Submission No. 832
Received 30 June 2016

Submission from Julie Robinson (BSW MSW)

I thank the Committee for the opportunity to present my submission, and the Members of the Committee for the work they do. However, the issues which the *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016* seeks to address are of such complexity and sensitivity, it is impossible to do them justice in one short submission.

I would therefore welcome the opportunity to meet with the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee to discuss my submission in detail, and provide further research for some of the points I will raise here (and others I can't due to time constraints.)

I wear a number of hats in the community but my training is in Social Work (BSW MSW) and I have for many years volunteered at a local (Brisbane based) well respected pregnancy support organization (Priceless) as a counsellor, educator and program director. My work there has involved journeying with women who are facing unplanned or crisis pregnancies. We provide support for these women (and their families) through counseling (via a 24 hour helpline and face to face - pre and post decision making), practical support in terms of maternity and baby clothes and other items, antenatal classes, fertility care, mentoring (COACH program) and a schools program for secondary School students. All our counsellors are professionally qualified. Priceless will provide its own submission as an organization. I am not speaking here on behalf of the organisation, merely giving some background as to my experience.

I am also the mother of seven children, including our youngest who arrived a week before my 43rd birthday, in the middle of my Masters degree, after six caesarean sections and following strong advice from our doctor not to have any more children. This allowed me a glimpse at some of the pressures women face when pregnancy results in less than ideal circumstances.
I haven't had a termination, but I have experienced pregnancy loss through miscarriages (one at 13 weeks and two at 9 weeks gestation) the last one requiring hospitalization and blood transfusions. I mention this personal information because each of these experiences have helped to shape my thinking, and the work I do, as well as my views on the issues that Mr Pyne's Bill addresses. This will become obvious later.

I also sit on Policy Committees for Child Safety and Families, Communities and Disabilities and have an active interest in policy, particularly as it connects with women, pregnancy, babies, children, families, parenting, disabilities, abortion, adoption, education and the services they involve.

In this submission I will argue that Pyne's Bill is irredeemably flawed and needs to be rejected in its entirety. Why?

Mr Pyne has not adequately researched or consulted in order to bring a piece of legislation to the Parliament that takes into consideration:

1. the views of all stakeholders
2. the complexities around "abortion choice" including research which indicates a significant number of women are coerced into abortion, either by their partners, their circumstances, lack of options or lack of support.
3. the depth of feeling, and differences of opinion amongst the Queensland public on this issue,
4. the wide ranging views of medical practitioners and other professionals who work with pregnant and post-abortive women,
5. the experiences of women themselves who face crisis pregnancies, those who have terminated their pregnancies, those who have adopted out their babies and those who have continued on and are parenting their children.
6. the impacts of the current law and abortion practices in Queensland or
7. what is happening other places eg where this Bill has been enacted in Victoria and Tasmania, and in other countries who have implemented other abortion legislation.

1. <u>Views of Stakeholders</u>

Mr Pyne, has by his own admission at a public briefing[1] said that in drafting the Bill, he consulted only with pro-abortion group Children by Choice and three pro-abortion Doctors. He openly admits he has never met with groups, medical practitioners or professionals who hold other views, or with women, men and families for whom abortion is a part of their lived experience.

"CHAIR: In relation to consultation, earlier you mentioned a number of research reports that you depended on. Did you consult with any broader stakeholders prior to bringing in the bill? What was your process prior to the introduction of the bill? Have you met with them across the spectrum in forming your views?
Mr Pyne: I met with Children by Choice, a very active local group in Brisbane; and, as I said earlier, with Dr Caroline de Costa, who I think is probably the leading medical and academic commentator in this area nationally; Dr Heather McNamee, who is a local practitioner; and Dr Carole Ford, who was awarded an OAM in the Queen's Birthday awards a couple of days ago for her services to women—and pro-choice.
CHAIR: Were all of their views consistent?
Mr Pyne: Correct.
CHAIR: Did you meet with any stakeholders who may have a differing view?
Mr Pyne: No, I did not. [2]"

[1] (On this matter of the public briefing, I would l ke to point out that it was not made known to the public. It was advertised briefing on the parliamentary website as a private briefing for MPs, but those of us who had asked to be kept advised of such meetings via email were not informed, and as such were unable to attend. The transcript however now (post the event) says it was a public briefing. I look forward to other public briefings where the public can be involved.)

[2] *HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE* , PUBLIC BRIEFING—INQUIRY INTO THE ABORTION LAW REFORM (WOMAN'S RIGHT TO CHOOSE) AMENDMENT BILL, TRANSCRIPT OF PROCEEDINGS WEDNESDAY, 15 JUNE 2016 Brisbane. page 8. https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/AbortionLR-WRC-AB2016/14-trns-15June2016.pdf

Who then are the stakeholders (other than Children by Choice and the three GPs mentioned at the Committee proceedings)? Stakeholders would include:

a) women - women facing or who have faced crisis pregnancies, including women who have terminated their pregnancies;
b) fathers, siblings, grandparents (other family members);
c) medical staff who work in this area – abortionists, general practitioners who refer, midwives, nursing and other staff who work in hospitals and private abortion clinics;
d) counsellors, organisations and mental health services which work with women in crisis;
e) taxpayers and last but not least
f) unborn babies to whom the law has some responsibility to protect.

Some would have us believe the reductionist abortion rhetoric that dominates in our society, that "abortion is a only matter between a woman and her doctor" and is only about "a woman's right to choose". But there are a great many stakeholders when it comes to abortion, and each deserves some consideration. In examining each stakeholder, various questions present themselves.

A)For **women** facing crisis pregnancies, there are questions around how they arrive at their "choice", whether they are free to make a well considered decision, or coerced into abortion through partner or family pressure, lack of resources, or lack of supportive relationships. Certainly research seems to indicate many abortions are the result of coercion, with domestic violence often involved. [3]

Just weeks ago, I sat with a young woman who on finding she was pregnant excitedly sent the photo of her baby's ultrasound to friends and family. She also shared her excitement with me and said she wanted to continue the pregnancy. Her partner however had other ideas, and insisted the time wasn't right for them to have a baby. He stood over her while she phoned the abortion clinic and made the appointment. I wondered then, as I wonder now, whether anyone at the clinic when she presented asked her if this really her own free choice? Sadly this woman's right to choose is not an isolated case.

Secondly, are women provided with independent counselling and full information, including informed consent - which spells out all possible risks and alternative pathways. While some women describe their abortion experiences in positive terms, a significant number of women report that their abortions carried an aftermath for which they were not prepared,[4] and a large body of credible research indicates women who terminate their pregnancies are at higher risks of [5]suicide, [6]depression,[7] anxiety, substance abuse, and

[3] Hall, m et al, Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis PLOS Medicine, 2014
[4] Melinda Tankard Reist (2000) Giving Sorrow Words: Stories of Womens Grief After Abortion. Duffy & Snellgrove
[5] Gissler, M. et. al., (2005), "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health,* **15**(5),459-63
[6] http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-mental-health/huge-new-study-abortion-and-mental-health-quantitative-synthesis-and-analysis-of-research-published-1995-2009/
[7] Fergusson, D.M. et. al., (2008), "Abortion and mental health disorders: evidence from a 30-year-longitudinal study," *The British Journal of Psychiatry*, **193**, 444 - 451].

eating and sleeping disorders. [8]There is also evidence of increased risks of negative physical impacts including infections, scarring, subsequent premature births and increased risks of breast cancer. [9]

b) **Family**. Those who believe as Mr Pyne does, that abortion is only a matter for a woman and her doctor have never sat, as I have, with grieving grandparents who have lost their first grandchild to abortion. Or with inconsolable fathers who had begged their partners to give birth to the child of their long planned for and long awaited pregnancy, with siblings who repeatedly wrestle with the question of why their brother or sister was terminated and not them, or with women and men who deeply regret their abortions. The voices and stories of these people (and many others) are consistently deliberately edited out of any conversation about abortion, but they have every right to be heard. I therefore reject the premise of this Bill that a woman's right to choose is the only thing that matters in a debate on abortion.

"There is far less research into the effect of termination on men whose offspring have been terminated. Most of this is at the level of clinical experience of therapists, published case studies and individual's stories. However most of this information has shown that the mechanisms for men developing negative mental health outcomes are similar to those of women. A particular risk factor is when a man objected to the termination, whether he was prepared to parent his child or not. Abortion Grief Australia Inc. which provides a post-termination telephone counselling service found that about 20% of their callers were men, so a separate Men and Abortion trauma phone-line was established to assist men. A review of available literature and clinical experience is on the Abortion Grief Australia website. http://www.abortiongrief.asn.au/men-and-abortion.php" [10]

c) **Medical Staff**. Mr Pyne has met with three doctors who have obviously provided him with compelling arguments as to why abortion is a right that supersedes the rights of all others. But until very recently the Hippocratic oath which governed the medical profession, exhorted Doctors to "do no harm" and explicitly prohibited the administration of abortion drugs or procedures. Abortion is rarely, if ever genuinely carried out to bring health or healing to which the medical profession is committed. And a great many other medical practitioners can and do present compelling arguments as to why abortion laws should not be liberalized.

Furthermore, as we have seen in Victoria under the Abortion Reform Act 2008, Doctors are now denied their rights to conscientiously object to being involved in abortions, with Dr Mark Hobart being charged under the Act for refusing to refer a couple for a sex selection abortion. Midwives and nurses

[8] Theresa Burke (2000) Forbidden Grief: The Unspoken Pain of Abortion. Acorn Books
[9] Brind et al (1996) Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis. J Epidemiol Community Health 50:481-496
Huang et al (2013) A meta-analysis of the association between induced abortion and breast cancer risk among Chinese females (http://www.lifeissues.org/press/2013/Huang%202013%20CHINA%20metaanalysis%20ABC.pdf)
[10] Grocott, D, 2013, Submission to the Parliament of Tasmania

also report experiencing vicarious trauma, and resentment among staff when having to care for women undergoing terminations. Their voices are also important in this debate.

d) **Counsellors and Mental Health Services.** The most ardent pro-abortion activists concur that at least ten per cent of women who terminate their pregnancies will suffer psychological trauma as a result. Many researchers and practitioners conclude it is much higher.

A meta-analysis was conducted by Dr Priscilla Coleman and published in the British Journal of Psychiatry in Sept 2011. Coleman is an Associate Professor at Bowling Green University and the most published researcher in the world on the topic of mental health outcomes for women after abortion. She concluded that women who have abortions have an 81% increased risk of mental health problems and she attributes ten per cent of all mental health problems to abortion. Priscilla presented her findings at Parliament House Queensland a few years ago, and I can provide a recording of her presentation for members of the Committee if desired.

However, even if we accept the very conservative pro-abortion figures of 10%, with somewhere around 12,000 abortions in Queensland every year, we can expect a minimum of 1,200 women each year to experience serious mental health implications. This figure is obviously cumulative – 1,200 last year, 1,200 this year, 1,200 next year… or around 3 to 4 women every day. The impact of these statistics upon already burdened Queensland mental health services should not be underestimated, and certainly not ignored.

e) **Taxpayers**. Although taxpayers are rarely considered in any debate on the liberalization of abortion laws, the facts remain that Medicare pays for many abortions. As such those who pay into the public purse have some right to express an opinion on how those tax dollars are spent. While Mr Pyne and his three doctors might profess that abortion is no different to any other medical procedure, and therefore the public concern is irrelevant, many would differ with that view. Funding which is allocated to one Budget expense cannot be allocated to another, and any economist knows about competing needs, limited resources and the choices that need to be made. Those who need balance the books are also stakeholders in this conversation.

f) **Unborn babies**. Mr Pyne advocates that the current legislation, written in 1899 is outdated, and no longer fits with community expectations. Common Law has actually refined this legislation over time, so updating has occurred. However, the facts are that abortion is in the Criminal Code because legislators at the time believed our unborn children were worth protecting.

Back in 1899, the human heart began beating at around 22 days from conception and by 8 weeks – the time most women suspect or confirm their pregnancies, every major organ in the fetus was in place and functioning – liver, kidneys, lungs, brain and so on. By around 12 weeks fingerprints were forming, thumb sucking occurred, the fetus could kick, move his or her toes,

and make a fist. By 16 weeks babies in utero could blink their eyes, vocal chords were formed, and the baby could move rhythmically to music.
By 20 weeks, the baby could do somersaults in the womb and by around 23-24 weeks gestation, with the inner ear fully developed, the baby could recognize his/her mother's voice, and some babies if delivered prematurely could live outside their mother's womb if given assistance and nourishment. With each week that followed, their chances of survival if born prematurely increased.

The question then must be asked, **"What about our unborn has changed that they warrant less protection today than they did in 1899?"** Certainly not their development or their milestones, and with today's technology and science we are more aware than we have ever been of the capacities and beauty of our unborn children.

What has changed is our view of the sacredness and value of human life. Whereas once life was valuable simply because it was human life, today life is valuable only if it meets certain criteria eg if its "wanted", healthy, comes at the right time, to the right kind of people, who already have their relationships sorted, their careers in place, their mortgage underway…

The problem with a society which allows for the indiscriminate, subjective valuing of human life is they are faced with the dilemma of who decides the criteria and what yardsticks are to be used. This will always be open to debate and to abuse. For example, I have already mentioned the case of Dr Mark Hobart who was charged under the very legislation Pyne expects to introduce here, because he refused to refer a couple for a sex selection abortion. Mr Pyne obviously has no problem with terminating an unborn baby's life because of its gender but I expect many Australians would.

In reality however, many more babies' lives are terminated because they don't meet other criteria. For example, around 95% of babies diagnosed with Downs Syndrome are aborted in Australia today, and for those of us who have experienced the joy of having a family member with Downs, this is a tragedy. It is difficult to understand why Mr Pyne, of all Members of Parliament would not be fighting tooth and nail for the protection of little ones with disabilities. These are the people most at risk, and I am concerned for the members of our community who live with disabilities, as they try to absorb the messages that Pyne's abortion bill will send to them about their worth.

Mr Pyne also has placed no restriction on the gestational age of babies who can be terminated. Despite what abortion advocates will profess, in Victoria where this legislation was passed in 2008, late term abortions have **increased, not decreased** and today around half all late term abortions are occurring for psychosocial reasons ie on healthy babies. Furthermore, because the Victorian legislation prohibits medical assistance to late term babies who survive abortion procedures, significant numbers are simply left to die.

The **2007** Annual Report of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (Victoria) showed that 52 out of the **181 late term babies** who were aborted for "abnormalities" survived late term abortions but died neo-natally. **(please note there were 181 late term abortions in 2007 prior to the decriminalization of abortion in 2008.)**

A report by the Consultative Council on Obstetric and Pediatric Mortality and Morbidity shows that in **2010** there were a total of **366 post 20-week** abortions in Victoria, and **378 in 2011**. (please note now 366 and 378 late term abortions – more than double the statistics of 2007 prior to legislative change) In 2010, 184 late-term abortions were carried out between 20-27 weeks, and 7 occurred between 28-31 weeks gestation.

In 2011, 172 were carried out between 20-27 weeks, and 10 between 28-31 weeks. In 2011, **one late-term abortion** was carried out for psychosocial reasons (that is a healthy baby) **after 37 weeks**.

Of these abortions, there were 24 babies in 2010, and 40 babies in 2011 who were born alive following premature labour induction.
Reports from staff present during these abortions indicate that these babies were not offered medical assistance and were left to die. [11]

Below is a table showing the annual figures on late term abortions according to the Victorian Perinatal and Morbidity Statistics. **In 2013, of the 358 late term abortions**, half of these (179) were carried out on healthy babies, and half (179) were carried out on babies who had suspected or confirmed fetal abnormalities. Please note that **43 of these babies survived the abortion procedures and were left to die.**

Table 1. Late term abortion statistics by year: Victoria

YEAR	TERMINATIONS FOR PSYCHOSOCIAL INDICATIONS	TERMINATIONS OR INDUCTION FOR CONGENITAL ABNORMALITY			OVERALL TOTAL
		STILLBIRTH (FOETAL	NEONATAL DEATH (BORN	(TOTAL)	

[11] Womens Forum Australia Fact Sheet: Infant Viability Bill 2015

		DEATH)	ALIVE)		
2013	179	136	43	(179)	358
2012	132	145	53	(198)	330
2011	183	155	40	(195)	378
2010	191	151	24	(175)	366
2009	214	154	42	(196)	410
2008	178	118	32	(150)	328
2007	164	129	52	(181)	345
2006	150	106	42	(148)	298
2005	178	84	45	(129)	309
2004	197	95	35	(130)	327
2003	103	75	41	(116)	219
2002	60	73	30	(103)	163
2001	45	71	35	(106)	151
2000	14			(98)	112
1999				(66)	

Reference: Victorian Perinatal and Morbidity Statistics (reports individually available at: www.realchoices.org.au/research

Despite the lack of transparency around abortion in Queensland, some figures are beginning to emerge as to the numbers of late term abortions here. Around 200 late term (post twenty weeks) babies survived abortion procedures over the past decade and were born alive, according to figures provided by Health Minister Cameron Dick in answer to a Question on Notice by Mark Robinson MP on 11th May 2016.[12]

The 2015 statistic of 27 babies born alive, prompted local medical student Ashley Leong to ask the Prime Minister about this on a recent Q&A program, in which the Prime Minister described them as “shocking cases”. [13]

These figures do not represent all the late term abortions that have occurred in Queensland over those years. These only represent the babies who survived the abortion procedures. We don’t know how many others were terminated and succumbed to death prior to being born, or anything about their particular cases.

We are still waiting on information as to the medical diagnoses of these babies born alive as well as the tabling of Annual Reports of private abortion clinics in Queensland, which are not usually made public. This information is critical so that legislators and researchers can gain a better understanding of current abortion practices in Queensland, and I urge the Committee to insist on obtaining these documents from the Minister via the Chief Medical Officer.

Women who are presented with diagnoses of lethal fetal defects in their unborn babies are placed in very difficult situations, and should be offered

[12] https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2016/77902016.pdf
[13] https://www.facebook.com/abcganda/videos/10153496754451831/

every support and assistance. However, many of these women are pressured to terminate these pregnancies, with no other options provided to them, such as perinatal hospice and palliative care for their babies. [14] The outcomes for these babies are of course tragic, but research is coming to light that the outcomes for mums and dads aren't good either.

A recent (2015) project investigated a diagnostically homogeneous group composed of 158 women and 109 men who lost a pregnancy to anencephaly, a lethal neural tube defect. Women who terminated reported significantly more despair ($p = 0.02$), avoidance ($p = 0.008$) and depression ($p = 0.04$) than women who continued the pregnancy. The researchers concluded, "There appears to be a psychological benefit to women to continue the pregnancy following a lethal fetal diagnosis. Following a lethal fetal diagnosis, the risks and benefits, including psychological effects, of termination and continuation of pregnancy should be discussed in detail with an effort to be as nondirective as possible." [15]

Mr Pyne also erroneously believes that should his legislation pass, Queensland doctors would never perform late term abortions on healthy babies. But again Mr Pyne is ill informed.

According to the Queensland Maternal and Perinatal Council Report 2015 (a Queensland Department of Health Document) statistics **for the year 2012-2013 indicate that there were four late term babies terminated for maternal psycho-social reasons** (ie healthy late term babies).
Of these four healthy late term babies, two were delivered still born and two were born alive.

In Queensland, babies who die at or after twenty weeks gestation (or who weigh more than 400 grams) are required by law to be given a death certificate acknowledging their humanity. I ask the Committee to consider the gravity of this information about these four babies, and respond accordingly.

I have heard it said that these late term babies who are born alive, do not show vitality and will just present with a "fluttering heartbeat" as they expire. The argument is that medical assistance should therefore not be rendered to them. This was certainly not the case for 22 week old Darwin baby Jessica Jane who cried for 80 minutes before she succumbed in 1998.
Andrew Bolt wrote of her sad situation in the Herald Sun in 2014[16] as well as other cases including the baby found alive in a bin by a cleaner at Westmead Hospital, Sydney that same year.

And the fluttering heartbeat argument dissipates when one meets Melissa Ohden, or Gianna Jessen or any of the many babies who have survived abortions in the US and who are adults today because medical assistance was given to them – medical assistance which is banned in Victoria under

[14] Tankard Reist, M (2006) Defiant Birth: Women Who Resist Medical Eugenics. Spinifex Press.
[15] Cope, H et al, Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated with improved psychological outcome† Perinatal Diagnosis, Volume 35, Issue 8 August 2015 pages 761–768
[16] Bolt A, We Kill Babies. Herald Sun November 10, 2004

similar legislation to Pyne's. The medical assistance is illegal because the amendment to the Abortion Reform Act 2008 which fought for it was voted down, along with dozens of other amendments, including pain relief to be provided to late term babies being aborted.

2. Complexities around "abortion choice".

It was Frederica Mathewes-Green who wrote, "There is a tremendous sadness and loneliness in the cry 'A woman's right to choose.' No one wants an abortion as she wants an ice-cream cone or a Porsche. She wants an abortion as an animal, caught in a trap, wants to gnaw off its own leg."

"Choice" is a strange word to describe what is for many women a terribly sad last resort. Women don't have abortions because they want to have abortions. As someone said recently, abortion is not on any woman's bucket list. Most women have abortions because they feel they have no other choice.

Therefore, the questions beg to be asked, "What other choices are we as a State, giving women facing crisis pregnancies?"

Where are the MPs calling for supportive services, accessible adoptions, changes to education and employment practices, accommodation and so on, which will help women to believe there really are other choices?

How can it be that the best we can offer a woman in crisis is more ways to kill her unborn child – all the while convincing her that we're providing her with a "service" and a "right" she should be grateful for?

Who is fighting for services like Priceless where women journey with women throughout their unplanned, fearful pregnancies and into those early years of parenting?

And where are the gutsy MP's, GP's, counselors, educators, policy makers and parents who are willing to say that unwanted pregnancies are not so much the problem as they are a symptom of a much bigger problem in our society?

One must also ask how free one's choice is if all the information required to make that choice is not given. For example, are women informed about the procedures they will undergo while acquiring their termination?

How are abortions in Australia performed? This is also an important question for legislators and the public to be aware of. There are two ways of procuring a termination – medical and surgical.

The medical abortion requires the taking of two tablets mifepristone and misoprostol. The first tablet is a progesterone blocker. It stops the foetus from receiving progesterone which is vital for his/her continued growth. 24 to 48 hours later, the second tablet is administered. This tablet causes the womb to contract, expelling the foetus. These terminations require medical supervision

as the process can somewhat uncomplicated, with the woman experiencing cramping and bleeding like a very heavy period, or it can take days with the possibility of haemorrhage, and retained tissue or placenta requiring surgery. RU486 is only meant to be prescribed for pregnancies up to nine weeks gestation, however the media reported Brisbane obstetrician Dr Adrienne Freeman prescribed these drugs to a woman pregnant at 16 weeks gestation, prompting disciplinary action, and raising concerns about its regulation. [17]

As a woman who has experienced pregnancy loss through miscarriage at that nine week mark, which required an ambulance, hospitalisation for days and blood transfusions, I want to express my concerns to the Committee about RU486 terminations being performed on Queensland women in isolated rural and regional areas. It is imperative that women are able to quickly access medical assistance in the event of haemorrhage or other complications.

As these medical abortions are becoming more common, Priceless counsellors are finding women contacting our service distraught about their decision to abort and wanting to change their minds. This is because of the 24-48 hour window between the administration of the first and second drugs which gives women time to think over their decision.

Some of these women have returned to their abortion providers seeking help and been told there is no way of reversing the termination, and they must complete the abortion. This is actually not true because if the woman has only taken the first drug mifepristone, and progesterone is reintroduced, the pregnancy can often be safely continued (in about 60% of cases), with no abnormality to the baby as a result. In recent days, five women known to Priceless have successfully reversed their terminations. Hundreds in the US have successfully done the same.

This raises questions around the ambivalence some women feel about their abortions. One Priceless client stated when she called the abortion service where she had been provided her with the drugs, she was turned her away with the comment, “we get ten calls like this a week.” Since then, there have been calls for RU486 providers to give information about its possible reversal along with the meds, and a website has been set up to provide assistance for women in these situations. www.mifepristone.org.au.

The second method of procuring an abortion is surgical. In the earlier stages of gestation – up to twelve weeks, this occurs through vacuum aspiration, where the cervix is dilated and through suction, the contents of the uterus are sucked out. As the age of gestation increases and the foetus’s body develops, instruments are required to cut the foetus into pieces to allow for removal. Medical staff are then required to reassemble the pieces to ensure all parts have been successfully removed. In later stages of pregnancy, abortions mainly occur through early induction methods, where labor is brought on, and the baby delivered early. Sometimes a potassium chloride injection to the

[17] www.couriermail.com.au/news/queensland/brisbane-obstretician-dr-adrienne-freeman-engaged-in-unprofessional-conduct-by-posting-online-instructions-on-how-to-conduct-home-abortions-qcat-decision-claims/story-e6freoof-1226435348281

heart is administered. However, there are also reports that the controversial partial birth abortion method has been/is being used in Victoria. This method was banned in the US under President George Bush. It requires the delivery of the baby's head only, at which time instruments are inserted through the back of the baby's neck and into the brain to ensure death before delivery.

Informed consent would mandate that the information above be given to women considering abortion. However, we find that women are often not adequately informed as to the medical and surgical procedures they will undergo or their opportunities to reverse them. Research shows that 95% of patients wish to be informed of all risks statistically associated with a procedure, even if the causal connection between the procedure and risk has not been fully proven. [18]

3.The depth of feeling, and difference of opinion among the Queensland public on this issue.

Mr Pyne has underestimated the feeling that exists in the Queensland public about liberalizing abortion laws. A recent e-petition opposing Pyne's Bill quickly gathered 23,869 signatures in a couple of weeks, and a Galaxy Poll conducted among 400 Queensland voters from 6th-8th May 2016 showed the majority surveyed:

- opposed the decriminalization of abortion;
- believed abortion takes a human life;
- believed that an unborn baby at 20 weeks is a person with rights;
- believed that abortion harms womens health and
- believed that women undergoing abortions should have independent counseling and cooling off periods.

The later the stage of pregnancy, the more respondents became uncomfortable with liberalizing abortion with 72% of people surveyed saying they disagreed with abortions past 13 weeks, with 85% of people opposing abortions past 20 weeks gestation.

4. The wide ranging views of medical practitioners and other professionals who work with pregnant and post-abortive women.

Despite some members of the medical fraternity supporting (if not initiating) Mr Pyne's Bill, there are many GP's who continue to hold to the original Hippocratic Oath, and I expect the Committee will hear from some.
Over time, many abortionists themselves have a change of heart about their work, and leave the industry.

Below are some excerpts I have taken from the work of Dr Dianne Grocott MB BS (UWA, 1983), FRANZCP (1989) Fellow of the Royal Australian and New Zealand College of Psychiatrists in her submission on March 4th 2013 to the Parliament of Tasmania, as they debated this same legislation.

[18] Coleman, P.K., Reardon, D.C., Lee, M.B., (2006), "Women's preferences for information and complication seriousness ratings related to elective medicalprocedures," *Journal of Medical Ethics*, **32**, 435 - 438

- Drs Haywood and Noreen Robinson were successful abortionists until Noreen became pregnant and they realised they "*couldn't continue to provide prenatal treatment for a young pregnant mother and then offer to kill her unborn child*" [19]

- Abby Johnson was a Manager of a Planned Parenthood facility in Texas. She had experienced her own termination prior to being married with children. She described herself as having firm "pro-choice" views and was comfortable in media debates against "anti-abortion" activists. However, in 2009 when she viewed an abortion performed with ultrasound guidance and saw the13 week foetus kicking to avoid the instrument before being sucked into the tube, she realised that much of what she had believed and had told pregnant women was not true. In her autobiography, she relates her subsequent emotional turmoil and then healing. [20]

- The Society of Centurions is an organisation which provides support and healing for former abortion-providers. It was started by Dr Philip Ney, a Canadian Psychiatrist who pioneered post-abortion trauma counseling, and Joan Appleton, a former head nurse at an abortion clinic who had sought his help for her depression after she had left her profession. Appleton reports that many former abortion providers experience extreme guilt, isolation and some who experience depression turn to alcohol, drugs or even suicide. Appleton is quoted as saying ""*One thing that needs to be understood is that those of us who were in the business of killing babies had to dehumanize them. So the healing process consists of rehumanization*." [21]

5. <u>The experiences of women themselves.</u>

Mr Pyne is no doubt motivated by what he perceives to be helping women. However, it is obvious he hasn't taken the time to listen to the stories of women who face unplanned or crisis pregnancies, those who have terminated their pregnancies, or those who have continued their pregnancies after weighing up the information.

It would serve him well to spend time listening to women, and to visit organisations which support pregnant women in crisis (other than Children by Choice). He would be welcome to meet with professionals from Priceless as would any member of the Committee.

It would also help him to familiarize himself with literature which can provide him with other perspectives. Books such as Australian author Melinda Tankard-Reist's work, *"Giving Sorrow Words: Stories of Grief After*

[19] Bereit, D and Carney, S, *"40 days For Life"* 2013, Cappella Books, pp 87-88.
[20] Johnson, A with Cindy Lambert, C, 2010, *UnPlanned*" Chicago, Illinois: Tyndale House Publishers, Inc., 2010
[21] National Catholic Register, Sept. 6-12, 1998. http://www.priestsforlife.org/clippings/98,0906ncregistercenturions.htm

Abortion" [22] in which some women share the painful stories of their abortion grief for the very first time.

Or psychologist and post-abortive mother Anne Lastman's book "*Redeeming Grief*" [23] in which she records similar themes of previously untold grief at the loss of what her clients consistently call "my baby". Lastman maintains that "no matter what they thought at the time of termination, by the time they present with symptoms for counseling, they are calling it "my baby". anne@victimsofabortion.org

He could also visit websites such as www.Afterabortion.com where there have been over 2 million posts from over thirty thousand "members" who have supported one other post-termination. The site is politically neutral, neither pro abortion or anti abortion, and non judgemental.

The stories of women need to be central in any discussion about abortion.

6.The impacts of the current law and abortion practices in Queensland

Abortion is currently in the Criminal Code in Queensland. This provides a clear statement that unborn children have a right to some protection under the law, while at the same time outlining cases in which the State allows the termination of pregnancy. No woman has ever been prosecuted for procuring an abortion in Queensland under this law, and Queensland women access around 12,000 abortions each year.

There is however little transparency around abortion practices in Queensland. It is hoped as information continues to trickle out, that we will gain a clearer picture of what is currently the case. Obviously, until we know the current state of affairs, legislators cannot even begin to entertain thoughts of change.

7. What is happening other places eg where this Bill has been enacted in Victoria and Tasmania, and in other countries who have implemented other abortion legislation.

I have already outlined some of the impacts of this legislation in the state of Victoria. Late term abortions have increased with about half of those terminations now being carried out on healthy fetuses. Doctors have lost the freedom to refuse to be involved in abortion referrals. When Rachel Carling-Jenkins MP recently introduced her Infant Viability Bill to try to bring back some protections for late term babies, it was voted down 27-11, indicating the once the laws are liberalized, it is very difficult to regain protections.

In countries overseas, abortion laws vary widely. But no country in the world has introduced legislation as extreme as what Mr Pyne expects the Queensland Parliament to pass.

[22] Tankard Reist, M, 2000, "Giving Sorrow Words: Women's Stories of Grief After Abortion", Acorn Books, ISBN 0964895749
[23] *"Redeeming Grief', 2013 Freedom Publishing, ISBN: 9780646476018*

In recent times, it has come to light that Planned Parenthood Abortion clinics in the US have been harvesting and selling organs and body parts of aborted babies. Our legislators must do all within their power to ensure this is not happening here, and never will. Abortion is a multi-million dollar industry. Profit motive is a powerful force and should have no place where the lives and welfare of vulnerable babies and their mothers are at stake. This is probably another area Mr Pyne has not considered or addressed but is an important part of this debate.

In conclusion, Mr Pyne's Abortion Law Reform (Womens Right to Choose) Amendment Bill 2016 is irredeemably flawed and needs to be rejected in its entirety. Pyne has failed to consult with important stakeholders, failed to research carefully, and failed to consider the ramifications should his Bill pass. He has been ill advised. His Bill in no way addresses the complexities that surround the issues of abortion and unplanned or crisis pregnancies. It is founded on the single concept and catchcry of "a woman's right to choose" and blatantly disregards the very real interests of many other stakeholders.

Secondly, the Bill assumes a premise that legal terminations are physically and psychologically safe for women, which many dispute. A significant number of women will develop negative mental health outcomes from their abortions, which will threaten their relationships, their futures and in some cases their lives. The outcomes for unborn babies are of course completely grim.

Thirdly, the Queensland Parliament can hardly seek to change existing legislation when practices under the current law are not known. It is imperative that full information about abortion practices in Queensland be disclosed and discussed, and I urge the Committee to pursue this.

Fourthly, I remind the bi-partisan Committee that both LNP and Labor Parties went to the last State election promising the people of Queensland, "no change to the current abortion laws". It is beholden upon both sides to honour their promise to the people, and to continue to uphold the current laws at least in this term of Government.

The Committee and the Queensland Parliament has a sober duty of care to all stakeholders as they consider the Bill before the House. As the current law provides some nominal protection for unborn Queenslanders, while also protecting women who feel they have genuine cases requiring terminations, and under which no woman has ever been prosecuted, **I urge the Committee to reject the Bill and uphold the current law.**

I also urge the Committee to make recommendations for **health regulations** which will allow for informed consent, independent professional counselling (not by abortion providers), ultrasounds, cooling off periods, and the mandatory provision of information to pregnant women about supportive services available, including adoption services, RU486 reversal options and post termination support.

I look forward to the day when Members of Parliament, professionals, organisations and communities will work together to bring legislation to the table which will genuinely seek to provide support and care for women facing crisis pregnancies, their families and their unborn children.