Submission No. 762
Received 29 June 2016

Submission to the Health, Communities, Disability Services and Domestic

Family Violence Prevention Committee

Inquiry into Abortion Law Reform

The Toowoomba branch of Cherish Life Queensland wishes to respond to this parliamentary committee which has been formed in response to the bill presented by Mr. Rob Pyne, Independent member for Cairns. We would like to address some of the questions posed by the committee in the Information paper.

1.What policy objectives should inform the law governing termination of pregnancy in Queensland?

We believe that good government demands that the best interests of all parties should be served in any legislation, but particularly in that pertaining to issues involving human life because without life itself, no other 'right' has any relevance. That abortion directly kills an unborn human being is a demonstrable truth, so if a human life is at stake, then that interest takes priority and precedence over other interests.

In the past when the facts about prenatal development were a dark secret, people could be forgiven for believing all manner of things about what was happening in the womb. However, we live in an age enlightened enormously by science, and no such ignorance should prevail. That the abortion industry thrives on promoting ignorance by referring to the unborn as a bunch of cells or ignoring it altogether speaks volumes about their honesty in the matter, but this should not be the position of any government which has a duty to inform itself of salient facts.

Government should also work to safeguard the health and well- being of mothers. It is still true that a mother is the most important person in a child's formative years, and so her health and well-being is important not just to herself, but her family as well. In the past, motherhood was seen as a blessing, new life in the form of a newborn baby is marvelled at, and society is recharged with new people for the future of the nation.

In the abortion debate, the alleged "right" of a woman to "her body" is pitted against the life of her child. However, most women do not approach the issue in this light, but rather are conflicted between wishing to keep the child on the one hand and looking for a solution to the issue at hand. In surveys on why women have abortions, many say that they felt they had no choice.

We are not insensitive to the distress caused by circumstances, and in fact our branch helps financially a pregnancy support service in Toowoomba. The amount of information available on the possible physical, psychological and social sequelae of abortion to the mother (and her family and the wider society) is mounting but is often not given any air space because of prejudice in the media and academia. This all has ramifications for

government health budgets, as they must take up the burden of treating these consequences.

There will also be an extra burden on the health system to accommodate the increased requests for abortion. For many people, what is legal is moral as the reasoning is that the law wouldn't allow abortion if it was a bad thing. If a government removes laws against an action, there is an incentive for others to make money out of it, there is an increased pressure to provide it, especially if it is described as a health benefit, and decreased controls over its practice.

2.What legal principles should inform the law governing termination of pregnancy?

We believe that ALL human life, born and unborn should enjoy the protection of the law against attempts to take that life. The protection of life and property is one of the fundamental tasks of the law. Due mainly to historical and evidentiary reasons, under the Queensland Criminal Code, the unborn child does not have a legal persona until he/she is born. The Criminal Code was derived from English law which relied upon the knowledge of the time. As explained above, that is outdated. The statutes within the Criminal Code are an acknowledgement that the law DOES have an interest in protecting the unborn child. To remove those as well strips any protection from preborn human life and makes of him/her a legal non-entity with no more protection than would be afforded a foetal cat or dog.

The mover of this bill has given no indication how he anticipates abortion to be controlled, what safeguards there are to be, what health regulations are to be followed and so on. In other states where abortion has been "decriminalised", abortion is treated like any other medical procedure. This demands that full information and disclosure of all relevant risks must be given to ensure informed consent which is a legal principle governing health matters. Not to do so is inviting legal action against the public health service.

Currently there is no prescribed content of information to be given to women through private abortion clinics as they are unscrutinised and left to themselves. We know from anecdotal information that information is limited to getting details of their blood group, allergies and previous medical history ie the bare minimum. This is to be expected since abortion is their "bread and butter" so they do not want it to sound serious.

3.What factors should be taken into account in deciding if a termination is lawful?

Since the McGuire ruling in 1986, the legal principle that determined 'lawfulness" was that if the pregnancy would cause a serious danger to her life, physical or mental health not being the usual risks of pregnancy and not out of proportion to the danger to be

averted. This was in accordance with the Menhennitt ruling. However, in practice this was hardly if ever observed since there was no mechanism to validate requests for abortion, the law was seen as not being enforced or observed in practice, and there was no political or judiciary enthusiasm for prosecutions. Given the fact that very few women wish to enter a police complaint about their abortion, it is left to police to gather the evidence for any misdemeanour.

In consequence abortion has been more limited by availability to larger centres and practitioners who will do them (an occupation disliked by many doctors).There is little if any regard for the reasons why it is being done, and more and more the reasons have been "socio-economic" rather than purely health driven. As there is no requirement for reporting the reasons for abortion, the data is limited to those subsidised by Medicare and described under the relevant Medicare items.

As an organisation, we not accept abortion is acceptable under any circumstances covered by the category of "socio-economic." Much of it has become a consequence of the society we live in where sexual mores and behaviour have abandoned all sense of responsibility for consequences. Abortion is seen as a stopgap measure and a "must-have" for failed contraception. Many women are left to cope with the consequences of casual relationships, but no government spends any time or uses its educational impact to try and change those attitudes by espousing values education.

We do not believe that foetal abnormality is a proper reason for abortion because it implies that abnormality per se negates a right to life or that a life lived with a disability is not worth living. Also, once that ethic is applied, it is too difficult to decide which abnormality is severe enough for abortion. We are aware that abortion will then be done for treatable and even trivial abnormalities.

It also makes it very difficult for couples with an unborn child diagnosed with an abnormality, especially a severe one or one with lifetime impacts such as Downs Syndrome. They can be reproached because they are seen as wasting health facilities by continuing the pregnancy as if their baby is a waste of time. This attitude is already common in the health industry as one result of the ability to diagnose foetal abnormality. In fact, it is virtually an imperative that every woman be given a battery of tests to do this, although they often do not appreciate that the real reason is in order to offer abortion whereas that wasn't in their thinking at all.

In the instance of definitely lethal abnormalities such as anencephaly, such that death will occur soon after birth if not before, some prolife doctors practice what they refer to as foetal palliative care. This is when birth can be induced after the age of viability for maternal distress, and the baby cared for. Sometimes he/she will die soon after birth, but sometimes they have been taken home and live for several days or even weeks.

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4.Should abortion be regulated according to the period of gestation?

Definitely not. Each unborn child is deserving of respect for his/her life and be protected. Moreover, with increasing gestational age comes increased risks, increased difficulty or a different type of procedure which will increase the chance they are born alive.

In a Question on notice asked on 11th May 2016 by the Honourable Member for Cleveland Mark Robinson to the Minister for Health Cameron Dick, Mr. Robinson asked the following question:

"How many babies aged 20 weeks or more were born alive after a termination procedure in Queensland hospitals each year between 2005 and 2015, and will the minister confirm whether those viable babies are provided pain relief or any other form of palliative care?"

The Minister answered in part by saying that there were 204 such babies, but didn't say what proportion of second or later trimester abortions this represented. He also didn't give any details of WHY the abortions were done, but said that "there were almost always severe circumstances leading to a small number of women who choose to terminate a pregnancy after 20 weeks". The numbers ranged from 8 in 2005 to 27 in 2015 and had steadily increased over those 10 years. If this is the situation when abortion is still criminalised, what will happen when there are no such restrictions as would occur under this bill?

One example of what has occurred is in Victoria since the Abortion Law Reform Act 2008. Prior to this, abortion was less restricted than in Queensland, despite it being allegedly also only legal under the provisions of Menhennitt. According to a report, over ten years between 1999-2009, late term abortions increased from 66 to 410 with more than half of these being undertaken for psychosocial reasons in every year since 2004 (except for 2007**) In other words, late term abortions were done on physically healthy babies at least 50% of the time!** Of those 410 post 20 weeks abortions, 210 were performed on physically healthy babies with 10 of those being conducted after 28 weeks of gestation.

It was reported in 2010, the first reporting year since the new law was adopted, that in one hospital, Melbourne's Royal Women's Hospital, staff were struggling to cope with a sixfold increase in later term abortions since 2008. Some of these babies were put on shelves and left to die, while one was dropped in a bucket of formaldehyde.

There is no reason why this state of affairs couldn't occur in Queensland should the Pyne bill, or a similar one be made law here. It is a complete misapprehension that late

trimester abortions are only performed for serious health reasons or lethal foetal abnormalities.

The recent exposure to the public of adult people with Downs Syndrome making great achievements should demonstrate that disability alone is no reason for pessimism or denigration of their right to life.

5.Should the law in Queensland provide for conscientious objection by health providers?

Definitely yes. This freedom of conscience should apply to all health workers involved both closely or more remotely (for example all theatre staff) to an abortion procedure.

Moreover, this freedom should also extend to any doctor from whom an abortion referral is requested. Currently, there is no legal requirement for such referral as the law itself doesn't request it as a prerequisite. Should there be any change in process, there should still be a conscientious right to refuse a referral AND not be obliged to refer on to another doctor. This is because a referral isn't simply a piece of paper. It is a declaration of sorts that the doctor regards the procedure as necessary for the furtherance of the medical management of the patient and/or that the doctor holds the person to whom he/she is referring the patient to be competent and reliable in the performance of the referral. If either or neither of these conditions apply to abortion in the opinion of the GP, a refusal should not be penalised.

Conclusion

It is a curious paradox both philosophically and in everyday practice and language that when pregnancy is a happy event (ie there is no question of abortion), the mother AND the unborn child are both treated as patients. But if there is any question of the pregnancy being problematic or 'unwanted', there is an immediate change of focus and terminology. The mental shutters come down, the unborn becomes "a pregnancy", and dishonesty and ignorance reigns supreme over the nature and effects of abortion and its consequences.

We sincerely hope that the government rejects the Pyne Bill for the harm it will cause, and instead concentrate on measures that will support women to enable them and their babies to enjoy life.