I think the difficult thing is, obviously, you are considering a much wider range of things besides the decriminalisation of abortion in Queensland. You must take into account that women have many reasons for having an abortion that we do not necessarily know about or imagine. This is really about women's dignity and having the right to choose.

CHAIR: Thank you. I will hand over to the deputy chair.

Mr McARDLE: Lyn, thank you very much for your submission. You refer to David Reardon, whom I do not know. I note also the report that Dr Coyle references, I suspect, in part; not all of the document. The most recent reference is 1987. As my friend pointed out, that is a long time ago. Do you have any comment upon the content of the report that we have been referred to, given your background? Do you know of Dr Reardon's qualifications clinically to make such a document?

Ms Shumack: According to Wikipedia, he is a graduate of the University of Illinois in electrical engineering and he has a PhD in biomedical ethics from Pacific Western University, an unaccredited correspondence school offering no classroom instruction. There is no further information about him, apart from the fact that Reardon's findings can fit with the view of the American Psychological Association, as well as other scientists and researchers, that abortion carries no greater mental health risk than carrying a foetus to full term.

Mr McARDLE: Given your background, would you question his capacity to put together an article of that kind, which carries the weight that we are told it should carry today?

Ms Shumack: I give that article very little credibility. It was copyrighted in 1990. Given also the age of the research that you have been given—I consider myself a behavioural scientist and I would not look at anything that old seriously, unless I knew that it was a ground-breaking thing that had never been subsequently discredited in any way. You really need to be looking at the last five to 10 years. I note you asked Dr de Costa about her students—I am not sure if it was you; it might have been Mr Kelly—and what sort of evidence would she consider acceptable. It is outside of the realms of proper scientific inquiry to consider something so old as credible, especially given that you have so much good research coming out of America in the last five years.

Mr McARDLE: Based on modern techniques, modern technologies and modern understandings, et cetera.

Ms Shumack: Yes. Also, it does not take into account medical abortion, of course.

Mr McARDLE: Very quickly, over the years there have been many reports either saying there is an impact psychologically or psychiatrically postabortion, and some that say there are not. We have been referred to a number. It is quite difficult for us, looking at that evidence, to come to a firm conclusion. Do you have a view on whether a termination causes mental anxiety—and I use that word advisedly? If it does, is it normally based upon a pre-existing condition that is exacerbated, potentially, by a termination or does the termination itself generate the condition?

Ms Shumack: It is actually quite difficult to answer that, because there is little research on it. The research that I mentioned before talks about the effect on women's mental health. I will just see if I can find the summary of the outcomes. They found that there is a variation in women's emotional responses certainly, but there is no mental health differences. That is the Turnaway research paper that I am talking about. Compared to birth, there are better physical health consequences. There are large socio differences in terms of what people's outcomes are, but there are small observable differences in the wellbeing of their existing children. That is a summary of the results from that.

I might add that I think it was Dr Coyle who referred to a thing called postabortion syndrome, which I have never heard of in my whole career. He said it was actually regarded as a serious problem in Western Australia. I am sure if it was the psychologists would know about it, especially me, since I am a forensic psychologist and very much keep up with the research on that sort of thing. It sounds like it is an invented term, actually. Giving him the benefit of the doubt, he might be confused about post-traumatic stress syndrome, which does affect people who have had a life threatening experience or have witnessed a life threatening experience. That is the very first criteria.

I will go back a little: we go by a diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders.* We are up to version 5 now, the DSM-5. If a syndrome is not described in there, it is not a credible syndrome. Post-traumatic stress disorder happens as a consequence of something that is personally life threatening and directly life threatening to you as an individual or something you have witnessed happening right in front of you to someone close to you, a loved one or even somebody you do not know. You have to take this with a little bit of leeway, but I believe that the incidence of that developing in any one individual experiencing those things is about one in five. They seem to get over it within about a month, in which case they are diagnosed with a different disorder for that month. You have to have it for a month before you are diagnosed with post-traumatic stress disorder. In that case it is called acute stress disorder. After a month, the vast majority of people resolve that. Again, it is about one-fifth of those. We do not know why those people develop an ongoing traumatised problem. We think it is probably genetic. Probably it is some sort of vulnerability in the person. It also has to do with what they have previously experienced in their life. The older we get, it seems the more vulnerable we are to psychological trauma. We do not actually learn to cope better with psychological trauma the longer we live. We get worse at coping with it. Young people have a resilience to that that older people simply do not have. I am not sure if I have answered every aspect of your question.

Mr McARDLE: Yes, you have. We have been told, as late as yesterday, that 25 per cent of terminations occur when conception happens in a domestic violence situation.

Ms Shumack: Could you repeat that?

Mr McARDLE: Certainly. We were told that 25 per cent of terminations occur when conception happens in a domestic violence situation. Would you agree with that?

Ms Shumack: No.

Mr McARDLE: Thank you.

Mr HARPER: Thank you for your contribution today. To confirm, as a clinical psychologist with the Tabbot Foundation, you have spoken to over 1,000 women?

Ms Shumack: No. That is how many the Tabbot Foundation has handled Australia-wide, since its commencement.

Mr HARPER: Are you undertaking some research of those particular clients?

Ms Shumack: I am. The submission has a typo in it. It is 15 per cent. The number of people coming from Queensland who are having terminations through the Tabbot Foundation is 15 per cent. I correct that.

Mr HARPER: Are you finding with your interactions with those clients that they are more likely to seek termination under 10 weeks? Do you have any thoughts on the terms of reference item No. 4 regarding regulating terminations based on gestational periods, from your interactions and experiences with those women?

Ms Shumack: I cannot really speak about that. It is actually a medical question, in my view, and I am not qualified to comment on that. I will say that before I speak to any of the women, they have been through a fairly strict screening process. They all have to be able to have the medication before 63 days. Often where they live is a factor in that because we must be sure that we are able to dispatch medication and have it delivered in time, so that they are within those guidelines. As I said, the rest of it I will not be commenting on.

Mr HARPER: Thank you.

Mr CRAMP: I have one question in regards to counselling: I am not sure, but I think it was Dr de Costa who stated that she was not happy when women attended who had just spoken to their husbands about the decision to terminate; she wanted them to speak to their mums, their sisters, their friends. Previous witnesses and other doctors have said that people are very resolute when they come to you, having made the decision. I go back to the fact that you yourself are an expert in counselling, understanding these processes and how to assist women in this situation to ensure that they are sure that they want to go through with the termination or they want to carry through to delivery. The argument for me is that if they have made this decision based on talking to lay people, as an expert are you satisfied that they have made a sound decision?

Ms Shumack: I am satisfied when they have spoken to all of those people and then they are speaking to me. Accredited pregnancy counselling psychologists are trained to be objective, impartial and non-judgemental. I think Dr Carette talked a little bit about the nondirective style of counselling. Really, that is about making sure that your patient is making her own decisions, that you can pick up

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on things that she is conflicting about or confused about, or influences on her that she is disturbed about, and discuss those with her. We have a fairly thorough interview. We not only cover the legal questions, starting off with making sure that they have got proper informed consent and that they are happy with all the information; they are thoroughly convinced that they know everything they need to know about medical terminations at this point. They have five legal questions asking them what they consider is important and then they have a series of statements that we collect data on, which actually give them enormous clarity. There are probably about 25 questions that we need to ask about, finding differences. Therefore, they are really clear by the end of that interview about why they are having it, what is going on for them, who was an influence or what was an influence on them and why it was. I am really satisfied with that. It is funny: it is a very short interview. I do not do anywhere near as thorough an assessment as you would if you are taking someone to court, for example.

Mr CRAMP: Based on that very point, do you think we give women the opportunity to have ready access to the counselling they need to make this decision? Do you think what you do is enough?

Ms Shumack: Yes, I do. Plus, not only are they screened for domestic violence—we ask them about that—but also at the end of the interview I say to them, 'Do you know that the Australian Psychological Society has accredited pregnancy counselling psychologists all over Australia? You just have to Google the Australian Psychological Society website under 'find a psychologist' and you will find an accredited pregnancy counselling psychologist who is objective and impartial.' I say to them, 'You can either Google it or I will give you the phone number. Would you like the number?' The vast majority of them say no. It is very rare—often they will say, 'I already have a psychologist. I'm already seeing a counsellor and I'm happy with that.' They have already made up their mind by that point. If they have not, they will just take the number and say, 'Thanks very much.' We certainly offer that. I think it is important that they are given that option and that they know where they can get good quality professional advice that is not going to try to coerce them one way or the other.

Mr KELLY: Thank you very much for your presentation. A number of people have contacted me during the course of this inquiry and have indicated that they fear that if we remove these three elements of the Criminal Code we will be setting up an environment whereby we move a step closer to designer babies. I know the response that I have given, but I would be interested in your thoughts because you obviously talk to women at a point where they are making decisions. In terms of gender, which is probably the only thing I am somewhat familiar with, it is my understanding that gender is not necessarily easily told until 16 to 20 weeks. On the evidence that I have heard, the vast bulk of women are making decisions well before that point. In your experience and the women that you have counselled, do these factors play any part at all in the decision-making processes?

Ms Shumack: Well, I have not come across one yet.

Mr KELLY: How many have you dealt with?

Ms Shumack: Fifteen per cent of 1,000, so 150.

Mrs SMITH: I am interested in how important it is for counsellors to be objective and impartial. As an expert, do you see that as quite important?

Ms Shumack: Yes, it is.

Mrs SMITH: That contrasts then with a women's health centre that we met with yesterday who said that they insisted that all their social workers were pro-choice. Do you have any comments in regard to that?

Ms Shumack: The Australian Psychological Society has an accreditation program where you have to do a professional development course and pass an exam in order to be accredited. I do not think social workers have the same requirement. I would not know really. We have a code of professional ethics that we conduct ourselves by. Complaints can be made easily online, as you might have observed. You are risking a lot to not be impartial when you talk to someone. Your job is to help them explore their options. Hopefully they can make a decision. They have almost always made a decision when they speak to me. In fact, I do not think I have come across one that has doubted their decision.

CHAIR: Thank you so much for coming in today and for answering our questions.

DRAFT

DILLON, Mr Jonathan, Private capacity

CHAIR: Jonathan, I know your time is limited. I think you have 10 minutes and then you have to leave. Is that right?

Mr Dillon: Yes, that is correct.

CHAIR: Would you like to make a brief opening statement and then we will ask questions?

Mr Dillon: Good afternoon. My name is Jonathan Dillon. I do not have the titles like our previous guests. I will just say that I am a resident of Cairns concerned and interested in this topic. I missed out on the opportunity to put in a written submission because I was caring for my disabled brother in Central Queensland during that window. When I heard that there would be a hearing in Cairns, I thank you for the opportunity to present today.

The first thing I would like to share is that for a younger person we do not know a lot in life and we learn as we go. Our understanding of the world and the things we learn along the way often only relate to the questions that we are asking at that time of life. As you are growing up, the issue of abortion, life and all of those things are not a concern when you are a teenager. Unless you face it head on, you do not actually need to learn about it either. For myself, it was not until about three or four years ago because of my interest in learning and reading biographies that I came across a book called *Beyond Choice* by Don Baker. It shared a true life story of a young lady who is a teenager called Debbie and her experience going through an abortion. As I read this biography, I was just amazed at what I did not know. The reality of what this young lady went through—she was in her graduating year of high school. She was in love. Life was good. She had a good family behind her. Then she fell pregnant. The journey that suddenly hit her was just so shocking.

The biography goes on to share that, due to poor information and counsel, Debbie did not receive the chance to have a good knowledge about the choice that she was making. She was very much informed that 'it is all your choice' but she did not have the background information to go with it. I am not sure what it is like in Queensland particularly now. I have been listening to the guest speakers here. It does appear that there is more information provided to people considering abortion. This particular biography was very clear that she did not get a lot. In fact, all she was advised was that, in essence, it is easy and it is a legal procedure.

Her story goes on to share that during the abortion she experienced it. She felt the pain. After the abortion it devastated her family relationships. It devastated her boyfriend who she was with at the time. She ran away from home, experienced abuse in other relationships and even attempted suicide less than two years after the abortion. Long-term physical health conditions that she developed and she shared were things that I do not fully understand—ovary disease, infection of her fallopian tubes, tumours. Her body was damaged. Her menstrual cycle did not repair for six months when they returned to normal. For a young person reading that book, it was just really sad that she had to go through that experience.

Having read that, it started me on a bit of a journey to learn is this real for a lot of people? I try to listen to other speakers where I can and read other information. The biggest thing I am seeing is is there enough information provided to people when they are faced with an unplanned pregnancy and is it unbiased? I think that was the big thing that I saw in this story of Debbie's life. There was not unbiased information and impartial information given to her about the consequences of the choice that she was about to make.

There is a website that I have seen—abortionchangesyou.com. There are over 500 stories of women whose lives have been negatively impacted because of the loss of a child through unplanned pregnancy and abortion. I commend that website to the panel, to review that. That is just the women speaking. There is a whole bunch of stories from the partners' perspective and the parents' perspective. It is quite in-depth. There is a book called *Giving Sorrow Words* by Melinda Tankard Reist that I have had a look at. She is an Australian author by the way. She shares the personal accounts of over 200 women of their mental and physical trauma due to abortion. It is a real thing that women are impacted by abortion.

When I look at the proposed changes, the amendment to this law, my question is: what protections will be in place that guarantee in law that women facing an unplanned pregnancy will have—it is not a good term—a cooling-off period from the moment they learn from a GP that they have suddenly become pregnant to being allowed to have an abortion, to give them time to speak to a counsellor, speak to a psychologist, gather more information? 'What are the risks to my health if I go through with this?' I do not know how to recommend this, but I feel that, if the law is amended and changed in Queensland, there needs to be something in legislation that protects that right for a

window of time for women to investigate and learn with impartial information. One example of that is a group in Brisbane called Priceless Life Centre that I have had contact with. They have a strong reputation for caring for young women. They have 24-hour counselling services and have a really solid reputation for caring for women.

The second thing I want to highlight is the gestation period issue. I currently work as a first responder for Queensland emergency services. The legislation that governs what we do on a daily basis very clearly says, 'Where reasonable and safe, we are to make all efforts to protect and save human life.' As a Queensland government, we proscribe to the Australian and New Zealand resuscitation councils' guidelines for all training provided to first responders. They provide the guidelines on things like cardiac arrest and CPR training that we are trained in. One of the very clear things coming out of that is that, if someone experiences a cardiac arrest—and I am not a doctor, so this is base level training for first responders—compression, CPR, needs to be commenced as soon as possible or within six minutes; otherwise there is potential for brain death, and it is very hard to bring that person back for a good recovery. The reality is that if there are compressions, if there is blood flowing, there is chance of life. If there is no blood moving, there is not a good chance of life.

The reason I mention this is that for the last nine months my wife and I have journeyed with a very close friend and they have gone through pregnancy for nine months. It is the first time I have ever seen photos of a baby at 12 weeks. They showed us this picture and you could very clearly see there was a baby. It was a picture of a child in the womb. They said to me, 'There is the heartbeat.' On the picture you could see clearly there was a heartbeat. I was shocked by that. I had never been taught that at school. I had never been told the actual development of a child in the womb.

CHAIR: Jonathan, I am sorry. I have given you just over five minutes. I will need to open it up for questions.

Mr McARDLE: I am trying to get my mind around whether you are pro-termination or anti-termination. If you are pro-termination, are you saying there needs to be more literature available for women who proceed down that path?

Mr Dillon: It is a fine balance between wanting to care for the mother and, having experienced seeing these pictures of a baby's heartbeat at six weeks and 12 weeks in operation, the child that exists. They are both alive. That is my personal view. They are both alive. How do we care for them both?

Mr KELLY: Jonathan, thank you for appearing today. In regard to counselling, what in relation to the current laws that sit in the Criminal Code guarantees that a woman will receive counselling?

Mr Dillon: Again, I do not have enough information about that. I would hope that there are some guarantees in the law, but I cannot speak to whether there is or not. I have not had time to look into that.

Mr KELLY: Are you a paramedic?

Mr Dillon: I wish to remain anonymous on that one.

Mr KELLY: You indicated that you are a first responder, so you are some sort of health professional perhaps. You are in a situation where you have to give health advice at times to people.

Mr Dillon: Or we are actually doing it, yes.

Mr KELLY: I am a nurse, so I have to give health advice to people at times, too. I do not see my role in that situation as to be someone who sits there and makes judgement calls on the options. I simply lay the options out. I certainly would point out the literature in terms of the various options and I would certainly point out risks. What gives you a sense at the moment that any doctor operating in Queensland is not providing that information to women who are seeking a termination?

Mr Dillon: As I just heard before, there is something called AHPRA. Perhaps AHPRA have guidelines on exactly what must be provided to women seeking an abortion. I am unsure on that. If there is, great. I would like to ask: is there detailed information provided on alternative options like adoption and the risks? What are the studies that are out there? I have seen basic information that there are studies in Finland and over in Europe where there are higher suicide rates for people who have been through abortions. Again, I am not a professional but that is what I have read. It is not a dodgy website; there was definitely a validity check on that.

Mr KELLY: You mentioned the book you read, *Beyond Choice*. It is obviously a powerful story that has affected you. I probably, as a clinician, would refer back to the guidelines by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and look at their outline in relation to psychological effects. While I would suggest that the information contained in that book

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may not be valid for that individual, over very large studies there has been shown to be varying impacts on people's mental health in relation to abortion and certainly not the sort of widespread trauma you are describing there. As a committee, what should we be relying on? Should we be relying on widespread peer reviewed, systematically reviewed data or, I guess, individual stories that take a different point of view?

Mr Dillon: I guess the one thing I have recognised, in Australia at least, is that whenever a poll of the public is conducted and released, only a certain percentage of that public is actually interviewed. These official studies that you are referring to do have some validity. I think it is important to access that. I think at the same time it is taking a full cross-section of experience—from parents, from partners, from women who potentially maybe did not want to participate in that study because of anonymity and potential of shame. All of these things could be part of it. I think it is a balanced approach.

Mr KELLY: If abortion remains regulated by the Criminal Code, you want a situation where women have access to better counselling options, from what I understand. How does maintaining a culture whereby it is a crime that they want counselling on assist with actually opening up the culture where we can actually have counselling?

Mr Dillon: At the moment the law is what it is. I think if anything the fact that it is a crime—like, I heard one of the doctors saying earlier that people come to them and they say, 'Actually, did you know it is illegal?' That at the moment gives them a bit of a reality check. 'Why is it illegal? Let's do some research. What is the information out there about why it might be illegal?' Going forward, making sure there is protection in law for those women to know the risks involved—knowing the information, knowing the options.

Mr KELLY: I would actually contend that doctors are already obligated at law to do exactly that.

Mr Dillon: Under the current Criminal Code?

Mr KELLY: No, it is a requirement as a medical practitioner to outline all risks involved in procedures and to obtain informed consent. I would actually suggest it is already a requirement of the law.

Mr Dillon: For GPs if it is, great. I would say that—

Mr KELLY: That would be for every single medical practitioner in the country.

Mr Dillon: My only question is: if you own the medical clinic that is conducting abortions, how can you be impartial in passing that other information on? What guarantee is there that that woman actually received that from that clinic, for example? That is my question.

CHAIR: Jonathan, thank you very much. I know that you patiently waited and I know that you need to get to work.

Mr Dillon: Thank you for your time. Enjoy Cairns.

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BYL, Mr Rodney, Private capacity

CHAIR: Rodney, I apologise profusely. I have not been allowed to have a bathroom break for about four hours. I am going to have to go and the deputy chair will take the chair for your opening statement. If you would like to make an opening statement, we will then ask questions.

Mr Byl: Thank you for the opportunity to speak to you this afternoon. I am no doctor, lawyer or politician. However, I am a dad, a hardworking man and a contributor to our community. I, together with my wife, Makeesha, have five children, all of whom we have seen develop from conception to today. Makeesha is a qualified counsellor and family therapist. I could say we are passionate about families.

It is evident to me that strong, healthy families form strong, healthy communities, which are the backbone of this great nation. Taking a look at the committee's terms of reference, I would like to focus my presentation on item 3. Whilst I agree that the abortion laws in this state should change, it is my view that the bill introduced by the member for Cairns, Mr Rob Pyne, ought to be rejected on a number of fundamental principles.

To start with, I would like to present a number of absolute truths on the topic of abortion. Firstly, under normal circumstances, if we do not touch the foetus it will become a human being. Secondly, the foetus is alive. Thirdly, abortion involves killing that which is alive. Fourthly, there are thousands of infertile couples in this nation desperate to be good parents and offer a good home.

As a parent, it was a joy to see our unborn children develop. With the ultrasound at 20 weeks we could view the life of our child in the womb, clasping his or her hands, sucking his or her thumb, yawning, stretching and getting the hiccups and even smiling. It is very clear to me that life begins at conception.

Those who justify abortion by claiming that no-one knows when life begins are not arguing science but rather their own brand of politics, philosophy or even religion. Their argument is not about when life begins but about when or whether that life deserves legal acknowledgement and protection. I would also argue if any person dares to look at the websites that show what happens to their baby in an abortion they would never go through with it.

Mr Pyne in his introductory speech said—

This bill will protect vulnerable Queensland women and the doctors who are risking prosecution to assist them.

I would like to discuss this. By definition, a vulnerable person is a person capable of being physically or emotionally wounded; a person in need of special care, support or protection because of age, disability or risk of abuse or neglect. Over 90 per cent of women who choose to have an abortion have by their own choices placed themselves in this place of vulnerability. They have the power and ability to choose to become pregnant. They are not necessarily vulnerable; they are just reaping the consequences of their action—something I would like to discuss further later.

It is very clear to me: the vulnerable ones in this debate are the unborn children. They are the ones who are being killed in their thousands with absolutely no choice. Brave women are coming forward in ever greater numbers to speak out about how abortion was not an act of empowerment but a result of abandonment, betrayal and desperation and how it has negatively affected their lives.

I believe it is time for women to see their true value and worth. They are not vulnerable; they just need to realise that they have the power to say no—say no to a pushy boyfriend. They need to realise that they can choose to use contraception. Every time people choose sex they are choosing the possibility of a baby. In my mind, if they are not ready for that they have not yet earned the right to have sex. I encourage women and young girls to stand up because they have the power.

In his speech to parliament Mr Pyne stated—

When nearly a third of women will seek an abortion over their lifetime, it is about time our laws reflected modern values that trust and empower women to make decisions about their own bodies.

Whilst I am not an expert in this field, I did not do some research on Google this morning. Maybe it is better for me to refer to some of the doctors who have presented the statistics but, looking at the survey, I will just go through the top 8 reasons women have abortions: 25 per cent are not ready for a child—it is the wrong timing; 23 per cent say that they cannot afford a baby now; 19 per cent have completed childbearing and have other people depending on them—

Mr McARDLE: Sorry, Rodney. We have to move on a little bit. Could you perhaps come to a conclusion so we can ask some questions of you, if you do not mind? I do apologise.

Mr Byl: That is fine. One of the things I love about teaching kids is seeing them develop. They develop by earning more and more responsibility. For example, if my teenage son does not make his lunch for school because he does not feel hungry now but then realises at lunchtime he is hungry, he will learn that his choices will have uncomfortable consequences so in future he will remember that and learn from the consequences of his emotion based decision. If I protected him from the consequences of his action by dropping off lunch, I would inhibit his growth and he would become more and more dependent on me and start developing a victim mindset. He will start to feel useless and vulnerable, but he is not; it just feels that way because he has not learned the concept of choice and consequence. In the same way, a couple must take responsibility for their choices. Let us face it: in most cases sex is a choice and it is fun. When we look at the statistics above, it is clear the reason most women—and men—use to abort their child is based on an unwillingness to take responsibility for their actions.

CHAIR: Rodney, I have to stop you there because I understand that you have had the five minutes and I am sure the committee would like to ask questions before we move on.

Mr McARDLE: Rodney, thank you very much. Am I right in saying that you believe women make themselves vulnerable, not the circumstances in which they are make them vulnerable?

Mr Byl: I think through the choices they make they put themselves in a vulnerable position.

Mr McARDLE: Do you then say that a woman who becomes pregnant by way of rape is in that position?

Mr Byl: No.

Mr McARDLE: There are exceptions, are there not?

Mr Byl: That is correct. If you look at the percentages, I think that category makes up about half of a per cent of the reasons women take abortion.

Mr McARDLE: You also say—if I am not correct please let me know—that women have the power to say no, that they need to learn to say no.

Mr Byl: That is correct.

Mr McARDLE: But there are a number of women in this state who live in domestic violence situations who are pregnant because of coercion by their male partner. In those circumstances, the research is that it is very hard for them to say no because their life is controlled in so many ways. Would you agree with that?

Mr Byl: I would agree with that, but I would not say that the female or the wife is a victim in the relationship. She still has choice to stay under the power of the perpetrator. She will sometimes have to bear the consequence of that, unfortunately.

Mr HARPER: Thank you very much, Rodney. I gave this same scenario yesterday in Emerald, and I respect everyone's views. I just want to form some kind of balance in my mind. If you have a young professional who is raped, hides that situation for a number of weeks and finds out she is pregnant, do you believe she should have a choice to continue her life because that is not something she wanted, could not say no to and was vulnerable to? In that situation, in that scenario, where does your mind sit in that particular instance where it is not welcomed?

Mr Byl: I think in that instance there is no balance of power and it is very unfortunate for the lady in that situation. My personal belief, though, is that life is sacred. There are many, many couples in Australia who would love to have the opportunity to care for a child. If that was the situation, I think that is what they should do.

Mrs SMITH: Rodney, in your opening statement you said that the law needs to change, but not to the way suggested by the member for Cairns, Rob Pyne, and I am paraphrasing. Can you expand on what you meant by the law needs to be changed but not to Rob Pyne's way?

Mr Byl: I have probably made it quite clear that life needs to be kept sacred and whenever there is a termination or an abortion there is an ending of life. That life is the most vulnerable. Those are the most vulnerable members of our community. As a government, we need to stand up for them. I do not know how the legislation can be changed. It is probably outside my area of expertise. It is probably something for another committee, but I think it needs to.

Mrs SMITH: I want to understand this: it needs to be changed to strengthen—

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Mr Byl: The anti-abortion legislation that currently exists.

Mr KELLY: Rodney, thank you for your presentation. How will maintaining the abortion regulations in the Criminal Code contribute to building the kind of healthy relationships that you are referring to there, dealing with domestic violence and assisting young people to have what I would consider to be fully empowered relationships, including sexual relationships?

Mr Byl: I think it is important for women and young girls to be informed about their options. I do apologise: I do not really understand your question.

Mr KELLY: You made a number of comments about people in relationships and your views on how they should be progressing in terms of their sexual relationships. What I am trying to get at is how does maintaining abortion to be regulated by the Criminal Code have any role to play in that?

Mr Byl: If you decriminalise the consequence or if you take the consequence out, people are going to continue to be living life and doing things and expecting that they do not reap the consequences of their actions, both in a relationship and outside a relationship.

Mr KELLY: You also made a statement earlier on that if we do not touch the foetus it will become a human being. These are rough statistics, pulled quickly off Google: 25 per cent of Australian women have a miscarriage; I have not looked up stillbirths; I have not looked up ectopic pregnancies; I have not looked up a severe foetal abnormality where, say, a baby is born without a brain or kidneys and is incapable of sustaining life beyond birth. Given those high numbers of miscarriages, what are your thoughts realistically on the capacity and the risks of the foetus not really always going to be viable if it is not touched?

Mr Byl: I will go back to my notes. I said 'under normal circumstances'. I am not including those that are obviously damaged.

Mr KELLY: I consider all those normal circumstances: a miscarriage, a stillbirth, an ectopic pregnancy. We could rule out foetal abnormality. All of those are. Let us take an ectopic pregnancy: that is simply a foetus ending up in the wrong spot. Nobody has intervened in that.

I want to move on and ask you one other quick question: you talked about when life starts and a lot of people have raised this. If you ask a lawyer, they will tell you that life starts when a baby is delivered and is viable outside of its mother. If you ask an ethicist, you will get a different answer. I do not want to try to give you their answer, because I struggle to follow what they say. If you ask a Jew, you will get a different answer. If you ask a Christian, you will get a different answer. If you ask different types of Christians you will get different answers. If you ask somebody from an Islamic background, you will get a different answer. In fact, you can read some of the stuff from the Catholic Church, whose position on abortion was not formulated until the 1850s with the doctrine of the Immaculate Conception. Given that we have all of these very large faith groups in our community—we will leave out the ethicists and the lawyers—arriving at different answers on when life actually starts, how do we as a committee determine when life actually starts?

Mr Byl: That is a difficult one. In my view, life is formed when the genetic material from both parents comes together. We are complicated with technology and we are complicated with our modern society. If you went back 300 years, I am not sure that we would have that problem.

Mr CRAMP: Rodney, thanks for coming in. I appreciate the fact that we do not always have to have experts and doctors. It is good to hear opinions from all walks of life. I want to ask you some questions regarding some of your statements. Obviously my colleague touched on a female who is raped. She does not have a choice. I also provide you with the example of a 14-year-old female who is the victim of incest from her father and falls pregnant. Should either a young girl in that situation or a woman of any age who is raped have access to an abortion, should they wish to have it?

Mr Byl: I struggle with that question, only because I really feel for the female in that situation. On the basis that life is life and it is precious, I would encourage the female or the woman to go through with the pregnancy—

Mr CRAMP: Even a 14-year-old girl who has been impregnated by her father? They are tough questions.

Mr Byl: They are, yes.

Mr CRAMP: I provide that example, not to put you on the spot but those are some of the deliberations that we are dealing with as a committee. It is very tough. I will put to you one premise that I live by. I have a son and two daughters. You spoke a lot about women's responsibility to ensure that they are empowered. I think there is a greater responsibility on men in society to ensure that our women are protected and that they have that ability to be empowered without being infringed upon.

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Do you think that there is a greater responsibility on the men in our society to ensure that this sort of thing, such as the two examples that I just provided, do not happen? Should men shoulder just as much responsibility, even if it is consensual?

Mr Byl: I absolutely support that. I think men need to grow up. There is too many kids running around, taking on adult responsibilities. I think if you are not willing to take on the responsibilities for what might happen when you have sex, then you are too young to take it on. As fathers, we need to engender that into our families. We need to teach them. I think that is how strong communities are formed.

Mr CRAMP: Thank you for having the courage to step up and speak to us today, Rodney. Well done.

CHAIR: Rodney, thank you very much for appearing today. I now invite William Tento to come to the table.

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TENTO, Mr William, Private capacity

CHAIR: William, similar to those before you, would you like to make a short opening statement of no longer than five minutes before we ask you questions?

Mr Tento: My name is William Tento. I do not have any medical background. I speak as a concerned member of the public. I do not identify as a Catholic or a member of any religious organisation, but I am pleased to say I believe I am a Christian. If I may, I would like to begin with a prayer.

CHAIR: No. You can make an opening statement, I am sorry.

Mr Tento: Okay. I am here today as an advocate for the unborn child, because I believe they are the ones who are left without a voice in this whole deliberation. In Mr Pyne's explanatory notes to the bill, Amanda Bradley from Children by Choice was quoted by the *Brisbane Times* as saying—

We get reports of self-abortion, some women we speak to say if I can't get an abortion I will do it myself.

The same paper, the *Brisbane Times*, in October 2015 reported that currently there are 17 active abortion clinics in Queensland with 11 of those concentrated in the south-east corner. That would indicate that Queensland is well serviced by providers of abortion. Dr de Costa confirms this when she says, in her submission, that the number of abortions in Queensland is estimated at 14,000 a year. That is a staggering figure.

It seems the issue is no longer a question of whether abortion is available or accessible, but that someone involved in the procurement of the abortion may carry the stigma that they did something wrong. Well, that is the fundamental purpose of the law: to define the line in the sand, as it were, and to ensure that the members of a humane and tolerant society stay on the right side of that line. Yet successive governments have ignored the application of the law such that, as Mr Pyne states, many people do not even know that abortion still sits in the Criminal Code until they need to make a decision about it. The law exists to protect the vulnerable and the innocent. If it does not do this, its role is effectively useless. Mr Pyne's bill completely ignores the group most in need of that advocacy. His bill is intent on redefining morality so that what was wrong is now right.

The bill's policy objectives state—

This Bill will protect vulnerable Queensland women and the doctors that are currently risking prosecution to assist them.

To assist them to do what, you might well ask. I will finish this sentence in my words: to assist them to procure the death of their unborn child. This disgraceful assertion has no place in a modern and humane society where so much is known about the uniqueness of every human life and about the milestones of each individual from conception. Many of these milestones are evident before the mother even knows she is pregnant. Indeed, in one, five or 10 years time, so much more will be known about these and other as yet unknown milestones. This is not a measure of the personhood of the unborn child, but rather of the technology we have to identify such milestones.

The existing law in Queensland has been framed to protect the innocent, but those who are tasked to uphold and apply the law are grossly left wanting in the discharge of their responsibility. The law must remain, must be defended, must be applied and, if anything, should be strengthened. However, before this can happen our modern society must have a rethink about its current direction and about what we value.

It is inexcusable that when so much is known about the preborn person, we resort to such barbaric measures in dealing with what are, in the main, social problems. The fact is that the unborn child is not the cause of these problems, so therefore cannot bring about the solution. We then, as part of a civilised society whose laws and principles are based on the Judeo-Christian ethic, must devise positive life-affirming solutions to what are essentially problems about adult relationships. The answer, I believe, is to be found in education, filtered through the virtues of compassion, forgiveness and love.

CHAIR: Thank you, William. William, can you envisage any circumstance in which you think that termination of a pregnancy is warranted, fair and just?

Mr Tento: Yes. In my submission, I cannot quite remember what my words were, but it was to save the life of the mother.

CHAIR: Thank you. So a circumstance of violence, or rape, or something like that?

Mr Tento: You see, pregnancy is not a death sentence, but abortion is. When we talk about those instances, we are not looking at the root of the problem. We need to look at why that violence is occurring and address that issue, not kill the unborn child.

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CHAIR: Can I say that I agree with you on two points. We need to address the cause as much as possible of violence and I think that life is precious. What I would say is, in a circumstance where a woman has been assaulted, or raped, surely to bring those values of compassion and love would be to understand that, while pregnancy is not an eternity, it is nine months of significant potential psychological distress for a woman who has already been violated. Would you not—

Mr Tento: I can understand that, and I can understand that, in caring for that woman through that time whilst she is pregnant, she will receive, I believe, far more care than if she is taken to an abortion clinic and a procedure is performed on her and she is sent home, because there is no after care. She is sent home and that is the end of the story. The doctors before said that people do not come back. In my view, if you took your car to someone for repair and they did not do exactly the job that you were happy with, they are the last people you would go back to.

CHAIR: Can I again say that, I think, life is tremendously precious. I have been lucky myself to have two young boys. Having also known and spoken in depth to a woman who was raped, I think what she may well say—and I cannot speak for all women in that situation, only to share what she said—is to put her in a situation where she had to then carry the child of her attacker would potentially place her life at risk. She may have taken her life because of the additional burden. I do not say for a second that life is not precious but, surely, the life of a woman in distress is also precious?

Mr Tento: Yes, and we need to work to minimise what is causing her distress and I believe that abortion will only add to that in later life. Rape in that case is often put up as the reason we should proceed with more liberal abortion. The thought comes to my mind, 'Hard cases make bad law.' As someone mentioned earlier, if we looked at the number of abortions that we would be performing because of rape, it would be a minuscule number, not the 14,000 that we are, which effectively says that we have abortion on demand, de facto abortion on demand.

CHAIR: I am not proposing that rape is the sole reason that you would look at any law reform change, but I am asking you to clarify whether there is ever any circumstance where you would consider that another point of view needs to be balanced with yours?

Mr Tento: Like I said, when the mother is going to die, which effectively means that the unborn child will also die.

CHAIR: Thank you.

Mrs SMITH: Thanks for presenting today. I really think it is important that people know that at these committee hearings we have to hear from a wide range of people. At the end of the day, it is about the laws that we are making for Queenslanders. I think it is really important that we hear from everybody—not just experts—who has a view. Thank you very much for coming.

Mr Tento: Thank you.

Mrs SMITH: You have made it clear, as you said in your submission, that no way is this in the best interests of the people of Queensland. We have been talking about the number of abortions in this state every year. Roughly, it is between about 10,000 and 11,000. That is the number that we were provided. What is the answer? Does the government have a role in providing sex education? Is that through schools? Is it from the parents? What is your view on the prevention side?

Mr Tento: I did provide some information in my submission, but when we talk about abortion and reforming the law we are really talking about after the horse has bolted. We really need to be taking a step back. We do not want to be at that place. The law as it stands is there to do its job. We really have to be having discussions about—and some of the speakers touched on it—relationships, about meaningful relationships, about people taking responsibility for their actions. This modern society is very much a, 'I have to blame somebody else for what has gone wrong' society and that has to be redressed. I have to say that our leaders are not doing that. When the leaders start to fall short, the community follows. That is part of the problem. We really need to be having conversations about taking responsibility, about the fact that sexuality is a real part of life, but it has a purpose and it has a meaning and it has a context. That is so trivialised in today's society. The television—soapies et cetera—portray it very cheaply.

Mrs SMITH: Thank you.

Mr HARPER: Mr Tento, thank you for coming and making your submission. Again, we hear a lot of divergent views on this issue. In your submission at page 2 in conclusion you make the pretty bold statement, I believe, that doctors who provide abortion benefit financially, as do others who have a vested interest in the abortion industry. There would be submitters today who presented who would respectfully disagree with your statement. I am just wondering how you can justify that statement? Is there evidence or data to support such a statement?

Mr Tento: I do not have anything with me, no.

Mr HARPER: Thank you very much.

CHAIR: Thank you for coming before the committee and for providing a written submission. We very much appreciate it.

Mr Tento: Thank you very much.

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WITHRINGTON, Mr Stuart, Private capacity

Mr Withrington: Thank you for having me here today.

CHAIR: Thank you, Stuart. I am sorry, we are running a little bit late. Would you like to make an opening statement?

Mr Withrington: Yes. I will start with a quote for you. I do not envy your task. 'A leader will rule in a way that brings fairness and just decisions. They will be a shelter from the wind, a safe place in a storm. People will listen to the leaders and those who are worried will understand. They will not listen to those who plan to take everything away from them.' The current law is set out in two sections. One protects the unborn child; the other protects a born child. It is that law that is protecting innocent children from the moment of conception and providing that shelter from the winds of the social and financial pressures. William mentioned that as well. Our society is becoming much more promiscuous and there is less the established family. That is where these abortion needs are coming from.

We look at the reasons. We have discussed that. I have a series of figures here. Basically, 80 per cent of abortions are for convenience. The pro abortion speakers say that it is a woman's right to choose if she has children, how many children she has and when she has them in her life plan. The time for that choice is before getting pregnant. It is not at the expense of an innocent child's life.

I agree with the other previous speakers that life begins at conception. It begins when the DNA of two people are joined together. The man and the woman become one in the child. It is clear to me that that is when life starts. An example that I thought of is a year or so ago I was driving down the road and I was doing 50 in a school zone. As it happens, there was a policeman there. The consequence of that action was, fortunately, it was not a dead child, which it could have been from speeding in a school zone. The consequence was a fine. I took that consequence. I did not go asking for the law to be changed so that I could drive at 50 and kill a child without any consequences.

We do not have capital punishment in Australia, except for the crime of being conceived to parents who do not want me. Our reproduction is an awesome and wonderful responsibility. God says that we are awesomely and wonderfully made and he watches us being formed in the womb. He does not start watching when we are born. Previous speakers have said about, 'How can we show a woman a picture of their foetus from the ultrasound? Why are you making the decision more complex? Because they are seeing what they are doing. They are killing a child and that is not something to be taken lightly. It is not something that you can go into an abortionist's office and say, 'I have already made my decision' and it is not without impact on the mother. I know there are scientific reports to say that there is no post abortion stress, or anything like that.

I was just reading a quick note from a friend. It says, It is sad for me to tell you that my mother and sister had abortions in their teenage years and have suffered greatly in different ways over the course of their lives. The consuming guilt I have witnessed in my mother is a terrible thing and she continues to attempt to seek solace to this day. Abortion affects not only the mother but all those in relationships with her throughout her life, as in the spouse, family members or subsequent children.

Regarding the previous question about rape, I have a meta-analysis study here from 2005—a study of 192 woman who conceived as a result of sexual assault. Seventy-eight per cent of the women who chose to abort regretted their decision. None of the women who continued their pregnancies regretted their decision. It is not the child's fault the mother was raped. Why are you punishing the child?

Regarding abortion rates and how they might change after the change of the law, when you look at abortion rates you can often see trends going down in Western countries. That is because they quote a figure per 1,000 women. If you look at the figures as a percentage of pregnancies, the abortion rates are going up. That is, I think, because of more freely available abortion.

CHAIR: Stuart, that is five minutes. Would you like to conclude there or make any final comment?

Mr Withrington: No, only that we need to support families. We need to support stable families so that children are conceived in an environment where they want to be loved and we should be trying to change this ethic that we are free to have sex with no consequences.

CHAIR: Thank you very much for your opening comments. I thank you for your considerate comment earlier that it is a complex issue that the committee is considering. Of course, there are very strong views on either end. There are intractable positions on either side of the debate. Can you envisage any way to balance these competing interests and find a way forward?

Mr Withrington: No.

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CHAIR: You spoke about a speeding fine as an example. I take that analogy to say that a speeding fine is something, of course, where there is a repercussion, you pay the fine and that matter is closed. However, does it concern you that, in a situation where women were perhaps unable to have a termination—and again I come back to appreciating and absolutely agreeing that life is precious—ambivalent parenting could also be something of significant concern?

Mr Withrington: Absolutely. I am quite involved in supporting families myself in my own time. Absolutely the parenting in Australia needs to improve. We need to put in place support in the community to help and support parents who are struggling. It is not an easy task.

CHAIR: I totally concur; parenting is not an easy task. However, I was more saying that if there were a situation where women, regardless of whatever condition, were forced to go to term, do you not think or see the potential for ambivalent parenting and, therefore, some significant cost to the child, being unwanted?

Mr Withrington: Do you mean cost to the state?

CHAIR: To the child; forcing somebody to have a child when they do not really want it, resulting in a neglected a child?

Mr Withrington: Isn't that better than killing the child?

CHAIR: I do not know. Have you had much experience with children in the child safety system? I suppose it is more that that is the consideration.

Mr Withrington: I understand that, yes. Statistics that show more postabortion mental issues and so on are often because the subsample of abortion people already have more mental problems in a lot of instances. Yes, definitely I can see that as being an issue. However, I do not see killing the child as the way to resolve that. The way to resolve that is improving the parenting, improving the support. Otherwise you are basically saying, 'You're not good enough to be a parent. You can have an abortion. That's okay.'

Mrs SMITH: Stuart, thank you for appearing today. Is this as much about morality as it is about the law?

Mr Withrington: I think the law has an important role. We see at the moment with the 14,000 abortions that the law is not actually stopping abortion. What it does is that it says, as a state we believe that abortion is not a desirable outcome. When you legalise it, you are saying that abortion is fine; it is another form of contraception.

Mr KELLY: We have heard evidence that suggests decriminalising abortion actually clears the way to taking a public health approach to dealing with unwanted pregnancies or terminations. I believe there have been some studies done where in countries that have adopted that approach there has been an overall decrease in the abortion rate. I think the Netherlands is one that I am referring to. I have read so much data, you will have to forgive me that I cannot put my finger on it.

Mr Withrington: That is okay.

Mr KELLY: If your policy objective is to reduce overall abortions or to eliminate them altogether and the current approach of criminalising abortion is not having any impact on the numbers of abortions, are you open to exploring other methods to try to achieve that policy objective?

Mr Withrington: As I said, I think the fact that abortion is in the Criminal Code is sending an important message. I agree that it is not reducing the abortion rates. I have not seen that report about the Netherlands, but the general impression I have had is that it does not reduce abortion. I do think that, if you want to reduce abortion and unwanted pregnancies, contraception is the way, avoiding unplanned pregnancies and making more stable homes where planned pregnancies can happen.

Mr KELLY: Thank you. I do not disagree with you on that. You mentioned that people have to realise there are consequences for sex. Presumably that means that a woman who has sex and gets pregnant is penalised if she obtains an abortion. What are the consequences for the man from a legal perspective under the current Queensland law, the father of the foetus?

Mr Withrington: Are you saying in the case where the woman has gone through an abortion—

Mr KELLY: I want to understand. You are saying we should have consequences for sex and, in fact, in our society we have almost no situations where we intrude into people's sex lives. We have very limited areas: minors, et cetera. I do not want to go through the list. It sickens me as much as it does you. On the consequences of a consenting pair of adults having sex, under this law, there are actually only consequences for one party.

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Mr Withrington: Only if that party kills the child. If that party brings the child to term and supports the child, then there are no consequences in the law. There should be consequences for the father in that he needs to be there and support the child; absolutely.

Mr KELLY: But under our current law there are none.

Mr Withrington: There is child support that they have to pay.

Mr KELLY: If the woman has an abortion, what are the legal consequences for the father?

Mr Withrington: What is the father's role in that abortion?

Mr KELLY: I want you to answer the question: what are the consequences of the sexual act that those two had?

Mr Withrington: It is not the sexual act. It is abortion that has the consequence.

Mr KELLY: Thank you.

Mr CRAMP: Stuart, you said before abortion rates are going up in terms of pregnancy. I get your analogy. Can you cite where that information is coming from? Is that from a legitimate source?

Mr Withrington: That is a report. I do not have the reference, but I think it was May this year in *The Lancet* journal. It is quite a big study. It is a global study, looking at abortion rates across the world and—

CHAIR: Stuart, you can take that on notice.

Mr CRAMP: Yes, I was going to say, perhaps you could take it on notice. If you would have the time, please send that citation to the committee's email address.

CHAIR: If you could also include in that email the reference where you mentioned regret after abortion for rape victims. Could you include that reference, as well?

Mr CRAMP: That was my other question. Could you send them both through to us, Stuart? That would be great, then we would have the reference. That was my question. I wanted to see the information regarding that. Again, thank you for coming in and speaking with us.

CHAIR: Thank you, Stuart, for appearing before the committee today. The time allocated for this briefing has expired. A draft transcript of proceedings will be sent to witnesses for any necessary corrections. I thank all those who have appeared before the committee today. I know that it can be an intimidating process for those who have not participated before. I thank you very much for making written submissions and appearing, including our medical doctors. I am sure that sometimes it can be a less than enjoyable experience, but we thank you for your expertise. Thank you to the public gallery for coming along today and taking an interest in this committee hearing. We very much appreciate it. I declare the briefing closed.

Committee adjourned at 5.38 pm

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