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

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Ms NA Boyd MP
Mr MA Hunt MP
Mr MF McArdle MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)
Ms R Stacey (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE TERMINATION OF PREGNANCY BILL 2018

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 12 SEPTEMBER 2018

Brisbane

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The committee met at 8.30 am.

CHAIR: Good morning, ladies and gentlemen. I declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. Other members of the committee with me are Mr Mark McArdle, the member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Joan Pease, the member for Lytton; and Nikki Boyd, the member for Pine Rivers, who has been appointed to the committee today to replace Barry O'Rourke, the member for Rockhampton.

Today's hearing is part of the committee's inquiry into the Termination of Pregnancy Bill 2018. The inquiry was referred to the committee on 22 August 2018 and we are required to report to the Legislative Assembly on 5 October 2018. Well over 6,200 groups and individuals have shared their views with the committee on this bill.

There are a few procedural matters to go through before we start. I understand Dr Goldstone is on the line, so I will do this as quickly as possible. 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 all witnesses that intentionally misleading the committee is a serious offence. Hansard will record the proceedings and a copy of the transcript will be available from our website. I remind all those in attendance today that these proceedings are similar to the parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to or excluded from the hearing at the committee's discretion. Please note this is a public hearing and you may be filmed or photographed.

This particular bill is the third iteration of the proposed legislation from the previous term of parliament. Mr McArdle and I were on the health committee that considered the abortion law reform bill. It did not have any caveats around it, but simply sought to decriminalise. It did not have any caveats around gestational periods, safe zones or conscientious objection. This bill does. The bill was referred to the Queensland Law Reform Commission and the subsequent draft bill has been presented to government and to the committee for consideration.

I ask that all submitters today contribute to this hearing in a manner befitting the subject in front of us and in a considerate and respectful way. With that, we will start with the first witness, Dr Philip Goldstone from Marie Stopes.

GOLDSTONE, Dr Philip, Medical Director, Marie Stopes (via telephone)

CHAIR: Good morning, Dr Goldstone. I understand you are tight for time. Can I ask you to start with an opening statement before we go to questions, please?

Dr Goldstone: Thanks for the introduction. My name is Dr Philip Goldstone. I am the medical director of Mary Stopes Australia. As you are probably aware, we are the largest provider of abortion services in Australia and in Queensland. I have been in my current role for almost 10 years, so I oversee our Australian clinic network. I still work 50 per cent of my time as a clinician, providing abortion and contraception services. I have worked in abortion care for more than 20 years now, including working across a number of different jurisdictions, including Queensland. You have obviously all seen the Marie Stopes Australia submission to the committee and are well aware of our support for the legislation. Therefore, I am here really just to answer any questions that you may have.

CHAIR: We might start with the first question from the member for Pine Rivers.

Ms BOYD: Doctor, can you describe how Marie Stopes clinicians go about obtaining informed consent from your patients?

Dr Goldstone: In the Marie Stopes clinics, our patients generally will see a trained nurse before they see the doctor. Very often, the nurse will have had an initial discussion with the patient to talk about their decision, explain the procedure and give a brief overview of the risks. When they see

the clinician or the procedural doctor after that, the doctor will then again go over the decision-making process and the procedure, make sure that they have a full understanding of the procedure and any potential risks of the procedure, answer any questions that the patient may have, clearly document the contents of that discussion and then the patient signs an informed consent form.

Ms BOYD: What would you expect a Marie Stopes clinician to do if they became aware that a woman seeking a termination might be experiencing coercion or domestic violence?

Dr Goldstone: We are in the process of developing a specific screening tool for that. At the moment, if the doctor were to become aware of that during the consultation they would make an appropriate referral to a counselling service. Marie Stopes does have a counselling service where we can make those kinds of referrals. If it was then necessary, external services would become involved as well.

Mr McARDLE: Thank you, Doctor, for your time today. I appreciate that. What sort of counselling is offered to women who come in to Marie Stopes seeking a termination?

Dr Goldstone: Women have the option of decision-making counselling by telephone prior to their appointment if they opt to seek that. Not all women will require extensive counselling. Many women, when they find out that they have an unplanned pregnancy and decide to proceed with a termination, are fairly comfortable and sure of their decision and do not require in-depth counselling. If they are uncertain or feel they need that before they come to the clinic, we offer that service by telephone.

In the clinic, as I mentioned in answer to the previous question, they will speak to the nurse and they will speak to the doctor. If the patient is comfortable with their decision after that consultation, then consent will be obtained and the procedure or treatment will proceed. If there is any ambivalence or any doubt about her decision, we would always err on the side of caution and not proceed with the termination on that day. We would offer the woman further counselling, either on that day or at a future date.

Mr McARDLE: I take it that the counselling is not undertaken by Marie Stopes; it is undertaken by a third party? Who is that third party?

Dr Goldstone: We have counsellors who are employed by Marie Stopes, but it is completely private and the contents of that counselling are not necessarily disclosed to the proceduralist if the patient does not wish that. If further counselling was required by an external provider, that could be provided as well.

Mr McARDLE: Doctor, is counselling offered automatically or does it have to be raised by the woman herself?

Dr Goldstone: There will be a level of counselling with every consultation, obviously, because we need to ascertain the woman's decision-making process and that she is comfortable with that decision. If the woman is comfortable with her decision and her reasons and does not feel that she needs further counselling other than discussion with the medical practitioner and the nurse, further counselling will not be offered. We would not support mandatory counselling.

I see women who I think fall into three groups. The majority of women have found out that they have an unplanned pregnancy and they know that it is not the right time for them in their life and they know that they need to have a termination. Some women are very comfortable with that decision. Other women are very sure of that decision, but are upset about the decision that they are sure about. There is a smaller group of women who are unsure of the decision and they are the women who need further decision-making counselling. I guess we see most women after they have spoken with their GP, their family and friends. Most women we see, by the time they come to the clinic, are sure of their decision and they will have varying emotional responses to the decision that they have come to.

Mr McARDLE: Finally, on the last occasion we considered a bill of this nature, there were statements—not by yourself, if I recall correctly—that data is collected by Marie Stopes and that data is forwarded to the state government on a regular basis. Is that still the case? How often is that data forwarded? What sort of data is collected?

Dr Goldstone: I am not aware that there is any mandatory reporting of data.

Mr McARDLE: I understand that, but do you do it?

Dr Goldstone: Internally we collect data. Obviously, we know the number of patients that we see, we know how many weeks gestation the patients we see are at and where they come from. It is very simple demographic data, yes.

Mr McARDLE: Can you take on notice whether or not that data is forwarded to the state government or Queensland Health?

Dr Goldstone: I would need to come back to you on that. I am not 100 per cent sure. It may be something that happens at a clinic level.

Mr McARDLE: Thank you, Doctor, for taking that on notice.

Mr BERKMAN: Thank you for being with us this morning, Doctor. You have gone some way to answering this question around consent and counselling. Can you describe any other processes in place, particularly at the Maroondah clinic, to ensure that patients are getting the best care in their circumstances?

Dr Goldstone: For the patients who attend our Maroondah clinic, and I assume that you are referring to those of a later gestation, we have a different process. We do have an on-site counsellor for those patients. All patients who are attending for a multistage procedure at mid second trimester, or 20 to 24 weeks, will have on-site counselling. That is on the day prior to the procedure. They will generally have counselling on the Thursday. Obviously, women who are attending at that stage in pregnancy often have very complex social circumstances, which has led to them presenting at a further along gestation. Yes, we provide a more in-depth counselling service for those patients.

Mr BERKMAN: Doctor, you would be aware that the legislation we are considering in Queensland includes a 22-week gestational limit. Can you describe for the committee what you might expect the consequences for women to be if that gestational limit was lowered to, for example, 20 weeks or 18 weeks?

Dr Goldstone: At the moment, we know that we have approximately one woman a fortnight travelling from Queensland to our Maroondah clinic. In the past 12 months, 21 women who were over 20 weeks travelled from Queensland. We would probably expect that the majority of those women would have accessed the service in Queensland if the legislation allowed them to access the service up to 22 weeks. Apart from the lack of a service being available to women who have to travel, they often have to make other arrangements and sometimes that cannot be done in a day or so. They may have to arrange child care and there are additional costs incurred by transport. Having legislation that would allow women to terminate pregnancies up to 22 weeks would remove that transport barrier for women and allow them to access a service in their home state, where they can have the support of their family and partner and less emotional stress associated with the whole process, which is already difficult for them.

Mr BERKMAN: Are there any additional issues that we should be mindful of around the likely timing of morphological scanning around that point in pregnancy?

Dr Goldstone: Personally, I think it would be great if we had uniform legislation. If the legislation was 24 weeks in all states, we would probably eliminate the need to travel interstate because of legislation. I understand the reasons why the legislation has been proposed at 22 weeks in Queensland, but certainly that will go quite a long way to removing a lot of the necessary interstate travel that occurs, although not all the way, obviously.

Ms PEASE: Thanks very much for coming in, Doctor. I want to ask a few questions about the safe zones. The current legislation will introduce safe zones around clinics. Two questions that relate to that are: what sort of behaviours are you currently seeing around clinics; and has there been any escalation or change regarding that of late?

Dr Goldstone: As I mentioned in my introduction, I work across our jurisdictions but I work currently primarily in New South Wales, where safe access zones have recently been introduced. Prior to a few months ago I used to face protesters on a weekly basis when arriving at my workplace at Westmead, and that has just completely stopped now. We used to have one woman in particular with very offensive, confronting photographs who would stand and almost block the pathway of women. Women would often come in upset and fearful about what they had to confront at the doorway.

I also work regularly in Canberra. I have seen the introduction of safe access zones there in the time that I have been working, and I have seen the big difference that that makes there. I am aware there is an increase in protests in Queensland at the moment. I think that safe access zones are a really important part of the legislation both for women accessing what is an essential medical service—they should not have to confront that—but also for the employees who work in those clinics.

CHAIR: In your submission you mention the Maroondah clinic. For the record, could you tell us where that is? Secondly, we have just travelled into regional and North Queensland, where we heard once again that women find it difficult to access termination services. Do you find that women are travelling to this clinic because of the criminalisation in existing legislation?

Dr Goldstone: I did not quite hear all of the question but I think I got the gist of it. Women travel to Victoria generally because they are unable to access the service in Queensland because of their gestation. Sometimes that is because they have been provided with inaccurate information. Women in rural and regional areas in particular are very often told that abortion is illegal or that they are too far pregnant and no-one can help them. Then very often when they start trying to seek out further information and gain access to information from relevant services they find out that that is not the case, and often that has led to an unnecessary delay in them seeking services. Sometimes the lack of clarity in the law causes the delay in access to the correct information, and then that can cause a delay in access to services and then force them into having to travel to a different jurisdiction where they could have previously had the service provided in their home state, definitely.

Mr HUNT: Doctor, in your submission at point 30 you recommend that the Termination of Pregnancy Bill 2018 should be accompanied by clear guidance to Queensland hospitals when considering whether to perform a termination of pregnancy after 22 weeks. Obviously, as legislators we are being asked to vote on this without knowing with that guidance would be. In your opinion, is clause 5 of the bill too vague or open to interpretation?

Dr Goldstone: That clause, as I understand it, is very similar to the Victorian legislation. I think it is important to allow enough scope for a medical practitioner and a woman to consider all the circumstances. Women who are terminating pregnancies late in their gestation do not make that decision lightly. There are often complex social and medical circumstances. I think to be too strict about the guidelines around that and to use words like ‘severe impact’ or ‘severe disability’ can be as grey as not having those guidelines as well. I think that it is appropriate the way it is worded, yes.

CHAIR: Thank you, Doctor. I apologise, we have run four minutes over and I wanted to keep a tight time line. I thank you for your contribution this morning. It is very helpful to the committee. We will move on to the next witness.

PORTMANN, Dr Carol, Private capacity

CHAIR: Dr Portmann, thank you for being here today. I will ask you to start with an opening statement before we move to questions.

Dr Portmann: I am Carol Portmann; I am an obstetrician, gynaecologist and maternal foetal medicine specialist. I have been working in Queensland doing obstetrics diagnostic counselling and termination of pregnancy for over 15 years. I think the bill as it stands is well researched and well balanced. I think it is a very appropriate step forward for women in Queensland, most particularly in providing access to disadvantaged women who find it greatly difficult to find a sympathetic doctor or hospital. It is that group of women in particular who I believe this bill will be able to assist.

Mr BERKMAN: I understand that you are the only private clinician in Queensland who performs surgical terminations up to 20 weeks; is that correct?

Dr Portmann: The only one up to 20 weeks. There is another provider who will do terminations at 18 to 19 weeks. It kind of depends on the person's circumstances and their history. Most of them, if at all, may go up to about 16 weeks, so I am pretty much the only one, yes.

Mr BERKMAN: You have heard my questions and the responses from Dr Goldstone. In your view, what would be the consequence of any lowering of the gestational limits proposed in this bill?

Dr Portmann: Twenty-two weeks is, I think, a reasonable balance when it comes to picking a gestational age. If you lower it, then you are going to have a significant number of people particularly with foetal abnormalities. There are people who unexpectedly find themselves much further along than they thought because of poor advice given to them based on a blood test, or who are still having periods while actually being pregnant, being pregnant when you have a Implanon in and not getting periods and not realising you are actually pregnant when they put it in.

All of sorts of reasons can come forward as to why someone may turn up and be in fact 20 weeks or 21 weeks. To lower it to something like 16 weeks or under will basically rule out most people with foetal abnormalities and a significant proportion of people whose circumstances have changed or who had unidentified pregnancies. Also, of course, there is that group of people who have to travel quite a lot and it takes them a couple of weeks to organise travel, organise child care, to get time off work and for their support person get time off work, and trying to narrow that into maybe a two-day time frame is almost impossible for these people.

CHAIR: Dr Portmann, we have heard from some submitters who oppose the bill about gender selection if this bill is passed. How do you respond to that?

Dr Portmann: Essentially, as doctors we do not support gender selection. It is not actually illegal per se, but it has been put forward, particularly with regard to assisted reproductive technologies, that gender selection for anything other than a medical reason is not supported. We would not specifically say, 'Yes, we will do that because you do not want a girl or a boy.'

The other thing is that to physically identify the gender you have to be at least over 11 weeks for the new blood test, and 12-week ultrasounds are only a guesstimate. They are not accurate. You really have to be about 15-16 weeks and have a good ultrasound, which is usually not the type of ultrasound that we provide. We do not look for gender when we are doing a termination of pregnancy. Most people would not find out physically the gender of the baby until their 19-week scan, and 19- to 20-week procedures are actually not very common at all, so I would not say that it is a large group of people who are coming forward. I cannot exclude that there might be someone who does not disclose to me that it was one of their reasons, but it is certainly not a big thing. You certainly cannot do these sorts of procedures before gender is recognisable, which is 11 to 12 weeks from the blood test.

Ms BOYD: We have heard some claims during this debate that abortions will be provided up to minutes before birth. In your view, do you think this bill, if passed, would lead to cases of abortion for healthy foetuses minutes from birth?

Dr Portmann: No. That fails to take into account what the process is. Basically, for a late termination of pregnancy you just do not induce a baby: you must do a procedure where the baby passes away. There are a handful of people who are able to provide that service, and they are primarily either in South-East Queensland and, I think, Townsville. You are not suddenly going to get a great number of people upskilling just to do this procedure. For that person to decide to provide that procedure they would want to have absolute certainty with other doctors that there was a reasonable indication to perform this. That means counselling; that means talking to the person.

If we are talking about a late termination, then it also means you would want to have an evaluation of that person's social and psychiatric wellbeing. If there is something wrong with the baby, then you need to be sure that what is wrong with the baby has an absolutely certain outcome. That

takes time. Our feeling about it as well is that it is not something that you would choose to do at 39½ weeks with a woman in labour. One of the things we counsel a person is that, if our decision with you is not made before you go into labour, then we are not doing the procedure.

Ms BOYD: How does abortion pose risks to the mental health of a woman, and how does this compare with the risks of being forced to carry an unwanted pregnancy to term?

Dr Portmann: I think you do need to split it up into foetal abnormalities versus a person's decision based on their other circumstances. If a person has a baby with foetal abnormalities, they are already undergoing a grief process through that diagnosis and through having to make a decision. It is generally believed that for about six months afterwards they are still undergoing that grief process, and that grief process is similar to that experienced if a person has a spontaneous loss.

We cannot ignore the fact that, when you have a baby that has significant needs or who needs to undergo surgery, there is a lot of mental stress on parents as well. There is quite a high divorce rate and depression associated with babies having major cardiac surgery, for instance. Multiple pregnancy can also cause significant mental health issues through stressors as well. While having to engage in a termination of pregnancy can affect someone for a period of time, the same can be said for continuing on with a pregnancy in those circumstances.

For women who are making choices based on their own social backgrounds or for other reasons, generally speaking if they feel very comfortable with the reason they are doing it then they are not particularly affected mental health wise. In fact, some people benefit because they are in such a bad mental place at the thought of pregnancy that their circumstances are improved by a termination of pregnancy rather than worsened.

Mr McARDLE: Thank you, Dr Portmann. I think you were here on the last occasion too.

Dr Portmann: That is right.

Mr McARDLE: Welcome back. Doctor, clause 5 of the bill deals with termination post 22 weeks and it requires a consultation to take place with a second medical practitioner. That is the term that is used. Whilst the term 'consult' is not defined, nor is level of medical experience or speciality defined in the term 'medical practitioner'. Can you elaborate as to what you think should happen in relation to their consultation? Should it be that they see the lady involved and then do an examination themselves? Should the practitioner be somebody who perhaps specialises in the particular concern or medical condition of the foetus?

Dr Portmann: If we are talking about foetal abnormality then I would say it is not always specifically necessary for a consultation to be face to face or in person. A doctor who understands the foetal abnormality, be it an ultrasound specialist or a geneticist or someone whose field is the problem which the baby has, can look at the ultrasounds, the genetic results, the MRI and can make a judgement based on those findings along with what the other doctor has said about what the mother feels to be able to make an assessment.

Mr McARDLE: The wording that you have used in that answer implies the doctor cannot just be telephoned and be told; they must make an assessment of the medical records of the lady involved, and you would anticipate that that practitioner would have the relevant knowledge to understand the implications of what the records are saying.

Dr Portmann: I have been telephoned for opinions already, but generally what they are doing also is they are emailing or messaging pictures of something, or you have access to results so some ability to see those things. Not everything needs that. If someone told me, 'We've found a baby that has no kidneys at 22 weeks,' I would not need any more information because I already know what that means and what that looks like. If the person who is talking to me about that is someone who knows what they are doing or the person who did the ultrasound knows what they are doing, then I would not feel I specifically had to see those things.

In terms of the speciality or experience of the second person, again it is really dependent upon what issue you are talking about. Is it a brain issue or a heart issue? What typically happens is that the mother has had, for instance, a heart ultrasound and the cardiologist has given their opinion. Then a second doctor can look at that ultrasound report. They do not have to be a specialist in the heart because that opinion has already been given, but they can assess what has been written on the report and discuss with the other doctor the feeling of the mother without having to speak to the mother.

Mr McARDLE: What you are indicating to me, however, is that there does need to be a full consultation between the practitioners and not simply a tick and flick exercise, as has been alleged in other places.

Dr Portmann: There has to be some discussion. I do not think it is going to be, 'I have this woman who has this; can you tick it off?' It is like, 'We have this woman, these are her circumstances, this is the genetic test and this is the finding on the ultrasound. What is your opinion?' I wouldn't call that tick and flick.

Mr McARDLE: So the word 'consultation' in this context means a full consultation.

Dr Portmann: Yes.

Mr McARDLE: And the word could be perhaps surrounded by words that ensure that is in fact the case?

Dr Portmann: That is right.

Mr McARDLE: The issue of counselling has always been one of the nubs of this debate. Whilst it may not be mandatory to have counselling, should it be mandatory to offer counselling in relation to a termination or at the very least mandatory to have it on offer?

Dr Portmann: As Philip was saying, a significant proportion of people do not require a level of counselling that needs a counsellor sitting next to you. I would say that is probably about 80 per cent of women, because they are very comfortable with their decision and in some ways would feel as if their decision and their personal assessment of themselves were being cast into doubt if they were constantly forced towards a counsellor.

Mr McARDLE: Could I put it this way? If I were a lady and I were pregnant and I came in to have a termination, would it be considered to be attacking my rights if I was simply asked, 'Would you like counselling?'

Dr Portmann: Not at all. I think that is a reasonable way of putting it.

Mr McARDLE: Exactly. Thank you very much.

CHAIR: Before we move to the member for Lytton, we heard from some other submitters that women are automatically counselled when they seek termination from some services that are provided out there.

Dr Portmann: Are or are not?

CHAIR: Are counselled automatically.

Dr Portmann: In terms of counselling what we mean is that we are going through what are their reasons, to be comfortable that they are comfortable with their reasons, and the physical process to ensure that they understand their physical risks and outcomes.

Ms PEASE: Thank you very much for coming in today. I am wondering if you have ever experienced a woman presenting to you seeking an abortion whom you suspect may be experiencing reproductive coercion.

Dr Portmann: Certainly there will be circumstances where we are sure that that is happening and then circumstances where we may get some small hint through the process, and there are probably numerous circumstances where we were unable to identify that that was happening. All women will see a nurse by themselves so their partner or support person does not take part in the initial consultation with a nurse to ensure that we can get any evidence that we can from a face-to-face discussion with them about whether it is their decision or not.

Sometimes even in the best of circumstances we understand that a person is to a degree being coerced but feel they still need to go ahead because it is their only choice because otherwise this person will leave them and their four kids. It is very hard to know what to do in those circumstances so you go ahead with what their choice is even though to a degree they are being coerced.

Ms PEASE: On the other side of the coin, have you ever come across other forms of reproductive coercion where women are being forced into having pregnancies where they are not wanting to?

Dr Portmann: Yes. There are definitely circumstances where we have had physical altercations between the partners in waiting rooms and had to ask them to leave because they were trying to stop the woman from presenting. We have had situations, particularly Children by Choice, of having to go through quite a bit to make sure that a woman safely is able to find their way to seek at least counselling and a service and be protected from that partner.

CHAIR: The Queensland Law Reform Commission undertook a significant body of work in 12 months in reviewing this issue. They spoke with some 1,200 submitters, many of them from the medical fraternity. They concluded that this is a health issue between a woman, her treating specialist and a family versus it sitting in the Criminal Code. Do you concur with that?

Dr Portmann: Absolutely.

CHAIR: Thank you very much, Dr Portmann. We thank you for your contribution today.

CLEARY, Dr Michael, Vice President, Australian Medical Association Queensland

MANOHARAN, Dr Bav, Director and Councillor, Australian Medical Association Queensland

MARKWELL, Dr Alex, Past President, Australian Medical Association Queensland

CHAIR: I welcome the representatives from the Australian Medical Association Queensland. Thank you for attending today and for your contribution to this issue. I invite you to make an opening statement before we move to questions.

Dr Cleary: Thank you very much for providing AMA Queensland with the opportunity to provide evidence directly to the committee today on this important piece of legislation. The AMA Queensland is largely supportive of the proposed Termination of Pregnancy Bill. Doctors in Queensland have a duty to provide the best patient care they can offer, and Queensland's current laws regarding the termination of pregnancy are a barrier to this. We welcome any change to the law that provides patients and doctors with the legal certainty they need to provide this care.

Termination of pregnancy in Queensland is only lawful if it is carried out to prevent serious danger to the woman's physical or mental health from the continuation of that pregnancy. Doctors performing terminations of pregnancy in Queensland do so in a legally grey area that puts both themselves and their patients at risk. For this reason, we support reforming Queensland's laws as they relate to termination of pregnancy so that women can receive safe, compassionate health care and doctors can practise with certainty.

The AMA Queensland came to this position after extensive consideration by its member-elected AMA Queensland Council. The AMA Queensland Council is made up of 28 medical practitioners who have a very broad range of skills and experience. The AMA Queensland Council is the policy-making body for the association. The position that AMA Queensland has taken is consistent with the federal AMA position on termination of pregnancy as well as other peak national and international bodies such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the International Federation of Gynaecology and Obstetrics and the World Health Organization.

Whilst the AMA Queensland supports the overall aims of this bill, we have two areas of concern that we would like to raise with the committee. The first relates to part 2, section 6 and specifically talks to the termination by medical practitioners after 22 weeks. These terminations are rare. They constitute less than one per cent of total terminations in Queensland. As stated in our submission, we believe it is important that the bill be amended to require a second medical practitioner to have consulted and examined the patient prior to making determinations on the appropriateness of termination. This could take place by means of telemedicine consultation if required for geographic isolation.

Apart from this important amendment, the AMA Queensland believes that the bill adequately addresses the significant complexity of terminations after 22 weeks of gestation. The Queensland Health clinical guidelines on therapeutic termination of pregnancy comprehensively address the clinical, psychosocial and medicolegal issues raised in relation to termination of pregnancy. The AMA Queensland recommends that these continue to be used, noting that they may need to be updated to reflect potential legislative changes.

The second area relates to part 2, subsection 8 and registered health practitioners with conscientious objections. AMA Queensland believes that the bill should have very strong conscientious objection provisions. However, the AMA also believes it is important for the legislation to recognise that in an emergency situation, regardless of whether or not a medical practitioner has conscientiously objected to a termination, they may lack the appropriate skill or training to perform such a procedure safely. The bill as currently drafted could require a medical practitioner to perform a termination of pregnancy in an emergency which we believe would be clinically inappropriate. We would therefore recommend that the legislation be amended to expressly recognise this challenge. The bill otherwise is consistent with the national and international ethical guidelines including the AMA's position statement on conscientious objection, specifically the universal principle of not impeding access to health care.

Finally, although not included explicitly in the bill, the AMA Queensland strongly opposes gender based terminations of pregnancy except in very rare cases of sex linked genetic diseases or illnesses described in the NHMRC ethical guidelines for the use of assisted reproductive technology. This position is consistent with other international health bodies such as the World Health Organization and the British Medical Association.

It is the view of the AMA Queensland that any practitioner who performs gender based terminations of pregnancy outside these guidelines could be subject to disciplinary action through agencies such as the Office of the Health Ombudsman or the Medical Board of Australia. Thank you again for allowing the AMA Queensland to present to the committee this morning. We would be very pleased to take any questions that you would wish to put to us.

CHAIR: Thank you very much, Dr Cleary. We will start with the member for Pine Rivers.

Ms BOYD: We have heard claims during these hearings that women are not giving their informed consent to abortions. Can you explain for the committee what constitutes informed consent in the context of a medical procedure?

Dr Cleary: Informed consent is very well articulated in the Queensland Health policy on termination of pregnancy. It goes into not only the legislative basis for that consent but provides very specific guidelines for such consent. In essence, capacity to consent is covered under the powers of attorney legislation and it requires three things: firstly, an understanding of the nature and effects of decision that you are making; secondly, the decision has to be made freely and voluntarily; and, finally, you need to be able to communicate the decision. When we are looking at patients who are asked to consent to procedures, we examine those three particular components especially where there is a challenge by way of a person's capacity to consent. Those three things have to be met.

Ms BOYD: In your opinion do the current clinical guidelines in Queensland provide sufficient direction and safeguards to ensure a woman is giving full consent to an abortion?

Dr Cleary: Yes, I believe that is the case. This is a very difficult decision at some time. The guidelines are there. They provide a very good framework for decision-making, but where these difficult decisions are made with a family and with a patient there will generally be more than one clinician involved. If it is required, then high-level legal advice may also be sought so that the decision-making complies with the legal framework but also good medical practice as per the Medical Board of Australia's requirements.

Mr McARDLE: You made the comment in your opening address that there should be a consultation and examination of a lady post 22 weeks by, I suspect, a qualified medical practitioner who was familiar with the circumstances that the woman is going through at that point in time. Why do you think it is important that the doctor consult with and examine the woman themselves?

Dr Manoharan: I think both medical practitioners that are involved in that decision-making process need to consider all the circumstances which are espoused in the proposed bill which is the physical, the psychological and the social circumstances. We do not think that a discussion with another medical practitioner will allow for that. That is not to say that the second medical practitioner needs to physically be able to consult with the patient. It could occur via teleconferencing or videoconferencing. It does not necessarily have to be another obstetrician. It could be a geneticist in the case of a late diagnosis of a congenital abnormality. The AMAQ does not agree with the position adopted by the Queensland Law Reform Commission in regard to the termination. We strongly encourage legislators to mandate in legislation that this consultation with a second practitioner occurs.

I suspect that for women who are seeking terminations who are from a regional or a rural setting there will be added costs involved with travelling for physical consultation. Again, that is another reason it should be allowed in a number of modalities.

Mr McARDLE: I think you made the comment that telehealth is an important tool in that scenario. I take it from what you are saying that consultation of some form either face to face or by telehealth is important for the second medical practitioner?

Dr Manoharan: Yes. In terms of an examination, an examination may involve a mental state examination if there is a psychological or psychiatric illness at play.

Mr McARDLE: Under clause 5 of the bill, the medical practitioners before coming to a conclusion of termination should occur are required to consider the physical, psychological and social circumstances. That is for the practitioner to make that call, as I read clause 5. Do you think it would be important if guidance was given as to what those words mean or do you think it is a matter for practitioners to come to a conclusion based upon all the circumstances?

Dr Markwell: In the way the legislation is drafted it is clear that all of those circumstances need to be considered. It also refers to the professional standards and guidelines. Dr Cleary has already outlined the Queensland Health guidelines which are thorough and excellent, and we would strongly recommend that they continue to underpin this particular clause in the draft legislation.

Mr McARDLE: I do not think there is any doubt in relation to paragraphs (a) about medical circumstances or (c). I am more concerned about paragraph (b). That is part of the consideration that the doctors have to come to as well. Would it be of assistance if some guidance could be given as to what those words mean or do they have their ordinary plain meaning determined against the circumstances of each case?

Dr Markwell: I think those words are clear and any doctor who undertakes good medical practice would understand that meaning and would follow it appropriately.

Mr McARDLE: Moving away from post 22 weeks, is the AMAQ of the opinion that there should be counselling at least proposed for a lady who comes in seeking termination? I am not suggesting that it be thrown at them or that they be directed to it, but it would be advantageous if counselling is were offered as part of the process. Again, it may be a general approach but if it were offered—and it should be offered—there may well be a tick in the box saying no, but it may well be appropriate to offer counselling prior to termination.

Dr Cleary: The AMA's position on this is that it is an option for counselling to be provided. The reason for that is that there is already a therapeutic relationship between the patient and their treating medical practitioner. As part of the normal consultation process, consideration would always be given to offering counselling as was described by the previous witness. I think that the level of counselling that was offered would be dependent upon the consideration at the time—the particular patient, their family, their personal circumstances and the types of procedures that were being undertaken—but it would be a normal component of good medical practice as required by the Medical Board of Australia.

Mr McARDLE: In relation to the number of terminations that have occurred in Queensland, my understanding is that no data is centrally gathered and no data is published. There are estimates between 10,000 and 14,000 per annum. I think they are surgical, not medical as well. Do you see a benefit in reporting of terminations and that being important in relation to ongoing medical care or ongoing development of policy?

Dr Markwell: In our submission we did support the collection of anonymous data.

Mr McARDLE: Of course.

Dr Markwell: There are some things that can be collected—for example, prescriptions of mifepristone for medical terminations. There are some data sources out there but they are not compiled. I think it would be helpful and I think AMA Queensland has supported that in the submission. Obviously it is important that it is anonymous.

Mr BERKMAN: You have made very clear your position on counselling being optional. In your submission you have also said that it is important that it should be delivered by an objective organisation or individual. Can you elaborate on that? Is it your view that any counselling offered should be all options as in it canvasses the possibility of parenting, adoption and abortion?

Dr Cleary: In terms of the approach that we were suggesting, in the therapeutic relationship between the patient and their treating medical practitioner the opportunity for counselling should be provided but it should be provided by someone who is able to provide an unbiased view and, therefore, not expressly leaning one way or another towards or away from termination of pregnancy and to be able to have a free and frank conversation with the patient and potentially their family. My understanding is that that is what is in place in many of the private clinics that operate in Queensland, and certainly within the public sector where termination is considered—and that is usually for serious medical or other health reasons—those same provisions apply. It is really just making it explicit that the counselling needs to be unbiased.

Mr BERKMAN: On the question of conscientious objection—you have already addressed this to some extent—as I understand it, there is an existing obligation around the requirement for medical practitioners not to impede access to treatments. Can you elaborate on what that entails in the context of these kinds of treatments? I am assuming that that is an obligation that every medical practitioner would be well aware of and largely reflects the conscientious objection provisions of the bill. Is that correct?

Dr Markwell: Yes. The conscientious objection provisions in the bill are consistent with national and international ethical guidelines on conscientious objection. The universal principle of that is that access to care should not be impeded. An individual can appropriately hold a conscientious objection but that should not affect their patient's ability to access care that they seek. The requirement for referral to another provider or to a health service that does not have the same objection is reasonable

and appropriate. It does not necessarily mean that you are referring to a provider of terminations. You are providing referral to another independent service so that that patient can consider the options. This wording is completely appropriate and consistent, with the exception of the duty in an emergency which we have already outlined.

Mr BERKMAN: We have already had discussion about the possibility of a second consultation being more fulsome than what is proposed in the bill at the moment. We have heard testimony around the time sensitivity of this—and I am sure you are well aware of the implications of any delay in a woman having access to these types of health services. Do you have any further comment on how, if there was to be any change to the second consultation requirements, we might ensure that that does not cause any additional time delay or create unnecessary barriers to the provision of these services?

Dr Cleary: In my experience time delays have not proven to be a challenge. When these sorts of matters are being considered everybody involved is aware of the critical nature of these decisions. Early and appropriate consultation is always organised. Again, that is in my experience.

In terms of the provisions in the legislation, I think they are adequate to cover those requirements, because again under the Medical Board of Australia's good medical practice documentational guidelines the requirement to organise very rapid consultation would fit within that framework. I think the legislation covers the requirements, but also there is an existing framework with the Medical Board of Australia's good medical practice guidelines which really would put the onus on the medical practitioners involved to ensure that those consultations occurred in a timely way.

Ms PEASE: Can you provide any information or comment around the current criminalisation of abortion in Queensland and the impact that it has on your members who may wish to specialise in sexual or reproductive health?

Dr Cleary: In terms of the legislation and the provisions that are there, which I am sure the committee is more than well aware of, there are some very significant limitations with that legislation, and I think I outlined some of those in my introductory comments. It does mean that there is a high degree of anxiety, and there is a degree of concern when medical practitioners are supporting women who have requested terminations or where the termination is being undertaken because of a significant foetal abnormality. There is a degree of concern.

Going back not all that long ago, medical terminations of pregnancy were not legal in Queensland and that caused a great deal of difficulty within the state. There were some changes made to the legislation at that time to allow for that amendment. To my knowledge, that has been the only amendment since the original provisions in the Criminal Code were introduced. It really was a very minor amendment, but at that time it did result in a significant reduction in the number of women who were accessing termination procedures in Queensland.

Dr Markwell: Specifically, currently the legislation prevents termination solely on the basis of foetal abnormality. We have heard some examples this morning. For example, in terms of renal agenesis, where the foetus has no kidneys, at this stage in Queensland the only lawful termination of that pregnancy is because of the impact it has on the mother, not as a result of the foetal abnormality in itself. That is a significant consideration as well.

Mr HUNT: You mentioned AMA guidelines around conscientious objection being not to impede the health treatment. The section requires a referral, however. Would a referral by a GP to a counselling service, for example, to someone who is in distress and asking for an abortion be in line with those guidelines?

Dr Markwell: The referral needs to be made to another service that does not share that objection and has to be able to explore the option. If you are a GP and you have an objection, you have an obligation to refer to another doctor, who may have a counselling service attached to it, but you are referring to another medical practitioner who does not share your objection.

Mr HUNT: So it would be an offence if a GP referred a person directly to a counsellor in their assessment of their patient—if they had a conscientious objection and they disclosed that, however, they said, 'As my assessment of you, because I've known you for a long time, I would rather refer you to counselling at this present time.'

Dr Markwell: Counselling may be an important part of that conversation, but unless you have enabled access for the care that the patient sought then you have not fulfilled your duties.

Mr HUNT: Are you comfortable that that is an offence now for a GP to refer somebody to counselling only?

Dr Markwell: In itself, it does not fulfil our obligations as they exist as stated in the Medical Board of Australia's document and also with every other national document that discusses conscientious objection. The AMA document specifically says that you need to take whatever steps are necessary to ensure your patient's access to care is not impeded. That would be a partial referral but would not discharge your duty under the—

Mr HUNT: It does not discharge your obligations. Thank you.

CHAIR: Dr Cleary, how long has AMA Queensland been established and how many members do you represent?

Dr Cleary: We represent about 6,000 members in Queensland. I apologise but I cannot tell you when it was formally constituted as an association.

CHAIR: Many, many years?

Dr Cleary: Many, many years.

CHAIR: It is a well-regarded and recognised professional body that submitted to the Queensland Law Reform Commission's review.

Dr Cleary: Yes. There was a submission to the Law Reform Commission, and the AMA has provided advice to the previous parliamentary committee that examined the last bill. Our views this time are consistent with, if not almost identical to, the ones from the previous iteration.

CHAIR: Fundamentally, the QLRC regards this as a health issue not a criminal one. What is the AMA's position on that?

Dr Cleary: The AMA regards this definitely as a health issue and not a criminal issue.

CHAIR: Thank you very much for your time. We do appreciate your contribution from the AMA.

JOHNSON, Ms Teeshan, Executive Director, Cherish Life

PURCELL, Dr Donna, President, Cherish Life

CHAIR: Good morning. Thank you for being here today. We are time sensitive and you did make a contribution in Townsville, so it will be a bit shorter today but we do appreciate you coming in. Could you start with a brief opening statement before we move to questions?

Dr Purcell: The government's Termination of Pregnancy Bill is almost a mirror image of Victoria's abortion laws, except Victorians have an ineffective gestational limit of 24 weeks, while this bill is proposing an ineffective limit of 22 weeks. Both are reckless, anti-life and anti-women abortion to birth frameworks—neither recognising the personhood and the subsequent rights of the unborn at any stage of pregnancy nor affording the particular care needed by a woman during pregnancy.

In Victoria in 2011, a healthy, viable baby over 37 weeks gestation to a healthy mother was aborted for psychosocial reasons. In the same year, 10 healthy babies to healthy mothers were aborted between 28 and 31 weeks gestation. These children would have no doubt survived with proper care. In recent years in Victoria, about 50 per cent of the late-term abortions have been performed for psychosocial reasons, having nothing to do with the health of the woman or the child. Why weren't these viable children given a chance at life outside the womb and perhaps put up for adoption? Why did the state sanction the brutal and painful killing of healthy and lively little Australians who could have thrived elsewhere? We all know how many people are looking for children to adopt.

In recent years in Victoria, two to three late-term abortions of healthy babies to healthy mothers occur every week for psychosocial reasons. If the Termination of Pregnancy Bill passes, we could expect comparable figures in our state as this is an almost identical bill. We do not want such laws here and Queenslanders do not wants these laws here. Last month a YouGov Galaxy poll showed that only six per cent of Queensland voters agreed with abortion to birth, which is exactly what this bill would legalise if passed.

When the Victorian Abortion Law Reform Act 2008 passed, all 40 amendments—which were put up by different members—were rejected. These amendments would have afforded at least some dignity to the unborn and protection to women who were shunned. They were probably not passed because the true intent of the bill was not about health care or what is best for women but to legalise abortion without restriction at any stage.

Some of these provisions were: protection of the life of a child born alive after an abortion; abortion providers to administer anaesthetic to the foetus through the abortion; a full conscientious provision for medical professionals so they would not be forced to refer for abortion; a provision to provide support and counselling for women; women to be informed of the health risks of an abortion; a ban on late-term abortion and partial birth abortion; and the mandatory reporting of suspected child or teenage victims of sex abuse if a suspected abuser takes them to an abortion clinic. All of these amendments were rejected.

CHAIR: Dr Purcell, a lot of this is in your submission. We will move to questions in the interests of time. Can you clarify your qualifications?

Dr Purcell: I am a GP. I am a registered practitioner in Queensland. I was registered in 1980.

CHAIR: Are you a member of the AMA?

Dr Purcell: No, I am not.

CHAIR: The AMA just sat in your seat and said this is a health issue. What are your views on that organisation's views?

Dr Purcell: I would have to say they do not represent mine and they do not represent a lot of doctors that I know as well.

CHAIR: They represent 6,000 in the state and they have just said that it is a health issue. Are they wrong?

Dr Purcell: Most definitely they are wrong, yes. My understanding is that 6,000 is about 28 per cent of the doctors in Queensland.

CHAIR: Ms Johnson, you have stated that if the proposed legislation is passed the number of late-term terminations will definitely rise. What evidence do you have to support that comment?

Ms Johnson: The loosening of criteria. If you say you can have a late-term termination for foetal abnormality now of serious risk to a mother's health and you extend it to include social reasons, I would say there would be an increase in late-term abortions in Queensland. I think that is logical.

CHAIR: Victoria has a different view since legislating that. Late-term terminations have actually reduced. Are you aware of that?

Ms Johnson: I have got the pre and post 2008 data. It has actually been up and down. There was a spike in the first year. I note 2009 had 410 late-term terminations. Since then, there has actually been an overall increase in what it was prior to decriminalisation looking at data back to 2000. There has been a steady increase. It has been a little bit up and down, but overall it has increased since decriminalisation. That is in our report in the appendix.

Ms BOYD: In what circumstances do you support a woman being permitted under law to have an abortion?

Dr Purcell: As an organisation, because abortion kills an unborn human being, we believe that that unborn human being has as much rights as a born person, so we do not actually approve of abortion in any circumstance and that includes foetal abnormality. We do not believe they should be killed because they are disabled. There may be some other reasons around the mother's health that requires a birth to be expedited—brought on early. Whether or not the unborn has a chance of survival obviously depends upon age and other circumstances.

Ms BOYD: Is it fair to say in fact that you do not support abortion in any form under any conditions?

Dr Purcell: That is right. If you are talking about directly going out to kill the unborn, whatever age that might be, that is right.

Ms Johnson: I think I said last time where the intent is to save the mother's life—for example, an ectopic pregnancy—the procedure is different, it is not an abortion. Once again, I think I gave the example of pre-eclampsia. As Dr Donna Purcell said, they might bring on labour early because the intent is to save the mother's life.

Ms BOYD: At what point do you think the weighting of the mother's life to the foetus's life actually changes? Is there a point in time where you actually think the balance of one outweighs the other?

Dr Purcell: No, not really, not if you are trying to set a definite time. In this bill you have viability. That just measures the maturity of the unborn child at that stage to survive outside the womb. Modern obstetrics and medicine has tried to serve the interests of both. If a woman wants to remain pregnant, all stops are pulled out, even when she is most seriously ill, to try to look after her and the baby.

Ms BOYD: In terms of conscientious objections, we have just heard from AMA Queensland that all doctors in fact have an obligation under the current standards and guidelines to refer patients on. As a medical professional yourself, doesn't this stand in stark contrast with what it is that you are recommending through this bill?

Dr Purcell: Yes, it is. There are a lot of doctors who do not agree with the AMA's position on that. They believe that they have a right to conscience not to be involved in the process.

Ms BOYD: Under the current guidelines you are required to refer on. Have there been instances where you yourself have not referred on a woman who is seeking a termination?

Dr Purcell: I have referred them to counsellors. I did not understand that my duty went beyond that according to what the AMA said, and generally counsellors will refer a woman back to you anyway.

Ms Johnson: Ms Boyd, I assume you know that you do not even need a doctor's referral to get an abortion in Queensland. Under the current laws, you do not need a doctor's referral. I assume you know that, just to clarify.

Mr BERKMAN: Thank you both for being here. Dr Purcell, you raised a variety of concerns and I think they were framed as amendments that might be considered or had been considered elsewhere but were not. Are you aware of the detail of the *Therapeutic termination of pregnancy* guidelines and how many or which of those issues are actually dealt with by those guidelines?

Dr Purcell: Are you referring to the government ones? Sorry, which guidelines are you referring to?

Mr BERKMAN: Yes. I understand that they are a Queensland Health publication, the *Therapeutic termination of pregnancy* guidelines of 2013.

Dr Purcell: Yes, I am aware of them and I have read them a few times now. I am not sure what you are saying. Are you saying whether the Victorian provisions are covered by that?

Mr BERKMAN: The issues that you raised as they were listed struck me as issues that are covered by those guidelines, which are guidelines that are required to be taken into account in the decision-making that this bill proposes. Do you accept that those are largely, if not all, issues that are required to be considered under those guidelines?

Dr Purcell: The ones that I read out were amendments to the Victorian abortion law after they were passed—things like, for example, as I just mentioned, giving anaesthetic to the foetuses for an abortion. That is not really covered under the guidelines, for example.

Mr BERKMAN: Okay. We may be speaking at cross-purposes here. We have heard extensive evidence and I would suggest—without having checked the *Hansard*, it is not yet available—that every single clinician who has given evidence here and around the state has made very clear that, whether they are a clinician or a counselling service, in their experience termination of pregnancy is a decision that is never taken lightly by women. This stands in stark contrast to the evidence we heard from you, Ms Johnson. First of all you agreed with the statement that this bill removes any limitation on abortion. You used language like it would lead to abortion for pretty much any reason or open slather abortion. Given the stark contrast between your evidence and that of clinicians, is there any of that that you would like to revisit?

Ms Johnson: I want to say first of all I think you received about 6,000 submissions and there have been a handful of people. You had Children by Choice which are a pro-abortion counselling provider. You have not really had, in my opinion, any of those pro-life or more moderate counselling groups, so I do not think that is a fair assessment. You have heard who you have heard, as a general observation, and I think it would. By having a provision for abortion for social reasons, current and future, as well as the usual psychological and mental, it really does make provision for abortion for any reason, and because there is no upper gestational limit, until birth, so that is a true statement and I stand by it.

Mr BERKMAN: You would be aware though—again, we have heard this from both legal experts and from AMA Queensland—that the suggestion that a termination might be allowed purely on psychosocial reasons or social reasons, even as I think you have suggested, stands in stark contrast to the provisions of the bill which require that all medical circumstances—physical, psychological, social reasons, considerations and the guidelines—must be considered in any decision around termination.

Ms Johnson: I will just say once again that in terms of the submissions there have been a number of lawyers who I personally know who have put submissions in raising alarm bells about this particular piece of proposed legislation. As I said before, there is a lack of impartiality. It could be an abortionist who is the first doctor and the second approving doctor could be an abortionist. The second doctor does not have to sight the woman or her file. I think there are clear very concerning poor governance issues around the second approval.

Mr BERKMAN: Just very quickly, you have used this term 'abortionist' quite routinely as well. Do you consider that any—

Ms Johnson: Sorry, I missed what you said. What did you say?

Mr BERKMAN: In your evidence previously and now you have used the term 'abortionist' quite routinely. With regard to any all-options counselling, which addresses the possibility of parenting, adoption or abortion, is anyone who gives that counselling necessarily an abortionist if it is a part of the consideration?

Ms Johnson: When I use the word 'abortionist' it refers to a medical doctor who performs abortions. That would be their career.

Mr BERKMAN: Thank you.

Mr McARDLE: Thank you, ladies, for coming in today. Dr Purcell, your answer to my friend's suggestion about objection based upon conscience raised a point. You are not a member of the AMAQ?

Dr Purcell: No.

Mr McARDLE: Do you consider yourself bound by their terms and conditions in relation to objection based upon conscience?

Dr Purcell: I do not feel myself bound by the AMA if I am not a member of it and I do believe that conscience is a very important issue for a doctor. A referral process is not just a bit of paper; it is a considered decision that the person that you are sending for an abortion, in this case, is necessary or is in her best interests. You have to consider what process you are sending them to, what might happen to them, all those sorts of things.

Mr McARDLE: Thank you very much.

CHAIR: Just to confirm, when you become a registered medical practitioner the very ethos of providing health care is first do no harm. Is that correct?

Dr Purcell: That is right, yes.

CHAIR: Thank you very much to Cherish Life for your time this morning.

ARONEY, Professor Nicholas, TC Beirne School of Law, University of Queensland

FOGERTY, Ms Rebecca, Deputy Chair, Criminal Law Committee, Queensland Law Society

HARPUR, Dr Paul, TC Beirne School of Law, University of Queensland

McLINDON, Dr Luke, TC Beirne School of Law, University of Queensland

TAYLOR, Mr Ken, President, Queensland Law Society

WALTERS, Ms Adrianne, Senior Lawyer, Human Rights Law Centre

WILLIAMS, Ms Karen, Chair, Health and Disability Law Committee, Queensland Law Society

CHAIR: Good morning, everybody, and thank you for being here today and contributing to the inquiry before us on termination of pregnancy. I do not know in which particular order you want to start, but I invite Dr Paul Harpur to make an opening statement.

Dr Harpur: We have a joint submission with my colleagues to my left, so I think Nick was going to do the joint opening and then give us—

CHAIR: That sounds fine. Go ahead.

Dr Aroney: Thank you for the opportunity to appear before the committee. In the written submission prepared by Dr Harpur and Dr McLindon and myself, we note that the Termination of Pregnancy Bill is based on the report of the Queensland Law Reform Commission and in our submission, while the report covers an admirably wide range of issues, we respectfully submit that the report gives insufficient attention to Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities and that this has given rise to significant shortcomings in the bill and the policy settings associated with it. Dr Harpur is able to brief the committee on the full breadth of Australia's obligations under the convention from the perspective of a person with disabilities and Dr McLindon is able to address the medical and clinical implications.

In short, our concerns relate to three issues: first, disability selective abortion; second, free informed consent to medical treatment; and, third, substituted decision-making, particularly as these relate to the problem of coercive abortion, especially for women with disabilities. In a separate submission to the committee, I have myself drawn attention to concerns about the safe access zones provisions in the bill and their impact on the constitutional freedom of political communication, and I will just very briefly outline those.

In 2016 I appeared before the committee in relation to the previous Health (Abortion Law Reform) Amendment Bill. At that time I submitted to the committee that there were significant doubts about the constitutional validity of the proposed law. The main thrust of my submission to the committee today is that, while the 2018 bill avoids the defects of the 2016 bill, there is significant risk that the bill errs in the opposite direction.

There are three important reasons why I submit that the current bill is constitutionally vulnerable. First, while the 2016 bill was limited to prohibiting conduct that was harassing, hindering, intimidating, interfering, threatening or obstructing, the current bill does not directly prohibit any of these obviously inappropriate behaviours that are liable to cause considerable distress to vulnerable women. This is very peculiar. Secondly, while the 2016 bill was limited to behaviours intended to stop a person from having or performing abortion, the current bill goes beyond this. Section 15 prohibits anything that, among other things, would be reasonably likely to deter someone from undergoing a termination. This is a lower threshold than was established in the 2016 bill.

Other Australian jurisdictions like the ACT say that the conduct must be intended to stop a person from having an abortion et cetera. Others like Victoria and Tasmania focus on conduct that is besetting or harassing et cetera or is reasonably likely to cause distress or anxiety. The current Queensland bill does not do any of this. It merely applies to conduct that is reasonably likely to deter a woman. Deter is a broader concept than to stop something from happening and reasonably likely is easier to satisfy than intended. On one view, reasonably likely to deter would be satisfied if a person within a safe access zone offers a woman reason merely to consider whether to have a termination.

That is drawing a very wide net. For example, offering personal, financial or emotional support or offering information that such support is available might well deter a woman from deciding to have an abortion.

But is it necessary to prohibit such unobtrusive, respectful and supportive conduct? Certainly conduct that is obtrusive or disrespectful or intimidating is a totally different matter. It is totally legitimate for the law to prohibit such behaviour, but it is not necessary to prohibit conduct that is entirely unobtrusive, respectful and supportive. On the contrary, such conduct is supportive of the dignity and wellbeing of women.

This brings me to my third key point—and I will close with this—that the High Court of Australia has tended recently to adopt a more rigorous approach to determining whether a law contravenes the constitutional freedom of political communication and in particular a majority of the court seem to be concerned very much that the law must be necessary in the sense that it must adopt the least intrusive means to achieve the objective and in my submission—and I can expand on this—I think there is a real risk that the bill as drafted would fail that test. Thank you.

CHAIR: Thank you very much. We will move to the Queensland Law Society at a point in time. We might just take to your points there so we do not lose the momentum of the questions. Obviously you are referring to the Queensland Law Reform Commission's provisions around, in the drafted bill, safe zone and the 150 metres. There are two cases, I think, in the High Court that are looking at that. Of course we have our sub judice rule in that we cannot talk to things that are before the courts, but we understand that there is something happening in other jurisdictions on that issue. I just wanted to clarify that for observers.

Mr McARDLE: Thank you, Professor. You were here last time, I recall, and gave similar advice in relation to Tasmania. Are you indicating that the clause as drafted could fail in total, or could parts be severed but the balance be maintained by the High Court if it got to that point?

Prof. Aroney: That is not an easy question to answer at such short notice, and I appreciate everything has been rather rushed. I think it would be very difficult to sever it. My submission is that a more direct provision that was aimed at behaviour that is obstructive and uses those words that are in the other legislation would be more narrowly tailored to address actions and conduct which is likely to cause a great deal of distress to a woman who might be approaching a termination clinic, rather than a very broad net that the act currently casts over behaviour that, on one hand, could be harassing—and that is what should be targeted—but there could be behaviour that is supportive and respectful and unobtrusive, and the legislation captures that as well. To my mind, that is the problem with the bill.

Mr McARDLE: Just say, for example, the court did determine that that clause was invalid. Can you offer an opinion that would not then invalidate the bill or the act?

Prof. Aroney: It would probably have an effect only to the particular section.

Mr McARDLE: Get that very clearly on the record. It is only in relation to that particular section of the act. It would not invalidate the rest of the bill because it is not crucial to the operation of the bill, per se, is it?

Prof. Aroney: The balance of the bill could still operate.

Mr McARDLE: The bill was drawn by the Queensland Law Reform Commission, and you would know the people on that commission. I suppose it goes to the point that no human being is infallible. There are always, with human nature, risks in simply adopting a stated position as being correct. At the end of the day, what one human being says is right or wrong—after winning all the way through, you could lose in the High Court and that could strike down the relevant section. Could you comment on that?

Prof. Aroney: That is true. As I mentioned, I think there are signs that members of the High Court are taking an increasingly rigorous view about discerning whether legislation contravenes the implied freedom of political communication. It is my submission that the requirement of necessity, and that legislation must adopt the least intrusive means to achieve its objectives, is the particular aspect of the current test that at least a plurality of the members of the court appear to be adopting is where this proposed legislation is most vulnerable.

Mr McARDLE: I am not quite certain where the matter is before the High Court in its stages. If the High Court came down against the provision in the Tasmanian legislation, in your mind that would cast serious doubt, would it not, on the particular viability of certain portions of this section in the Queensland legislation?

Prof. Aroney: I would submit that in this particular respect it raises that issue. One of the reasons the court struck down the legislation in Tasmania was that the definition of a protected business access area was vague and very difficult to apply in practice. I would submit that this could well be the case in Queensland for another matter that I have not mentioned. That is, the safe access zones are defined, as you know, as an area within 150 metres of premises where terminations are ordinarily provided. Given that terminations can be provided by the administration of a drug, any suburban medical practice which has received the necessary accreditation could be the centre of a safe access zone—but who would know whether a particular medical practice had received the accreditation?

I had a quick look at my local village shopping centre and I noticed that there seemed to be at least three medical centres there. The consequence of this bill would be that the whole shopping village would become a safe access zone, so that would mean that if I even met a friend who happened to be walking to a clinic where that service was being provided and I had a conversation with them and something that I said could dissuade them or at least make them consider whether termination—I could offer them support, for example. That could well be caught under the bill, because it is so broadly drafted. That is probably not the intention of the drafters, but the difficulty, and the defect in the legislation, with all due respect, is the breadth at which it is stated.

Mr McARDLE: I think you said the High Court had determined the Tasmanian matter; is that right?

Prof. Aroney: Yes.

Mr McARDLE: It has?

Prof. Aroney: We are talking about the environmental protest legislation that was struck down. Quite distinct from that, there is other abortion zone access area legislation that is currently before the High Court that has not been determined.

Mr McARDLE: Would you give to our secretariat the citation of the High Court determination? There may be a relevance in relation to this particular—

Prof. Aroney: That appears in my written submission as well.

Mr McARDLE: Thank you very much.

Ms BOYD: In your submission you suggest that the safe access zone provisions of the bill are unconstitutional in so far as they breach the implied freedom to political communication. What is your interpretation of the kinds of behaviour that would be prohibited within the safe access zones under the provisions of the bill?

Prof. Aroney: As I was indicating, it captures any behaviour that could be reasonably thought to be likely to deter someone from having a termination. Therefore, it captures obtrusive and rude and harassing behaviour—that is what the law should be targeted at—but in addition it would capture behaviour that is unobtrusive and respectful and compassionate. That is where the legislation overreaches, in my submission.

Ms BOYD: Can you explain to the committee how the conduct of protestors towards women accessing the clinic could be categorised as political communication?

Prof. Aroney: That is probably most easily answered by reference to an analogy. One of the decisions the High Court had to consider some years ago was Levy in Victoria. That involved a gentleman by the name of Mr Levy who wished to protest against duck hunting, and there was a law in Victoria which prohibited entry into a duck-hunting zone during the hunting season. It was stated that Mr Levy wanted to be there physically present to protest against the action of duck hunting, to be seen publicly to be rescuing injured ducks, to draw the attention of the public to what duck hunting actually involved. I would propose that, by analogy—there are a lot of analogies to the conduct of people who are, on one hand, protesting abortion, which does happen, but also people who are providing or wanting to provide support to people who might be facing such a difficult decision.

Mr HUNT: Do you broadly support there being a safe access zone with provisions that include harassment and some of the other things you mentioned that may stand up in the High Court?

Prof. Aroney: I do support legislation that is narrowly tailored and targeted at what is obstructive or harassing behaviour. I do think, though, that there are some questions to be asked about a provision that would be targeted at legislation which might cause distress, if the test is subjective to the person involved.

There does seem to be some indication in the High Court that freedom of political communication does involve understanding that political debate is a robust thing and that sometimes things are said that are subjectively hurtful and the High Court has to strike a balance with that. There

is a very interesting decision involving a fellow called Monis, who unfortunately is well known for other reasons, and the sorts of things that he wrote. He wrote letters to people and they were very, very distressing, but the High Court still split on that issue about whether political communication might necessarily involve causing people some distress. It is a very difficult decision that the court faces in situations like that.

Mr HUNT: Certainly, with 30 years as a police officer myself, I have seen a lot of protest activity and a lot of intimidation, harassment et cetera. What makes this unique? Are the current laws sufficient to protect people in these situations?

Prof. Aroney: I have not done research to see whether the current, existing laws are sufficient, so I have no comment specifically on that, but I would reiterate—

Mr HUNT: Public nuisance, for example.

Prof. Aroney: Yes, but I am not in a position to comment specifically on that.

CHAIR: I thank representatives from the school of law, University of Queensland, for your contribution. We are going to move over to the Queensland Law Society and Mr Ken Taylor. Just in the interests of fairness and time, we might now give some time to the Queensland Law Society. Would you like to start with an opening statement?

Mr Taylor: Thank you for inviting the Queensland Law Society to appear at the public hearing on the Termination of Pregnancy Bill. My name is Ken Taylor. I am the president of the Queensland Law Society. The society is an independent, apolitical representative body and the peak professional body for the state's legal practitioners, whom we represent, educate and support. In carrying out its central ethos of advocating for good law and good lawyers, the society advocates for upholding the rule of law and ensuring that legislation aligns with fundamental legislative principles and is a reflection of evidence based policy.

The Law Society has considered the issues raised by the QLRC inquiry and contained in the bill at length for several years. In 2012 the society provided a letter of support to the Medico-Legal Society in response to their call for a review of termination laws in Queensland. More recently the Law Society health and disability law committee has been considering these issues in depth since 2017, prior to the Law Reform Commission's recent inquiry. Since January 2018 the Law Society has consulted with members in a concentrated manner following the referral of the issue to the QLRC. In this process we received feedback from our wider membership.

A comprehensive review of the issues was undertaken by expert practitioners who practise in areas relevant to this inquiry by several Law Society policy committees. In particular, I note the efforts of the expert practitioners who comprise the Law Society health and disability law committee, the criminal law committee and the family and domestic violence committee, whose members assisted in compiling written submissions on the bill.

I refer the committee to the society's comments in our submission with respect to safe access zones. It is our submission the definition of 'prohibited behaviour' as drafted demonstrates some inconsistency with the policy intent described in the explanatory notes regarding the behaviours which are to be prohibited within the designated zone. I appear today alongside two of our subject matter experts on these issues, Rebecca Fogerty, who is an accredited specialist in criminal law and the deputy chair of the Law Society criminal law committee; and Karen Williams, who is the chair of the health and disability law committee. Karen and Rebecca would be pleased to field questions from the committee which relate to the bill or the Law Society's submission.

CHAIR: Thank you very much. Ms Walters, did you want to make any statements before we open up to this particular group? I think you all share a common interest in this area. Did you want to make any remarks?

Ms Walters: Thank you for the opportunity to appear. The Human Rights Law Centre welcomes the Termination of Pregnancy Bill. It will at long last bring Queensland's archaic abortion laws into the 21st century and, in doing so, promote the right of every single Queenslander to control their bodies and their lives.

Queensland's current abortion laws are hopelessly out of step with community values and modern medical practice. Although it is legal to access and provide an abortion in some circumstances, it nonetheless remains a criminal offence in Queensland. The laws lack clarity and they create fear and confusion for women and doctors.

Women's basic rights to non-discrimination and to freely choose if and when we have children are undermined by a system that threatens prosecution for personal medical decisions. Queensland women are being forced to travel long distance and even interstate, at great personal and economic

cost, for health care that can and should be provided in Queensland. Some women are even resorting to self-abortion—so trying to procure an abortion themselves. This is plainly unfair and unacceptable in 2018 and it must change.

The Human Rights Law Centre supports the passing of this historic bill. It is essential to improving health outcomes for women. It would see abortion finally treated as a health matter to be determined between a woman and her doctor. Ideally, we would like to see an amendment made to the safe access zone provisions so that they better fulfil their vital purpose of protecting the wellbeing, safety and dignity of women, patients and staff. We would also like to see the use of gender-inclusive terms.

Passing the bill would demonstrate that Queensland parliament not only respects women as competent decision-makers over their bodies but also is committed to promoting women's health, safety and equality. We urge the Queensland parliament to pass this bill and we urge the Queensland government to make sure that services are affordable and accessible to all Queenslanders.

Ms PEASE: Thank you very much for coming in, everyone. I appreciate your time and all of your submissions. My question is to the Law Society with regard to the evidence we have heard about the distress and fear experienced by staff of clinics as a consequence of protest activity. What do you feel about the rights of those workers to a safe workplace free of harassment provides a valid justification for limitation on the freedom of political communication in the 150-metre zone?

Ms Fogerty: There are a number of different aspects to your question. The first is directed towards constitutional issues. Another aspect of your question, as I understand it, is in relation to health workers who are accessing clinics in the course of their ordinary employment. The Queensland Law Society's position in relation to the draft bill is that safe access zones are important, because much behaviour that occurs outside a clinic, whether it is targeted at a patient or at a health worker, does not necessarily fit within many of the pre-existing provisions. For instance, protest would not amount to a public nuisance offence; harassment would not necessarily amount to a public nuisance offence; nor would prayers or displaying placards.

It is difficult to see how that behaviour could be captured by other pre-existing criminal laws, such as stalking or an offence that is often referred to but rarely utilised, that is, use of a carriage service to menace, harass or cause offence. In our view, safe access zones, therefore, provide an acceptable balance towards achieving a safe work space for people who work in clinics, as well as access to safe and dignified medical treatment.

In terms of the constitutional questions, currently there is a matter before the courts. It cannot be said that there are not potential constitutional issues. It is the clear law in Australia, though, that the right to freedom of speech and freedom of communication is not an unqualified right and that safe access zones represent an extremely modest restriction on free speech. Anti-abortion campaigners are still free to protest anywhere else they like; they are just not able to protest within 150 metres of a person who is seeking to access an abortion.

To use the words of the United States Supreme Court, which has upheld the constitutional validity of safe access zones—arguably a jurisdiction with a far more vigorous and established jurisprudence on freedom of speech—safe access zones are a bright-line prophylactic. They are, in fact, one of the best ways to guarantee and promote freedom of speech in this context, because of the clarity and—subject to Professor Aroney's comments—lack of subjectivity that they provide compared to other options. Does that answer your question?

Ms PEASE: Thank you very much.

Ms BOYD: My question is to the panel. We have heard from other submitters that the bill ought to prescribe the mechanism for obtaining free and informed consent, a cooling-off period and a requirement for a woman seeking a termination to receive counselling. What is your position on those suggestions?

Mr Taylor: It is really a question that is to be decided by others, to be frank. If there was to be any proposed legislation dealing with those matters, we would be happy to consider that to see if it would achieve the objectives that you wish to achieve and to see if there would be any unintended consequences with that. We have not ourselves considered anything about the need for counselling as such. We have confined our submissions and consideration really to the black letter law, so to speak.

Ms BOYD: In terms of the Queensland Law Society, these particular components are not things that you have identified as issues within the current legislation before the House?

Mr Taylor: No, not that anyone has considered those.

Ms BOYD: Ms Walters, would you like to make some comments?

Ms Walters: In relation to cooling-off periods and mandatory counselling, we absolutely do not support those things being included in the bill. They are two measures where the biggest impact would be felt by the most marginalised and vulnerable women. They would see women delayed in terms of accessing treatment. There is no evidence to show that mandatory counselling would benefit women in their decision-making. Absolutely, counselling should be available pre and post abortion for those women who seek it. We absolutely support that. However, it should never be a mandatory requirement in law. Women are quite capable of making decisions about whether they need counselling.

In terms of cooling-off periods, I am aware that in the United States these measures have been implemented. For women, for example, in regional and remote areas it can mean having to travel vast distances to access health care on more than one occasion, despite the fact that a decision has been made about what treatment is needed. Each time she has to travel to access that treatment, it can mean a day off work; it can mean needing to find care for existing children. The implications of it will be that those women who are in the most difficult circumstances are the most disadvantaged.

Ms BOYD: Would the witnesses from UQ like to add anything on that question?

Dr Harpur: I just note, as a person with a disability, I think I am the only person here with a disability; at least, I am the only person with a guide dog. There is an issue around supported decision-making and substituted decision-making for women with disabilities. I notice the report did not deal much with the Convention on the Rights of Persons with Disabilities. The Committee on the Rights of Persons with Disabilities, the CRPD, has talked about Australia's rights around abortions for women with disabilities.

One issue they have identified when talking about Australia's abortion laws was the issues around supported decision-making and the lack thereof. There is a general comment on that. We really should be paying attention to the Convention on the Rights of Persons with Disabilities, because ultimately it is the declaration of ability equality for persons with disabilities. It has a lot of protections for women with disabilities who have consent but, again, it is making sure that you understand what their wishes are. For some impairment categories, that can be challenging.

Ms BOYD: Dr Harpur, am I to understand that you do not feel as though the current legal and professional frameworks for informed consent and substitute decision-making are adequate?

Dr Harpur: Overall, there has been a lot of criticism that laws in Australia have not enshrined supported decision-making. I think there could be some reconsideration. We have not had time to go into it in depth. I think there is definitely scope for greater consideration of mandating that women, for example, who have difficulty in articulating their wishes have that support mandated, so that the support is given to them to make sure that they are consenting to or refusing the abortion and we do not have the situation of forced abortions, which the convention has noted has been occurring. The OECD puts out statistics about these issues, so it is out there. I think we could make sure that the most vulnerable in the community are protected.

Ms BOYD: Does the QLS or the Human Rights Law Centre have a view on that particular issue?

Ms Williams: We have not formed a view in particular, but we note that these are important points, particularly in relation to the supported decision-making discussion. We would happily accept that as a question on notice, should the committee require further evidence. It is important to get clarity on the legislation and that has been our focus.

Ms Walters: I share Dr Harpur's concerns in terms of making sure that women and girls with a disability are able to make free and informed decisions about accessing health care. But I think it goes beyond abortion and beyond this bill. Certainly it is an issue in terms of sterilisation and other fertility treatments. It is something that probably warrants a dedicated focus and a focus on the rights of women and girls with disabilities, rather than trying to tack something onto a bill at this stage without proper consideration and consultation with those most affected.

Mr BERKMAN: I was interested in the section of the HRLC submission around gender selection and what you have put forward as the absence of evidence. Is there anything more that you might address the committee on with that issue?

Ms Walters: First of all, I think this has come up in the context of a Victorian study. It is a study of Victorian births, not Queensland births. In terms of the ratio of males to females born, overall the ratio was normal. It was as it should be. There was some variation in the ratio in relation to parents from particular countries, but it appears that that has been taken wildly out of context to suggest that

this bill is in some way going to result in sex-selective abortions happening throughout Queensland or an increase in that happening, if it is happening in Queensland at the moment. I am not aware of evidence that it is happening in Queensland.

There is an absolute lack of evidence that I am aware of to suggest that, by improving women's access to health services, information and support, you are going to end up with more sex-selective abortions. There is no evidence to support that. I think what would result instead is that you would have women from particular ethnic and racial minorities stereotyped and racially profiled and asked inappropriate questions by doctors who do not support abortion. The result would be that those women would have lesser access to health care than other women. That is an incredibly concerning thing. If sex-selective abortion is an issue in Queensland, I would encourage socioeconomic measures that tackle the attitudes and the values across all sectors of society that see women valued less than men.

CHAIR: That was very well articulated, Ms Walters. Dr Harpur, were you going to make a contribution?

Dr Harpur: I was not going to weigh in, but I would like to comment on disability selective abortions. On what you have just said there about valuing women above men, I think the idea that you could terminate a pregnancy on the basis of a disability says a lot about how society values people with disabilities. That is something that the Committee on the Rights of Persons with Disabilities has picked up on. It has criticised disability selective abortions in Australia, Hungary, Spain and the UK. It is very critical of their existence, because essentially it says to people with disabilities, 'You are not valued'. That is something that I think we should really consider. International norms are against these types of abortions.

Mr HUNT: Ms Fogerty, does the Queensland Law Society support broader safe access zones around other workplaces or is it just unique support to abortion clinics and those providing those services? If not, why are they unique?

CHAIR: That is drifting away from the intent of the bill, but I will allow the response.

Ms Fogerty: The Queensland Law Society has considered the issue of safe access zones in the context of the bill currently under consideration. We have not further considered the issue outside the scope of the bill currently before parliament.

Mr McARDLE: Thank you all for being here. My question is to any of the three representatives of the Queensland Law Society. We have had an argument not just in this hearing but also in other hearings that the safe access zone is an important criteria within the confines of the bill. There is also a desire in the public's eye for certain conduct not to take place. My comment is that is all well and good, but to try to put that into legislation could lead to that particular section being struck down by the court. Though you may have a desired outcome, the reality is that the court will instruct you as to what you can put in a section of that nature and we need to be guided by that process, not simply run on an emotional idea or ideal.

Ms Fogerty: That is so.

Mr McARDLE: My point is that, though people might want certain conduct excluded, the High Court may well say, 'No, you can't do that,' and so is very careful to ensure that any section in this bill falls within what the High Court says is valid and not simply run on a desired outcome without taking that consideration into account.

Ms Fogerty: That would apply to every law enacted; that it complies with any decision of the High Court.

CHAIR: I thank the representatives from the Queensland Law Society, the Human Rights Law Centre and the University of Queensland's School of Law for your important contributions.

McKENZIE, Ms Melanie, Harrison's Little Wings Inc.

CHAIR: Welcome. Thank you for joining us today, Melanie, from Harrison's Little Wings, which I understand is a not-for-profit organisation that supports women. I invite you to make an opening statement of maybe five minutes before we move to questions.

Ms McKenzie: My name is Melanie McKenzie, director and founder of a registered charity called Harrison's Little Wings—consumer on the Queensland Maternity and Perinatal Quality Council's congenital anomaly subcommittee.

Thank you for allowing me to come and share today the experiences of the families we support. These parents face perhaps the hardest decision of all when told of a fatal diagnosis of their unborn baby: whether or not to have a late termination. This is never a decision taken lightly or without much medical testing, diagnosis and medical advice. Some examples of diagnoses which as an organisation we have supported in the past are Trisomy 13, Trisomy 18 and foetal skeletal dysplasia just to name a few.

Harrison's Little Wings was established in 2011 after my fourth son received a diagnosis of diaphragmatic hernia. This was discovered at our 20-week morphology scan. We chose to continue with our pregnancy. Harrison was born full term weighing eight pounds 14 ounces. I watched my son who was in obvious pain having to have invasive medical procedures. I felt helpless as a mother and I was not even able to hold him to give him comfort. After 28 hours of life, we were told by the neonatologist that due to the lack of oxygen he was brain dead. We were advised to turn the life support off. This is a decision no parent should ever have to make. We made our decision out of love and turned the machines off. I then did what no parent should ever have to do. I held my son in my arms as he died.

I set up Harrison's Little Wings to provide support to families to try to ease unnecessary burdens on them at the hardest time of their lives. Harrison's Little Wings is a not-for-profit organisation that offers support to families who receive a poor or fatal diagnosis in pregnancy or the mother has a health issue that puts her life or her baby's life at risk. Our support services are peer support and practical support for families.

Harrison's Little Wings offers a compassionate, non-judgmental, safe and supportive space. At no time do we give families medical advice or influence their decision of whether they choose to terminate their pregnancy or continue with their pregnancy. That is a decision process that is with the woman, her family and her medical team. When a family comes to our organisation, the woman and her partner have already made the decision that is right for their family, their circumstances and made on advice from medical professionals and their baby's diagnosis.

We offer services to help families create memories around their baby. Creating keepsakes for families is extremely important. When you lose a baby you do not get to have a lifetime of memories. You have a small window to capture that baby's life story. We help facilitate photos, hands and feet moulds of their baby, and special outfits so they have everlasting memories.

Harrison's Little Wings supports families through their difficult pregnancy. That can be through sharing our volunteers' personal stories who have already gone through a similar experience to prepare them for what may come. Our volunteers share what they would have liked to have known when they were in that situation. We provide peer support, grief counselling and practical support like house cleaning, yard maintenance or nanny service.

We also have a heavy advocating presence within the maternity sector to ensure families who receive a poor or fatal diagnosis receive the best care possible. When receiving a poor or fatal diagnosis, families are devastated by the diagnosis and find the decisions they have to make traumatic and they are not made lightly. These babies are wanted babies and are very much loved. Families will consider what their baby's life would look like if they continued but, most importantly, they consider the impact the diagnosis has on their unborn child and their baby's quality of life. They make the difficult decision because they feel it is in the best interests of their child. They make the decision out of love. One of our families said, 'We make the decision to take away our baby's pain but we now carry that pain for the rest of our lives.'

The current abortion law does not allow women to make a decision on their baby's diagnosis. Many families find themselves in a situation where they feel that they have to lie about the mother's mental capacity to make the decision to terminate. This is unfair and is the beginning of cruel and unnecessary stigma placed around having a late-term abortion. Families should not be traumatised because the law does not allow them to decide on their baby's health.

Further, because of the greyness of the law, hospitals currently have a process in place which, whilst it is aimed at protecting health professionals, creates an added time pressure, lack of autonomy and burden on women making these difficult decisions. They are able to make the decision between them and their doctor now before 22 weeks but know that after this the decision will rest with an anonymous hospital committee. This is especially difficult for women who may have a diagnosis later than 18 to 20 weeks because of delayed scanning and/or those who require further testing, medical advice or counselling.

We support the proposed changes to the abortion law that after 22 weeks upon agreement of two doctors a woman can terminate her pregnancy. I would like to add that we would like to ensure the woman would not be traumatised anymore and not be required to meet with a second doctor and be forced to retell her situation unless she chooses to request a second opinion. We would like the two doctors to be able to consult professionally between themselves about the medical diagnosis of the baby.

Families are allowed to turn off a life support machine but women who want to terminate a pregnancy due to a poor or fatal diagnosis are unable to make a similar decision without lying about the woman's mental capacity. Many women make this decision not knowing that it is a criminal offence and then are horrified to find this out later. We support mandatory offering of counselling but it is the woman's choice if she takes that service.

Before I finish, I would like to thank the mothers whom our organisation has supported who have bravely attended the hearings over the last few days to also share their stories. I thank them for the courage it has taken to step forward and share such private and intimate details of their lives and the lives of their babies. I thank you in advance for your compassion and understanding towards us all.

CHAIR: Thank you very much, Melanie. What a remarkable story. You were with Ashleigh in Townsville and Zena Mason in Cairns offering peer support. Can I thank you, because I had no idea how Harrison's Little Wings has evolved? Harrison has left a legacy—a wonderful legacy.

Ms McKenzie: Absolutely. I was very blessed to have him and it is an amazing legacy.

CHAIR: Thank you for sharing your deeply personal story as well and for the wonderful work that you, and no doubt others in your organisation, do for women facing this incredibly difficult circumstance in their life. We might start with some questions.

Ms BOYD: Thank you, Melanie. I feel as though you have been with us through pretty much every submission over the last couple of days. What year did you found Harrison's Little Wings?

Ms McKenzie: 2011.

Ms BOYD: How many families have you supported since that time?

Ms McKenzie: We operate on a purely volunteer basis and so we have not really maintained records, as that helps with funding which we are seeking at this time to make our service a lot more sustainable, because we are the only ones in Australia who provide this service. We are in the process of doing that. We probably have not maintained the best of records in that process.

Ms BOYD: I know from talking with Zena yesterday and hearing her story that she discovered the existence of your foundation after she had made her decision and the support came post that. Typically, when do women or families contact your service—at what stage in their journey?

Ms McKenzie: Usually we are recommending for maternal foetal medicine units and health professionals upon diagnosis because then we can walk them through the process. We also give them information. We lay all the pathways out on the table of what there is to offer—whether they want to go down palliative care, for example. We try to make it so that it is very fair and the decisions are theirs. We provide them with what women wanted to know about the pathways when they went through their own pregnancy.

Ms BOYD: In your opening remarks you mentioned that to be eligible for the procedure women often lie about why they are having an abortion and that they find out through the process that it is a criminal offence. Do you support the proposed Termination of Pregnancy Bill 2018?

Ms McKenzie: Yes, absolutely.

Ms BOYD: What would you say to members of parliament who are considering whether or not to vote for this bill?

Ms McKenzie: I think it is really important to bear in mind the stories of the women you have heard over the last two days. This has not been an easy process for them. There is nothing worse than the additional trauma of having to wonder 'What if they say no?' because they have already made the decision, which is then put to a panel. It is already a difficult decision and they have already

gone through those processes. I have heard of families measuring the width of hallways, but a lot of these babies are not going to have any quality of life. A lot of them are in a vegetative state and doctors have said what their future is. These families are making decisions in the best interests of their babies.

I think it is all well and good to say that we should not have late-term abortions, but at the end of the day who is going to be there to support these families if they continue? Who is going to pay their mortgage when one person has to quit their job because they are a full-time carer? Who is going to give them family counselling when their marriage is breaking down because they do not have the capacity to leave that child because it needs 24-hour care? We just do not have that support system around families, and I think it is unfair to put them in a situation like that.

Ms PEASE: Thank you so much for coming in and thank you very much for the great work that you are doing in the community. I would like to share that I experienced a similar circumstance to you. Fortunately for me, my daughter was born healthy and I did not have to make that tough decision. Thank you for all of the work that you have done, because I know from personal experience what a difficult time it is. That is why it is really important to be reminded of the personal stories that we all have. We have all come across women and families who have had to make decisions, so thank you very much for supporting them.

I note what you said with regard to incompatibility with life. What do you say with regard to comments that there will be an increase in late-term abortions if this legislation is passed?

Ms McKenzie: I do not believe that at all. I have heard it said many times over the last two days that women with healthy babies will terminate and have late-term abortions. I cannot imagine that that would happen, considering that they have to go through many, many processes and they have to go through hours of labour to deliver their babies. It is not something that is just a medical procedure, where you walk out that day and it is done and dusted. It is actually giving birth, and that can be unbearable pain for hours and hours, if not days. I just find that very unlikely.

Ms PEASE: I am sorry about getting emotional, but I really appreciate the time that you have taken. I was not able to attend the other hearings, but I know how supportive you have been to many families through what is a very difficult time. Your comments concerning the impact of supporting the family financially were very interesting. They were all considerations that my husband and I had to make, so I appreciate you bringing them up.

Mr BERKMAN: Like everyone, I want to thank you for not just appearing today but for all your support for other witnesses who have appeared throughout the week. This point came up late in Zena's evidence yesterday. Can you reflect on the way that the current criminalisation of abortion has affected those women who you are supporting with something as fundamental as coming along and providing their stories and their evidence to the committee?

Ms McKenzie: It has been so important for the women. They are angry. They are over this sensationalisation in the media about what it really is like to have a late-term abortion, and they are angry that this sits in the Criminal Code. They are angry that they have to be subjected to that as well. At the end of the day, there is a stigma around it. Being in the Criminal Code creates more of a stigma because these women have to then be told they are criminals because of what they have done, when they made a parenting decision purely out of love.

Mr HUNT: Once again I will pass on my thanks too. It was a unique thing to hear people's emotional stories. It was emotional for all of us, I am sure, to hear people express the love they have for their children. It was a great submission to this inquiry.

In relation to a question about other aspects of the bill, do you agree that termination should be lawful on request up to 22 weeks? You have indicated that you are undecided. I invite you to leave it at that, but if you wish you may care to comment around other aspects of the bill.

Ms McKenzie: I am here representing Harrison's Little Wings. Obviously we support women whose babies have poor or fatal diagnoses, so we felt we could not have an opinion on that because it does not fall within our scope of work. We do not have women coming along and sharing those stories, so I did not feel that we could voice that. Obviously, we agree with exclusion zones. We do not feel like any woman should ever be harassed. I cannot speak on behalf of women who decide to terminate earlier, but it is not an easy decision to end your baby's life. I totally agree with exclusion zones and no woman should have to go through that.

In terms of counselling, as I said in my opening statement, we think that it should be mandatorily offered but then left up to the woman whether she chooses it or not. I think that counselling is a bit of an interesting area, because our organisation has a specialised grief counsellor. It is not just a normal counsellor: it is a grief counsellor. We think that grief counselling is different and we think that someone should be specialised in that area.

Ms BOYD: In terms of the submissions that we have heard from you today and also from Zena and Ashleigh over the last couple of days, it is my understanding that the current legislation causes women to rush their decisions. I also wanted to know if you support women who experience delays as a result of the current legal framework. Can you comment on those two things?

Ms McKenzie: We definitely hear that a lot of women feel rushed because there is this 22-week kind of barrier and obviously then it goes to a panel. Often women feel a bit stressed and think that they have to lie about it. From my understanding, if the baby is late term there is a bit of a different procedure, so that also is added stress. I think the hospitals prefer to have it done before 22 weeks if possible. There is a form of being rushed, which does make it difficult. When we advocate for women in this situation in the hospitals, we recommend that the process is slowed down so they are absolutely sure. I do not feel that any woman should be coerced into making a very quick decision. All the information should be laid out. We do recommend that it be slowed down so they can make that decision and create memories and things around their baby rather than making a quick decision. What was the second half of the question?

Ms BOYD: Do women experience delays?

Ms McKenzie: At times they can due to further testing. Because these are wanted babies, they want to make sure that the information they are given is absolutely 100 per cent correct, so sometimes there are delays in testing. Sometimes they are transferred. Some of the stories are horrific when they are bounced from hospital to hospital. That is why in our submission we said that we support two doctors, but we do not want women to have to be transferred to another health service to get a second opinion. It should be within the one service.

We hear of women who already have been through four hospitals to have this done because their diagnosis was done at one; that hospital does not have the capacity to do further diagnostic testing; so then they are sent to another. Here in Brisbane we have a Catholic hospital that does not do terminations, so when they go down that road they are then forwarded to another. Then the Royal Brisbane Hospital does the procedure and then they are sent back to their local hospital, so that is extremely traumatic and very fragmented care. These women fall through the cracks and are lost in our system. It is quite sad.

Mr McARDLE: Again I echo the sentiment of all on the committee, particularly Joan. I think it was a very brave statement to make in an open forum of this nature.

In relation to the question of consultation, you said that the lady need not go for a physical consultation, but you would anticipate that with two doctors it would be more than simply one doctor following the other and giving verbal consent. You would want the second doctor—given the condition the family are in concerning the foetus—to have a sit-down full conversation about exactly what the tests are showing to ascertain what is right, whether more tests need to be done and, more importantly, if the diagnosis is absolutely accurate.

Ms McKenzie: Yes, a lot of families go for additional testing to make sure. It is very traumatic if they have to then go to another service, retell their whole story again and have to go for additional tests. The expense on the health service would be huge and the expense on a family could potentially be huge. To have two consenting doctors within a health service to professionally consult between themselves and provide the diagnosis—and obviously the testing that has already been done—sit down and have a chat with the woman and her family.

Mr McARDLE: Would you like to see that consultation take place with the lady present so that she is advised by both doctors as to what their conclusions are so she is then fully informed and she can also then be reassured? I suspect any mother is going to say, 'They may have got it wrong,' but the second opinion of a doctor of equal status in relation to the issue being dealt with is equally important.

Ms McKenzie: I do agree with that, but I do not want the mother to be any more traumatised than she already is. Obviously it should be done in a very compassionate and empathetic way. We do not want to traumatise the families any more. I hope that our medical profession has ethics and morals and can speak to the woman and have those conversations with her. If she feels comfortable with that, then yes, absolutely.

Ms PEASE: Further to what we have been talking about with regard to the women who seek your support, given that it is currently criminalised how do they cope with that? Are they aware of it?

Ms McKenzie: Under the Criminal Code?

Ms PEASE: Under the Criminal Code currently.

Ms McKenzie: Most of our families will find out after this has happened. They are not informed that it is illegal to do this. Then they get angry. They are angry about it because why should their decision be taken away from them or potentially be up for prosecution? I know that the women who have come and spoken over the last two days are angry. They know there could be legal ramifications, but at the end of the day they are over the misconception out there of what it is like and how traumatic it is for families and how loved those babies are.

Ms PEASE: That is right: those decisions have been made out of love.

Ms McKenzie: Yes, absolutely.

Ms PEASE: What you are saying is that you do believe that abortion should be a health issue and not a criminal issue.

Ms McKenzie: Absolutely.

Mr BERKMAN: It just occurred to me it was a common feature of the testimony from Ashleigh and Zena that each of them felt very rushed in the need to make an extraordinarily tough decision. Can you tell us from your experience how common that is? How do you anticipate the bill may change the current situation?

Ms McKenzie: They absolutely do feel rushed. Health services are under a timely demand as well. They are often rushed through the process. That 22 weeks seems to be this big red warning, flashing light, that we have to get it done. I think changing the law will help that. It will help slow the process down because there will not be the rigmarole that has to be gone through now—a lot of lying, I know even for health professionals.

I do not think there are accurate statistics on what is really going on out there currently, because a lot of the time they are put down as stillbirths. There is not any true reflection within our statistics of what is going on out there and why women are terminating and what issues there are. I think it will definitely help in slowing that process down and taking away that rushed process, because it will be only two consenting doctors and then it can go on and the woman will not have that glaring 22 weeks. Even though there still will be two consenting doctors, I think that is a kinder process than what we have now.

Mr BERKMAN: Is it fair to say, given your experience in this space, that by slowing the process down and giving families more time to make these decisions we are not necessarily going to be giving—we will see a variety of outcomes, whether that is continuing with the pregnancy or termination? It is not simply that they have more time to decide to terminate?

Ms McKenzie: No. Even if you talk to Ashleigh and Zena over the last two days. Both of them said they would never change their decision. It is not about changing their decision: it is more about creating memories and supporting that mum and her taking that time and doing what she needs to do and not feeling that the process is rushed. I think Ashleigh was the one who said she would have given an extra week just to be pregnant again, just to feel her baby move inside, and spend that time. It is about creating memories, and that is so important for any parent who loses a baby. You do not have a lifetime of memories of when they rode a bike for the first time or took their first step. It is about capturing a very, very brief moment with very limited things to create memories around. Taking that time is so important.

CHAIR: Ms McKenzie, on behalf of the committee I thank you. Thank you for the work you do. It has been wonderful for you to present here today and support those ladies in the past couple of days in the regions. We really value your contribution. Thank you for your time today.

BAKER, Mr Alan, State Committee Member, Australian Family Association

DUFF, Mrs Angela, Queensland Vice-President, Australian Family Association

CHAIR: Welcome to you both and good morning. Thank you for your contribution today. We look forward to hearing from you. I ask that you start with an opening statement before we move to questions.

Mrs Duff: The Australian Family Association strongly opposes the abortion bill before the Queensland parliament which is extreme, brutal, antiwomen and unnecessary. It is extreme because the price of endorsing the removal of any restriction on abortion in the first 22 weeks of pregnancy is that abortion will be legal for sex selection. This is a fact. Abortion for any reason includes sex selection. Abortion for sex selection is not legal under current Queensland law as interpreted by the courts because this is not a situation where there is a serious danger to the woman's physical or mental health. The inconvenient truth is that abortion for any reason means legalising the killing of unborn female babies for the crime of being a girl.

Our YouGov Galaxy poll of 1,000 Queensland voters in August 2018 shows that only eight per cent of Queenslanders, including just five per cent of women, support sex-selective abortions, with 83 per cent opposed. It is brutal because abortion from 22 weeks to birth would be legal with the approval of two doctors for social reasons. If the bill is passed, the number of late-term abortions definitely will rise because of loose rules and expanded criteria. The 22-week gestational limit is a sham to trick the Queensland public into thinking there will be an effective restriction against late-term abortion. The fact is that the second doctor does not even have to see or talk with the woman and is not required to examine her file. If the abortionist does not bother to get a second opinion, there is no legal penalty. A law without a penalty is no law at all.

It is shocking to think that this new law would permit the destruction of viable babies of healthy mothers for social reasons. Because births and deaths of babies after 20 weeks of pregnancy are recorded by the government, these little ones are officially dead Australians. Some of the babies who would be killed under the proposed law will be older than wanted premature babies in the neonatal nursery in the same hospital. Over the last decade almost half of the late-term abortions in Victoria, which has a similar so-called limit, have been performed on psychosocial grounds. Our YouGov Galaxy poll in August 2018 showed that only six per cent of Queensland voters, including just three per cent of women, support abortion after 23 weeks, with 76 per cent opposed.

It is antiwomen because the bill contains no protection for women against coercion. Our YouGov Galaxy poll in August 2018 shows that 26 per cent of Queensland voters know at least one woman who was pressured by another person to have an abortion. Unfortunately, coercion on women and girls to have an abortion by their boyfriends, partners, husbands and even parents is very much a real thing in our society.

The poll showed that voters overwhelmingly want safeguards for women which are ignored in this bill. Eighty-eight per cent of Queenslanders believe that before having an abortion a woman should be receive free, independent counselling. Eighty-five per cent support an informed consent requirement where a woman considering abortion receives information on the development of the unborn child, the nature of the procedure, the physical and psychological risks associated with abortion and the support available should she wish to continue with the pregnancy.

Seventy-nine per cent support a cooling-off period of two or three days before making an appointment for an abortion and the actual procedure; however, the bill has none of these measures to protect women from coercion to have an abortion and to ensure informed consent. This is not a situation in which women have free and informed choice, and because of the absence of these safeguards and lack of support there is a lot of unwanted abortion. This is not a pro-choice bill; it is a pro-abortion bill.

The bill is unnecessary because under the current law abortion on request up to 22 weeks is already very accessible, with about 14,000 terminations performed every year in 23 private clinics throughout the state. The existing Queensland law against abortion should be retained because it has a vital educative role. It instructs society as to the seriousness of the act of abortion while the removal from the criminal law of any references to abortion would tell society that this form of intentional killing is morally trivial.

Our YouGov Galaxy research in August 2018 is the only opinion poll which has asked Queensland voters specific questions about the provisions of the Termination of Pregnancy Bill. It shows that 52 per cent of Queensland voters, including 57 per cent of women, oppose legalising abortion on request for any reason until 22 weeks of pregnancy, while just 29 per cent support this.

Sixty-two per cent of Queensland voters, including 70 per cent of women, oppose legalising abortion from 22 weeks until birth under a number of criteria, including social circumstances. Just 22 per cent support this.

Please listen to Queensland women and recommend that this extreme bill not be passed. Women deserve better than abortion.

CHAIR: Thank you, Mrs Duff. Polls are wonderful things. Politicians know polls very well. There are five million Queenslanders. You had a thousand people surveyed, and you called them voters. At least half of those five million will no doubt have the ability to vote but a thousand, I do not think—in my opinion—represents the voice of this state.

We have heard over the last few days, particularly in regional and remote Queensland, the difficulties faced by women. You have just sat here in this room and listened to Melanie share her story about the tragic personal experience of having to get a termination post 22 weeks because of foetal abnormalities. You have made a statement that any abortion is just not warranted. Do you stand by that statement? I am talking about foetal abnormalities, where the mother's life is put at risk. Do you stand by the statement that all abortions should never be performed? Is there a situation where terminations, in your mind, have to occur? I would ask Mrs Duff. She made the statement. I just want her response.

Mr McARDLE: Mr Chair, it is the association's statement.

CHAIR: Sorry, the association's statement.

Mr Baker: With respect, Mr Chairman, I do not believe she addressed that particular issue you are questioning us on now, and I do not think it is in the scope of this inquiry. We are dealing with the bill.

CHAIR: Your submission says the bill states 'there would be no regulation of abortion at any stage up to birth.' Do you stand by that statement?

Mr Baker: We do. Until 22 weeks it is on request, no questions asked. After 22 weeks it is with the consent of two doctors, and there are lots of doctors who have the ideology of placing a woman's absolute autonomy over the rights of the unborn child, even after viability.

CHAIR: You said in your opening statement that after 20 weeks a birth certificate is given.

Mr Baker: After 20 weeks.

CHAIR: That is correct.

Mr Baker: That is Queensland law.

CHAIR: Yes, it is. We just sat here with Melanie, who had to share her experience. I have family who, sadly, birthed two dead children. That gives them the right to bury those children who did not make it. I would just ask you to consider that in the context of this inquiry. The births, deaths and marriages act allows for 20 weeks for people to be able to bury their children who did not make it at birth.

Mr Baker: We support that.

Ms BOYD: You describe that your YouGov Galaxy polling has indicated popular support for abortion remaining in the Criminal Code. Does your organisation support that view?

Mr Baker: We do. As was said in the opening statement, the law is an educator. Abortion has been referred to quite a number of times in this inquiry. One of the principles this bill is based on is the concept that abortion should be taken out of the Criminal Code and treated as a health issue, but it is not like—

Ms BOYD: You think that abortion should stay in the Criminal Code in Queensland?

Mr Baker: We do.

Ms BOYD: Do you believe that doctors should face imprisonment for conducting abortions?

Mr Baker: If they are against the current law.

Ms BOYD: Do you believe that women should face imprisonment for having an abortion?

Mr Baker: No, and there is no chance of that happening under the current law. No woman has ever been convicted or jailed for an abortion in Queensland in the 119 years this law has been in operation, and there is no chance of that ever happening, and we are very pleased about that.

Ms BOYD: In your submission you state—

State parties are called on to address the power imbalances between men and women, which often impede women's autonomy, particularly in the exercise of choices on safe and responsible sex practices. Again, this is the feminist position on women, to be free from the patriarchal family, able to roam as a sexual predator in the same way as man at his worst, which ignores a woman's longing in her heart for motherhood and a lifelong relationship with the father of her children.

Do you stand by that statement?

Mrs Duff: I would, yes, because it is denying a woman's biology. There is an essential inherent in a lot of women I know that we are made for motherhood, and it is something that society should support and there should be policies to support motherhood.

Ms BOYD: Do you think every woman longs in her heart for motherhood?

Mrs Duff: It might not be biological motherhood, but there is an essential in caring and in reaching out.

Ms BOYD: Do you think a woman seeks an abortion to allow her 'to roam as a sexual predator'?

Mrs Duff: No. It is a statement that is saying we are denying a woman's biology and we are not supporting.

Ms BOYD: You also say—

Physical risks include infertility and breast cancer. Psychological risks include depression and other mental illness, suicide, attempted suicide, drug and alcohol abuse, sexual promiscuity or frigidity and general poor self-esteem. The psychological aftermath of abortion affects a woman's relationships with her partner, other children and her ability to cope with life's demands.

Do you believe that this statement is based on fact?

Mrs Duff: Yes, on evidence and research. We would not have put that into the submission.

Ms BOYD: I also understand that you believe there is a link between abortion and breast cancer. What is your evidence for that claim?

Mr Baker: There have been many studies around the world that show that. The medical profession generally does not accept that. The medical profession with this issue is where the medical profession was about 50 years ago with a link between tobacco and lung cancer. There are powerful sections within the medical profession that deny there is a link, but if you examine the biology there is a link. When a woman falls pregnant, hormonally her breasts start to change. If an abortion occurs early in the pregnancy, particularly if it is a first abortion, it does increase the risk of her getting breast cancer subsequently. Biologically, this is a fact because her breast cells—

Ms BOYD: It is a fact that doctors disagree with.

Mr Baker:—have stopped developing halfway through the process.

Ms BOYD: What studies show a connection between a woman having an abortion and becoming frigid or promiscuous as a result?

Mr Baker: I can cite a study that was on the front page of the *Sydney Morning Herald* in 2008. It is an important study for the committee to consider and it is in the submission. It is a gold standard 30-year longitudinal study published in the *British Journal of Psychiatry* by Professor Fergusson from New Zealand. It is stated—

A self-described pro-choice atheist and rationalist, Dr David M. Fergusson, Professor of Psychology at the University of Otago in Christchurch, New Zealand, undertook his first investigation with the expectation that his cohort data would prove that the apparent link between abortion and mental health problems would be explained by pre-existing factors. Instead, his data revealed that abortion was an independent "risk factor for the onset of mental illness."

The study found abortion increased the risk of suicide ideation by 61%, the risk of major depression by 31%, the risk of anxiety disorder by 131%, the risk of alcohol—

CHAIR: Mr Baker, that is a decade-old study. We have submissions that give us some accurate data—and I think we spoke about this in the last couple of days—that might contest that. It is study versus study. We will look at both of those in their light.

Ms BOYD: Just to go to the point, Chair, it does not actually address the question either.

Mr Baker: Actually, I was just about to address the question. It continues—

… the risk of alcohol dependence by 188% and the risk of illicit drug dependence by 185%.

You cannot dismiss this study. It is gold standard. It is a 30-year longitudinal study published by someone who is a self-described prochoice atheist. You cannot dismiss it because it is 10 years old.

Mr McARDLE: I think the Chair made a valid point. There are so many studies out there. The committee will have to assess each study as we go through. I think we simply endorse your right to make the comment. Others may, shall we say, argue the point but that does not take away from the veracity of your right to make the comment. We will then come to a conclusion as to which, if any, can be relied upon and that may take some time. The point is well made by yourself and I think we should now move on, Chair.

CHAIR: Thank you, Deputy Chair.

Ms PEASE: In your submission, you state—

The Bill has no recognition of men who provide the sperm which impregnates the woman's egg to create the unborn child. Clearly the Bill intends that men will not be involved or have any say in a women's decisions to abort their unborn child.

What about when a woman has been the victim of sexual assault or a violent rape?

Mr Baker: The current interpretation of the law allows for that to be legal on the grounds of serious threat to the mother's mental health. I do not know why we are focusing on that instead of getting rid of what laws already exist. Our position is the status quo. We want to see the law stay as it is under the current interpretation from 1986 by Justice McGuire.

Ms PEASE: Do you believe that a man should be able to prevent a woman from having an abortion if she does not wish to continue the pregnancy?

Mr Baker: I do not think the law should allow that.

Mrs Duff: I think we are looking at it from the other point of view—men coercing women into having an abortion. By taking it out of the Criminal Code, that safeguard is gone. There is a lot of pressure on a woman to have an abortion because there is a lot of responsibility with having a child. I think it is probably more from that point of view.

Ms PEASE: Your statement in your submission clearly indicates that you feel that men should have a right to be able to object; that was in the quote I read out from your submission. Do you believe a man should be able to say to a woman, 'You're not allowed to have that abortion'?

Mr Baker: No. That would be, as it is described, reproductive coercion. No-one is in favour of that. The pro-abortion advocates seem to close their eyes to this reality, pushing the line that reproductive coercion is just where an abusive partner prevents a woman from obtaining an abortion. We would be opposed to that. We just think men should have a say in the matter. Both common sense and the data will tell you that there are many more men who coerce women to have an abortion than to continue with an unwanted pregnancy. This is because domestic violence perpetrators typically do not want the financial responsibility of supporting a child for the next 18 years and they also want their partners to be sexually available to them. That is just common sense, and I have data here that I can refer to.

Ms PEASE: That is fine. Further, you were here when Melanie was talking about Harrison's Little Wings. In terms of keeping the status quo—and you have indicated that that is what you would like to see—Melanie mentioned the fact that women who have had to make a very tough decision made out of love then face being told that they have committed a crime. By maintaining the status quo, the women who have gone through what Melanie and other presenters have gone through would be a criminal. Would you like to comment on that?

Mr Baker: If you want to put forward a specific law to allow abortion for foetal abnormalities, in principle we would not support that. Ninety-five per cent of Down syndrome children are killed in utero as a result of search and destroy missions by medical eugenicists. We are not supportive of discriminating against the disabled in utero any more than we are in support of discriminating against born people who are disabled. It is legal under the definition, under the current law, with the judicial interpretation of Justice McGuire where there is a serious risk to the mother's mental health. That is the way in which foetal abnormality abortions occur. That is the status quo. With reference to the previous witness, I believe her situation was one where the baby had a lethal abnormality. Is that right?

Ms PEASE: Yes.

Mr Baker: Our position on that is to be pro life is not necessarily to be pro full term. I have had a friend in this situation and she gave birth early. The parents hugged and cuddled that child until it died a few hours later. The older brothers were there doing the same thing. It was a sad situation, but

a woman in that situation counsels with a doctor and she might decide to induce the baby early, and that is entirely her right to do so because she is not killing the baby. What kills the baby is the lethal abnormality that is inconsistent with life outside the womb.

CHAIR: Before we move to other questions, I just wanted to apologise. It is not my normal demeanour to start off with a barrage of questions but, quite frankly, I found the 'dead Australians' remark offensive.

Mrs Duff: What remark sorry?

CHAIR: The 'dead Australians' remark. I personally took that as offensive in the context that you were putting it. It was so important to my family to be able to bury their children with a birth certificate. That is not my normal demeanour so I wanted to clarify that. Did the Queensland Law Reform Commission get it wrong? This is a huge body of work. They are saying it is a health issue. You are saying it belongs in the Criminal Code. The AMA says it is a health issue.

Mrs Duff: Certainly, when you look at the majority of abortions which are performed for social reasons—to terminate a pregnancy is abnormal.

Mr Baker: This is a comment by Sir William Liley—

> The only thing medical about abortion is that doctors do them and must handle the complications afterwards.

Sir William Liley was the inventor of intrauterine blood transfusions. Professor Sir William Liley, the pioneer of modern fetology, said this about 40 years ago—

> No matter how bad mother's heart disease, renal complaint, diabetes or mental illness, no one would be suggesting abortion was essential if mother wanted the baby.

Abortion is a so-called medical solution to social problems. Can I say also that the reason we think it should stay in the Criminal Code is that it is not like any other health procedure. There is no other health procedure in Australia that kills another innocent human being.

Mr BERKMAN: Thank you for being here to give evidence. In your opening statement, Mrs Duff, you said that if this law passes the number of late-term abortions 'definitely will rise'. We have heard similar claims made by previous witnesses which appear to be based on no data. Do you have any evidence with data to back that up, or is it simply an assertion of your opinion based on certain logic?

Mrs Duff: It is the opinion when you consider the Victorian laws that were passed. The statistics in terms of what happened in Victoria show that late-term abortions did rise.

Mr BERKMAN: You have made a comment in your submission that the requirement for referral on conscientious objection is draconian. Are you aware that that is currently an obligation that all medical practitioners are subject to under the Medical Board of Australia's guidelines for good medical practice?

Mrs Duff: The requirement under the bill is that the doctor refers to a doctor who would refer for an abortion. That is the draconian part about it.

Mr BERKMAN: To be clear, the bill requires that referral be made to another medical practitioner who does not share the objection of the first practitioner. On the evidence that we have heard from the AMA this morning, this aligns directly with the current best practice guidelines and the obligations of medical practitioners. Do you accept that?

Mr Baker: It depends on how you interpret the guidelines, I must say, because the guidelines say that the doctor has an obligation to refer that woman for care. The best care may be counselling. It may not—

Mr BERKMAN: The guidelines say, if I might interrupt you just to be sure that we are talking to the same requirements, that good medical practice involves—

> Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

Mr Baker: We would say—and I am sure this is the position that pro-life doctors take—that abortion is so accessible in Queensland with 23 clinics that a woman does not need a referral. She can go straight to the clinic—

Mr BERKMAN: I am sorry. I am asking you do you accept that it is a current part of medical practitioners' obligations to refer?

Mr Baker: No, we do not, not on that wording. All the wording says is that they must not impede.

Mr BERKMAN: So you disagree with the AMA.

Mrs Duff: If they consider that it is not good medical practice for the woman to have an abortion—

Mr Baker: Not in her medical best interests then ethically they are bound not to refer.

Mrs Duff: Yes.

Mr BERKMAN: I would question your expertise in comparison to that of the AMA, but we will move on from that.

Mr Baker: The AMA represents 28 per cent of doctors. They are hardly representative of the majority of doctors in this state.

Mr BERKMAN: Thank you for that observation. You are an unashamedly ecumenical organisation.

Mrs Duff: Yes.

Mr Baker: Well, we are based on the Judeo-Christian ethic. We are not a religious organisation.

Mr BERKMAN: Your position is based on quite fundamentally a religious position—a Judeo-Christian tradition, you have said.

Mr Baker: Judeo-Christian values.

Mrs Duff: It draws on those principles, yes.

Mr BERKMAN: Do you believe that we, as legislators, should be making law on the basis of these same religious values?

Mrs Duff: I would ask you to consider it, yes.

Mr Baker: I would add that you ought to be making laws based on the best science and the best ethical and moral values based on the Judeo-Christian ethic, which is the foundation of Australian society.

Mrs Duff: This parliament has drawn on Judeo-Christian principles.

Mr BERKMAN: And we represent a highly secular society, but I will move on from that. A few witnesses have given evidence which refer to the role of law as a teacher. There appears to be no dispute in your evidence or in your position that abortion does happen. We accept that it is a reality in society. Is the law's role here as a teacher one that would teach women in difficult situations that they are criminals?

Mrs Duff: No. You are talking about in difficult situations to consider abortion. I would like them to consider other alternatives too, not to be driven to abortion as a solution to their difficult circumstances.

Mr BERKMAN: All-options counselling is something that you would support?

Mrs Duff: Yes.

Mr BERKMAN: Counselling that does include, that does contemplate, parenting, adoption and abortion as very real avenues for women to take?

Mr Baker: That is reality. Pro-life pregnancy counselling services in this state are non-directive.

Mrs Duff: You cannot force a woman not to have an abortion in this society. What is occurring with this bill is that if they are in difficult circumstances that is the only real option that they are given. Certainly we need to consider all options and alternatives.

Mr BERKMAN: That is not consistent with the evidence that we have heard from organisations that provide all-options counselling. I have taken my time. I will let other members have a go.

Mr McARDLE: Let's change tack a bit, shall we? Let's talk about access zones and areas around termination facilities, as wide as that term may be. Do you support that there should be zones around facilities that provide either advice and/or termination services so that people who are entering—either workers or women or their husbands or partners who are with them—are not accosted?

Mrs Duff: No. I do not support those safe access zones.

Mr McARDLE: What sort of conduct would you condone that would take place around that facility?

Mrs Duff: Conduct that does not harass, that does not block, that is within the current laws that we have.

Mr McARDLE: Would you endorse placards, prayer vigils, handing out pamphlets to women who are entering?

Mrs Duff: Yes.

Mr McARDLE: Would you also endorse the staff being spoken to as they are coming in and out of the facility about what they are doing is wrong?

Mr Baker: I make the comment that no-one supports women being harassed or intimidated.

Mr McARDLE: No, I am not suggesting that. I can come to you, Mr Baker, and talk to you very gently: 'Do you know, sir'—or madam as the case may be—'that you are doing the wrong thing here?' Do you support that one-on-one contact?

Mr Baker: If it were repeated enough, that would constitute harassment, wouldn't it? The current laws in this state allow the police to move on and arrest people for being a public nuisance. We believe that the police should be doing their job under the current laws to prevent women being harassed or intimidated in general cases of harassment and intimidation. We also think that that should apply to the staff.

Mr McARDLE: You would say that there is a fine line between the right of the police to move on and the right of protest and that could take place right up to the door or the steps of the premises?

Mrs Duff: It usually doesn't.

Mr McARDLE: No, but I am saying let's look at reality here as well in the sense that, if the law does not exist and it is not going to breach state law, that would on your interpretation give the right to me as a person to hold a placard outside the front door and people coming in would see the writing and I could hand them a pamphlet. You would see that as being a legitimate use of the authority you have?

Mrs Duff: Yes.

Mr Baker: On that point, we said in our submission that we received legal advice to the effect that the provision in this bill on safe zones would criminalise the actions within 150 metres of an abortion facility of a mother trying to persuade her daughter to continue with the pregnancy or of a boyfriend offering support to his partner if she decided to have her child. That is overreach, isn't it? We would put that to you.

Mr McARDLE: That is your commentary. If you want to table the legal advice, you can seek leave of the committee. I am not going to comment upon a piece of paper that I have not seen or have not read, and nor will the committee at this point in time enter into a debate about that. The other point I would like to look at is counselling. You referred to my colleague's suggestion of counselling as being a good one. Is that right?

Mrs Duff: Yes.

Mr Baker: Yes.

Mr McARDLE: How would that operate? Give me an idea of what you would do with counselling? How would it function? When a lady comes to your association, what happens?

Mrs Duff: We are not a counselling association.

Mr McARDLE: No, but what happens though? You must refer to somebody.

Mrs Duff: In counselling you would cover the risks of abortion—the psychological and the physical risks. You would look at other alternatives—adoption and support that they can access.

Mr McARDLE: That would be a good step, wouldn't it? Let's accept that the bill may well be passed. I know that you object to that. I understand your objection and I accept your right to have that objection. Counselling would be a critical component of any process, wouldn't it, from day one?

Mr Baker: Well it should be, but it is not required in this bill. There are no protections for women.

Mr McARDLE: I take that comment. You talk about sections 224, 225 and 226 of the Criminal Code and you say that their mere existence provide protection to a woman and their unborn child. We have between 10,000 and 14,000 terminations per annum in this state alone. You said, Mr Baker, 'It is never going to happen that a woman will, in fact, be charged in this state with an offence under

the Criminal Code,' and you made the comment, 'I don't think any doctor outside of Bayliss has been charged with a breach of the Criminal Code.' Leaving aside Cairns—they are fairly unique circumstances up there and really dealt with different charges entirely—the code has not been successful, has it? It has not stopped terminations?

Mr Baker: No. It has not. The current situation is like a social truce between those who are pro-life and those who would describe themselves as being pro-choice.

Mr McARDLE: Yes.

Mr Baker: I would like to see some common ground in this debate. I would like to see that women are protected from coercion.

Mr McARDLE: I agree.

Mr Baker: I think that there are a lot of unwanted abortions. We found that mandatory independent counselling occurred in South Australia in the early 2000s in the royal Adelaide women's hospital. Social workers provided that counselling. Then 12 months after that was brought in the abortion rate fell by 25 per cent. We hear about unwanted pregnancies but there are a lot of unwanted abortions. We ought to be doing better for women by providing free independent counselling separate from the abortion clinic with no vested financial interests and having an informed consent booklet like the ACT and a cooling-off period. These are basic consumer protections.

Mr McARDLE: The chair made the comment about a thousand people in relation to a sample. With respect, Galaxy and Newspoll poll politics on a regular basis with a lot fewer than that and we salivate over them.

CHAIR: I do not. That is a good point. Thank you both for appearing and for your contribution today. We will move on with our last witness for the day.

Mr Baker: Mr Chairman, can I seek leave to table a letter from YouGov Galaxy as to the veracity and accuracy of their poll?

CHAIR: Is leave granted?

Mr BERKMAN: I want to seek clarification. That was commissioned by Cherish Life and the Australian Family Association. Is that right?

Mr Baker: That is right.

Mr BERKMAN: Would I be right in assuming that the content of the questions asked were also put to YouGov Galaxy by AFA and Cherish Life?

Mr Baker: We did, but the Manager Director of YouGov Galaxy, David Briggs, says in this letter that YouGov designed the questionnaire.

CHAIR: I will pull it up there, Mr Baker, because, as you will recall, in the last parliament we gained the services of some academics to look at the polling that was provided and it showed that it was very middle of the road because it can be skewed one way or the other. We will have a quick look at the letter before leave is granted. Leave is granted.

PELLICAAN, Mr Peter, Private Secretary to the Archbishop, Archdiocese of Brisbane

CHAIR: Good morning, Mr Pellicaan. Thank you for being here today. Would you like to make an opening statement? We have limited time, as we have gone over, but we do value your contribution here today.

Mr Pellicaan: I will start by clarifying why I am here. The Archbishop—that is, the Catholic Archbishop—received an invitation earlier this week. He is in Sydney this week, so he sent me as his delegate. My statement today is on his behalf as a delegate of the Archdiocese of Brisbane, so it is not related to my own personal submission. I just wanted to clarify where I am coming from with this.

The review of termination of pregnancy law in Queensland and the proposed bill offers us an opportunity to address the following questions: what kind of society do we want to have, what values underpin such a society and how does legislation facilitate toward the kind of society we want? We, like others, wish to see progress, but what we mean by progress might differ at times from those who define themselves as progressive.

Most would agree that a society that recognises the value, equality and dignity of every human life and the freedom of every individual to make their own choices is a good society. What makes legislation regarding the termination of pregnancy so difficult is that the issue brings the abovementioned values into conflict. Freedom to choose and the protection of human life come into conflict because what we are debating is in relation to two lives, not just one, and both lives matter.

To speak of a woman's right is very important, but what of the rights of the unborn? Thus, our concerns regarding the proposed legislation are as follows, and I will list four. Firstly, the proposed bill does not adequately address the rights of unborn children. The legislation before the parliament implies that the unborn child has no rights and therefore no choice. If the right to life is the foundation of all other rights, it would appear that this proposed bill undermines the very foundation of all human rights. Thus, we maintain that there are never reasonable moral grounds for termination of pregnancy as defined by the commission in the Queensland Law Reform Commission WP 76.

Having made this position clear, we also point out that in the proposed bill there is no protection for the unborn before 22 weeks and after that an assessment is made on broad criteria that includes future physical, psychological and social circumstances which in our view are not adequately defined. Nowhere does the law make specific provisions to protect the interests of the child. As such, gender selective termination is lawful until 22 weeks gestation and possible until full term. Such gender discrimination is remarkable even by progressive standards and should be condemned and made unlawful.

Our position presupposes alternatives to termination which I now address as our second concern with the proposed bill. Secondly, women considering termination should be adequately informed of their options. Alternatives to termination should be made available and be supported by government, the law, civil society and religious institutions. It is only a person who is fully aware of all their options that really does have choice. Alternatives to termination include adoption, material, psychological and spiritual support for people in difficult circumstances who wish to keep their child after birth, and perinatal palliative cases in cases of foetal abnormality.

Given that termination is already widely available and practised in Queensland, we encourage the commission, this committee, the parliament and those involved in the development of clinical practice to ensure that these alternatives to termination are in place and that women are adequately informed of these in order to protect their own autonomy. It is our sincere hope that in doing so we can minimise the number of pregnancies that are actually terminated—something which should be desirable in our society.

Thirdly, non-governmental institutions should have the right to decline to be involved in the termination of pregnancy. The explanatory notes state that the provision of conscientious objection does not extend to hospitals, institutions or services. We object to this, firstly, because our Catholic healthcare institutions must have the freedom to choose the services they provide and ensure that these services reflect the values of the institution. This is indeed a decision of the governance boards of these institutions and not merely the medical practitioners. Secondly, it is an overreach of government authority to be dictating to non-governmental institutions what services they must provide. This aspect of the proposed bill is flawed both with regard to the termination of pregnancy but more broadly with regard to the relationship between government and private enterprise.

Fourthly, the law should facilitate a culture of care for the vulnerable. Law plays an essential role in informing culture and cultural norms. For example, whilst we have penalties for those who do not obey the speed limit, the law aims to develop the virtue of safe driving so that in the situation of

uncertainty such as an unmarked mountain pass we will drive at a safe speed and on the left hand side of the road. With this in view, abortion is always an undesirable scenario. No-one gets pregnant just so that they can have an abortion. Thus, we should not make laws that make light of these difficult situations and treat them as if the decisions made are as routine as a minor cosmetic procedure. They go to the heart of our society and, whilst we may wish to ensure that those who do choose to terminate are not further stigmatised or harmed, we should not treat exceptions as the norm.

In short, we oppose the proposed Termination of Pregnancy Bill 2018 on the grounds that it does not adequately address the rights of the unborn, it does not ensure adequate counselling and support for women, it does not protect non-governmental healthcare institutions, and it does not facilitate a culture in our state that cares for the most vulnerable in our society. We wish to collaborate and be part of the conversation with government in developing a society that recognises the value, equality and dignity of all human life and the freedom of every individual to make choices, but this bill as it stands is not the way forward. Thanks.

CHAIR: Thank you, Mr Pellicaan, for reading the archbishop's statement. As you have clarified, you have put your own submission in.

Mr Pellicaan: These are not his words, I should clarify.

CHAIR: Sorry, they are not his words; okay.

Mr Pellicaan: It is on behalf of the archdiocese.

CHAIR: Okay. Thank you for clarifying that. In fact, Bishop Harris in Townsville—a great man who does some great work in our local area—made some comments in the *Townsville Bulletin* on 15 August very similar to some of the words you spoke in your opening statement about the rights of the child. He said—

We speak about the rights of the mother, but the child seems to have none.

It goes further—

There is a disturbing trend in this country to devalue life from the beginning or in the womb or even at the end of life, where the sick and elderly are just as vulnerable.

That is something else that is going to test the health committee in time. He asks MPs to use our conscience to vote down the bill and speak courageously about our reasons. I can say as an MP in Townsville my reasoning is I believe it is a health issue. I take that from a significant time in treating people in my previous career. I think the position taken by the diocese seems to completely ignore a woman's right to have agency over her own body. That would be my response to that. It disregards the sometimes devastating reason why a woman chooses, and you have heard some of those stories here today, to access an abortion.

I understand it is a delicate position to have because you play such an important role in society and there are divergent views here, but it is a matter for the parliament and this committee to report on what we have heard to date. We thank you for your considerable air of expertise in coming from the religious sector with Catholic views as to why they oppose it, but it will ultimately be a matter for the parliament and for a conscience for all members. I am just trying to be as respectful as I can because I know the important work that you do in the community.

Mr Pellicaan: In response to the comment about autonomy for women, absolutely, and the church's position is very much in favour of women's autonomy, but the church is also very much of the position that there is more than one life going on here. Autonomy over my body does not necessitate the unborn child, which is a separate body. It is making that distinction that we are trying to say by saying both lives matter.

CHAIR: Okay. We will open it up for some questions, Mr Pellicaan.

Mr HUNT: Peter, thanks for coming along today. Full disclosure: I am a Catholic man myself, so I certainly understand the value we talk about in terms of the unborn child. You were present for the last presentation by the Family Association. I found some of that language to be quite judgemental and strong. I forget the exact words around abortion of children with Down syndrome, but it was very strong judgemental language. Does the Catholic Church endorse that sort of judgemental language? Do you think it takes the debate any further?

Mr Pellicaan: We do not think it takes the debate further usually, but I would just clarify to say that at the heart of the Catholic faith is love. Jesus says to love God with all your heart and love your neighbour as yourself. Regardless of our position in a given debate, it is essential that the how we go about debating is in the context of love. Using language that is unnecessarily inflammatory is not conducive to producing love and so it is not our approach to come out guns blazing with aggressive

language. We want to be in a conversation and in a dialogue about what is best for our state, and we are a stakeholder in that—a very large stakeholder—but we are not keen to be a part of inflammatory language and a heated, angry debate.

Mr HUNT: I agree. We heard earlier about disability abortion and the rights of the disabled person and the value of people with disabilities and also heard comments around who will be there to support us, who will be there to look after us, and it is a very difficult thing for a family to go through obviously. Despite the recent royal commission findings, the church does have a long history of assistance for people. Can you outline some of the things that the church does to support people in this situation as opposed to going down the decision to have a termination for a diagnosis of a disability?

Mr Pellicaan: To cover the main three, obviously we are a large healthcare provider nationally but also in the Archdiocese of Brisbane with our hospitals. We also have Centacare, which is a very large operation. One of our key areas in Centacare is care for the disabled. The other area of course is our schooling and our inclusion policies in our schooling that make it possible then to try and care for various situations that people might find themselves in. We are doing some things. Are we doing enough? Probably not. Can we do more? Absolutely. Sometimes we are good at saying no but not good at providing alternatives, and that is something that we need to work on.

Mr HUNT: Thanks.

Ms BOYD: I am also a Catholic, so it is a great opportunity to ask you some questions today. What is your understanding of the genesis of this bill, Mr Pellicaan, because I note in your submission you refer to it as the Jackie Trad abortion bill? You also reference the outcomes of this bill and attribute them to the Labor Party. What is your understanding of the genesis of this bill?

Mr Pellicaan: My own submission is not relevant to this conversation.

Ms BOYD: You just want to talk about the Archbishop's submission?

CHAIR: He did say that, yes.

Ms BOYD: That is great.

Mr Pellicaan: I was not invited—

Mr McARDLE: If I could interrupt, I think he is making it quite clear. The submission is not his.

Ms BOYD: I am talking about his own personal submission. I am referencing his own personal submission.

Mr McARDLE: But I think it is on behalf of the archdiocese.

Mr Pellicaan: The reason I clarify is that the invitation was to the Archbishop or a delegate, not to me as a resident of Aspley. My understanding partly was due to the submission that the bishops made to the Queensland Law Reform Commission, which is not this committee.

CHAIR: Just to clarify, members, you did say in your opening statement that you would not be referring to your personal submission, so we will just keep it in the context of that.

Ms BOYD: I am happy just to refer to the Archbishop's submission.

CHAIR: Thank you.

Ms BOYD: In the Archbishop's previous statements he has said that decriminalising abortion reduces abortion to just another birth control option. Do you think that women routinely rely on abortion as a contraceptive option at present?

Mr Pellicaan: I do not have any statistics, so I cannot give you a definite answer. People might surmise that that might happen, but I could not give you a definite yes or no on that without doing some research.

Ms BOYD: Are you able to take that on notice and come back to us with a response?

Mr Pellicaan: I can; sure.

Ms BOYD: Great; thank you. Do you support the use of contraception? Does the church support the use of contraception?

Mr Pellicaan: The church's position on contraception is controversial even amongst Catholics. The church does not support the use of contraceptive methods other than natural family planning that uses the body's own cycle. It is not an expectation that the government and anyone beyond the church would subscribe to that. There is a theology and a philosophy that flows out of that in terms of openness to life and an openness to full giving of self in a marriage relationship. There is a debate around that and there is good philosophical and theological reasoning for it, but I do not know that it is something that would inform this discussion.

Ms BOYD: Given that these comments have been made around abortion being just another birth control option, do you think that a woman takes the decision to have an abortion lightly?

Mr Pellicaan: No, I do not. Just to clarify or speak to the Archbishop's comments, I think what he is getting at that there—and this has been noted in the court of law, at least in America—is that at times people have abortions because of failed contraception. That is what he is getting at there. They have had sex, they have used contraception, the contraception has not worked, they have fallen pregnant and therefore are in a position where they have an unwanted pregnancy.

Ms BOYD: I see. In a recent online video, the Archbishop stated—

The Catholic Church ... is often slammed by people who say how dare we speak about abortion when we've done so many things wrong with child sexual abuse.

But if there is one thing the church has learned at great cost in recent years it's the need to protect the vulnerable at every point of the journey and the journey begins in the womb.

I've come to see that there's a link between abortion and child abuse.

Would you elaborate on the link you perceive between abortion and child abuse? Do you consider abortion to be equivalent to child abuse?

Mr Pellicaan: That is a good question. The answer to that lies in where you see human life beginning. Science tells us that human life, in whatever form, begins at least at conception and then moves towards birth. Where you draw that line of personhood is an academic question that continues the debate.

In the case of the abortion of a viable child, essentially you are taking a human life. The question is: when is it okay to take the life of another human; when is it okay to take human life? We are making that parallel between abusing children in any way which is absolute horror in our society and I have children myself; but doing that even before they are born is also a horror. That is the parallel that he is making.

Ms BOYD: Where you do actually strike that balance? Where is it along a gestational limit, for instance, that the weight of the foetus actual overtakes the weight of a mother? Say a mother has an illness and perhaps it is not possible for her to see the pregnancy through. Where is the church on that spectrum?

Mr Pellicaan: I would not use the language of 'overtake', because you have two humans who have equal value. I think that is an important clarification. However, there is clinical practice around that. What we are against fundamentally is the termination of a viable pregnancy. In the situation where if the child was to be born the mother would die, already there is in place clinical principles that deal with that situation and that is fundamentally different to the intent of killing a viable child.

Ms PEASE: Thank you very much for coming in. I am also a Catholic. I want to comment on the previous submission by the Archbishop. He stated that any attempt to harm an innocent human life is always morally inexcusable as it violates fundamental and basic natural justice. What would your advice be then to a woman who has become pregnant as a result of rape or been told that her foetus cannot survive?

Mr Pellicaan: Which question do you want me to answer?

Ms PEASE: Both.

Mr Pellicaan: Obviously, it is an incredibly difficult situation. I think just providing a clinical answer does not give credence to the situation that the woman is in, in terms of the horror of the experience of rape, the way that she feels concerning that and the fact that she is now bearing the child of her abuser. Therefore, it would be ill of me not to begin by saying that is a very serious situation that requires incredible wisdom in terms of pastoral care, counselling and support from family and the community that she is in. Whether it be a church community, a school community, a university community, she needs support.

In terms of the Catholic viewpoint, a human life has intrinsic value regardless of its origin. Therefore, again we come back to the case of when is it okay to take a life? Is it okay to take human life because I do not want it? We would say, no, that life has purpose and has meaning and, even though it was not intended, it can have a life of its own that can be incredibly profound and bring life to others. That is how we would respond there. The focus for us would be very much on support of the woman and how to walk her through that. Obviously she has autonomy to do as she wishes, but that would be our position.

Ms PEASE: Earlier, you said that the basic tenet of Jesus Christ is one of love. How can you show love and support to a woman who has experienced great trauma, either having been raped or had a child that, out of love, she has had to make some very tough decisions around. How can you treat her as a criminal? Can you justify that?

Mr Pellicaan: Treat her as a criminal in the current code; is that what you are saying? That is an interesting question, because then it is not so much about providing love and care for the person. Are you talking about the case where they have had an abortion and how you respond? Can you clarify that for me?

Ms PEASE: You about Jesus Christ being about love.

Mr Pellicaan: Absolutely.

Ms PEASE: That is our No. 1 tenet.

Mr Pellicaan: Yes, it is fundamental.

Ms PEASE: With that in mind, any woman who has had to make a tough decision is currently being treated like a criminal for making that tough call. Would that decision not be better placed under a health code rather than the Criminal Code, because it would really be talking about love in that position?

Mr Pellicaan: It is difficult to answer that question without looking at a specific case. Our flat-line position obviously is that no abortion is a good abortion. That is our bottom line. However, we accept that we are in a world that is full of difficult situations and relationships. Even for Catholics, though the ideal might be here, the reality of our lives is on a spectrum somewhere from here to here. In society we need laws that help people in every situation of their lives. It is important not to make laws that are just about the exception. It is also important to think about legislation in terms of the effect it has on culture. Therefore, is it a good thing culturally to say you can do this up to 22 weeks with no questions asked? We would say, no, because it says something about the lack of value on the unborn child. That is our concern there.

Mr McARDLE: Peter, thank you very much for being here today. I refer to the quote read out by the member for Pine Rivers, which appeared in Saturday's *Courier-Mail*. The Archbishop commented on a link between abortion and child abuse. Given the context of the term 'child abuse' in recent years in the royal commission, the Archbishop could have said the link between abortion and murder, manslaughter or unlawful killing. However, he deliberately used a term that is exceptionally provocative given the history of the royal commission and the findings. That concerns me a little. He says that he has found 'there's a link between abortion and child abuse'. If we accept child abuse in the common parlance as it is used in this day and age, what is the link? I do not understand that link as opposed to linking, potentially, in his theology, abortion to murder, manslaughter or unlawful killing. How is it child abuse?

Mr Pellicaan: The link between abuse and abortion—

Mr McARDLE: No, child abuse. That is what I am getting at.

Mr Pellicaan: The link philosophically between child abuse and abortion is that abuse of any other human being of any kind is in a category and it can go from fairly mild—many have experienced low levels of abuse and may not even recognise it is abuse—right up to the most extreme forms. Sometimes on that spectrum of abuse, you move from physical violence, sexual abuse, child sexual abuse is an incredible horror—

Mr McARDLE: Correct.

Mr Pellicaan: Taking someone else's life is also an incredible horror. On that gradient of abuse, there is a link in terms that they are both abuse, they are both horrors. That is the point that he is trying to make there.

Mr McARDLE: You do not think that there is an argument that could be put that the Archbishop is deliberately using a term to be provocative in relation to recent historical findings, et cetera, to make that link? That is what worries me. I have never seen that term used as a link to abortion. That is what worries me. It seems to be a very emotive intent behind it to make some sort of connection.

Mr Pellicaan: As I understand it, I do not believe his intent is how you are interpreting it. How I understand it is that he is trying to show that we are listening, we have heard from the royal commission, we have seen the horror of this and we have another horror here that we need to address as well. I do not believe that he is trying to be unnecessarily political, but I take your point and I am happy to share that with him.

Mr McARDLE: I do not mind whether or not you share it with him. If the Archbishop was here, I would ask him to comment on whether it is in context. Let us face it: news reporters do not always contextualise commentary, but the bold face of the statement is quite startling.

Mr Pellicaan: It is very difficult to handle how people use his words. There is a six-and-a-half-minute video online where he does talk about that and uses that kind of language. It is near the end of that video. You could get the full context of the statement from that.

CHAIR: Thank you, Mr Pellicaan, for your contribution today on behalf of the Catholic Diocese. We appreciate your time and that of all submitters who have contributed today. I now declare this public hearing complete.

The committee adjourned at 12.09 pm.