



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

**Members present:**

Ms L Linard MP (Chair)  
Mr MF McArdle MP  
Mr SE Cramp MP  
Mr AD Harper MP  
Mr DC Janetzki MP  
Mr JP Kelly MP

**Staff present:**

Ms S Cawcutt (Research Director)  
Ms T Struber (Inquiry Secretary)

## **PUBLIC HEARING—HEALTH (ABORTION LAW REFORM) AMENDMENT BILL 2016**

### **TRANSCRIPT OF PROCEEDINGS**

**THURSDAY, 27 OCTOBER 2016**

**Brisbane**

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### **Committee met at 9.30 am**

**CHAIR:** Good morning, ladies and gentlemen. Before we start, could I please request that mobile phones be turned off or switched to silent? I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Health (Abortion Law Reform) Amendment Bill 2016.

I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders, past, present and emerging. I am Leanne Linard, the chair of the committee and the member for Nudgee. The other members of the committee are Mr Mark McArdle MP, deputy chair and member for Caloundra; Mr Joe Kelly MP, member for Greenslopes; Mr Sid Cramp MP, member for Gaven; Mr Aaron Harper MP, member for Thuringowa; and Mr David Janetzki, member for Toowoomba South.

Today's hearing is part of the committee's inquiry into the Health (Abortion Law Reform) Amendment Bill 2016. In examining the bill, the committee will consider the policy which the bill proposes to implement and the application of the fundamental legislative principles. The bill, if passed, would make it an offence for someone other than a qualified health practitioner to perform an abortion; regulate decisions about abortion if a woman is more than 24 weeks pregnant; provide for conscientious objection by a doctor or nurse, except where an abortion is necessary to save a woman's life or prevent serious injury; and prohibit certain behaviour in areas around facilities where abortions are performed and prohibit publication of images of people entering or leaving those facilities unless they have consented.

There are a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan 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 you that intentionally misleading the committee is a serious offence.

Witnesses have been provided with a copy of the instructions for witnesses so we will take those as read. Hansard will record the proceedings and witnesses will be provided with a copy of the transcript. This hearing will also be broadcast. I remind those attending today that these proceedings are similar to parliament in that the public cannot participate. Members of the public may be admitted to or excluded from the hearing at the discretion of the committee. Please also note that this is a public hearing and you may be filmed or photographed.

I thank all witnesses for their submissions, which are published on the committee's inquiry web page. Further submissions will be published as we formally accept them and authorise their publication. We will invite each witness to make a brief opening statement of up to five minutes, and members will then ask questions. I ask witnesses to please identify themselves before speaking for the first time and to speak clearly into the microphone when addressing the committee. I now welcome our first witnesses.

### **PURCELL, Ms Donna, Vice-President, Cherish Life Queensland**

### **THOMAS, Ms Kara, Director of Research, Policy and Advocacy, Cherish Life Queensland**

**CHAIR:** Ms Thomas, I understand that you will be making an opening statement.

**Ms Thomas:** Good morning. Thank you for this opportunity to address the committee. Cherish Life believes the current abortion debate is a moment in our state's history that will affect the way people are treated throughout our society for it is a debate about humanity itself, who we are as people, how we ought to live together and what meaning human life has. We believe every human, born and unborn, has the non-derogable right to life by virtue of who they are: members of the human family.

At the heart of this debate is the question ‘What are the unborn?’ for ideas have consequences and the idea that the unborn child can be dehumanised as a non-person and excluded from the human family based on size, level of development, location or age is a dangerous idea and one that is seriously damaging, perhaps even destroying, the credibility of human rights. We cannot diminish the value of one category of human life—the unborn—without diminishing the value of all human life. Will we be a society that has a higher respect for human life, putting moral restraints on our behaviour in order to elevate the other before the self, or will we arbitrarily decide that the unborn are non-persons and give women, whether by choice or coercion, disposal rights over their children?

The committee’s report on the first Pyne bill stated that there is no precedent in international law for the terms ‘child’, ‘human being’ or ‘human persons’ to be interpreted to include a foetus, yet a foetus of human parents is obviously a human foetus. The science of embryology tells us that the unborn are unique, living and whole human beings from conception, actively involved in developing themselves from within. There is no essential difference between the adult you are today and the foetus you once were that would justify killing you at that earlier stage of development. Therefore, all moral obligations and rights that apply to other members of the human family apply to the human foetus as well. If the unborn are human, which they are, then abortion is discrimination based on age and size.

Furthermore, abortion discriminates based on location. A 24-week baby in neonatal intensive care is protected from dismemberment, lethal injection or cranial decompression regardless of the complex circumstances her mother faces because of where she is, but since when does location determine our value? What occurs in abortion is confronting. In her recently published book entitled *What the Nurse Saw: Eyewitness to Abortion*, Brenda Pratt-Shafer wrote of watching D&E dismemberment abortions on ultrasound, the babies frantically moving away from the forceps until they were ripped apart and died. She also witnessed a number of partial-birth abortions, with babies 20 weeks and over being pulled out feet first after a three-day cervical dilation, being stabbed in the back of the neck and having their brains sucked out while the head was still in the birth canal. Brenda said that most of the women in the clinic she worked in were crying and upset. The women were lied to about the development of their unborn child, the foetal monitors were silenced and they were not shown an ultrasound because the clinic was a business selling abortions. This did not look like choice to her.

The fact that there are many unwanted abortions due to lack of real choice for women is illustrated by Frederica Mathewes-Green, who said in her recent book *Real Choices*, ‘Women want an abortion like an animal in a trap wants to gnaw off its own leg.’ Abortion is not liberation; it is coercive deception. It is abandonment of our women at our most vulnerable time in their pregnancy. It harms women because it violently interrupts the natural progression of pregnancy with serious physical and psychological consequences, and given its ineffectual late-term limit this bill would allow this barbarism as a solution to crisis pregnancy.

The last thing women need is more permissive abortion laws. Instead, they need whatever protection the current law can provide as well as full and accurate information, real support and safeguards such as independent counselling and cooling-off periods. If we want to reduce abortion, we need a behaviour change and that starts with a change of heart that only the truth will transform. The truth of what the unborn are and what abortion does to them and women must be shared, because intentionally killing innocent humans is morally wrong, and immoral acts result in unjust relationships that produce social suffering. Martin Luther King, who fought for the right of all human beings to be treated equally, said, ‘Injustice anywhere is a threat to justice everywhere.’ It is the recognition of the inherent dignity and inalienable rights of all members of the human family that is the foundation of freedom, justice and peace.

**CHAIR:** Ms Thomas, in your submission—and you have just made the same point here verbally—you talk about informed consent, non-biased counselling and better data. You are obviously recommending that you feel these things need to be improved. Do you not feel that the current regime of having legislation which sits within the Criminal Code could better serve those purposes if there were a health act of some description? What are your thoughts on that?

**Ms Thomas:** I think having it in the Criminal Code is recognition that the unborn are human and, therefore, intentionally destroying that life without adequate justification is wrong. You could add certain provisions in social policy to ensure women are fully informed so they have a full understanding of human development, they have an understanding of what abortion is, what it does and what the risks are physically and mentally so they can make a fully informed decision as to whatever risks are being posed to their health and wellbeing that is leading them towards that decision and so they understand the consequences of their decision.

**CHAIR:** You have cited a number of cases, but what evidence do you have that women are not being provided with this sort of information, particularly those who go through Queensland Health, which has rigorous processes about providing that information to ensure informed consent?

**Ms Thomas:** Through public health it most likely is because they have to follow the full Criminal Code, but we have had anecdotal stories from women. If you read Madeleine's story, she was told that her eight-week foetus was just a clump of cells no bigger than half her little fingernail. When she found out later that that was not correct, she was horrified and she struggled with depression and anxiety for a long time. Her story is in our submission and the full report is on Abortion Rethink if you want to watch it. Emma's story is also on there. As far as I can see, women are not being fully informed.

**CHAIR:** Ms Thomas, do you think that the conversation that would occur between, I assume, a health professional and a woman would be better served or better enabled to occur if there were not this element of the Criminal Code or criminality present? Some submitters have said that that is part of the limitation or the issue. If the termination were treated differently in different legislation, those sorts of conversations might take the form of what other informed consent medical procedures have taken.

**Ms Thomas:** Because we believe that life begins at conception, I do not believe abortion is like any other surgical procedure. I think it is the intentional ending of life. Therefore, unless it meets very strict codes, it is not really about informed consent about a surgical procedure. It would be surrounding whether or not there was adequate justification to end that life—

**CHAIR:** You are talking about very specific situations. Could you give an example of a specific situation in which you would consider it appropriate that the conversation be had?

**Ms Thomas:** From my perspective, because I believe humans get human rights, there would be very limited justifications. From my perspective, I can see an argument for rape and incest but I do not think that is what this legislation is about. We are not talking about arguing from the hard cases; we are talking about arguing on demand to 24 weeks. You would have cases which I would not consider abortion where you have a tubal pregnancy or where a woman may have a cancerous uterus and therefore you are removing the pathological organ and the baby's death is an unintentional consequence of that surgery, but you are not intentionally ending the child's life.

**CHAIR:** If I understand your submission correctly—and please tell me if I am wrong—you do not support the legislation but if there was a change to legislation you believe issues like informed consent and counselling should be covered within that?

**Ms Thomas:** Since we are looking to reduce abortion through social policy issues, which seems to be what the majority of Queenslanders and Australians want based on research—they want it reduced through social policy, not necessarily through legislation—if we want to move towards a place where no woman feels she needs to have an abortion, then we need to start that process by educating the public, having fully informed consent and telling the whole truth about the unborn and abortion.

**CHAIR:** And your submission is supportive of what is proposed in regard to conscientious objection striking the right balance? There is no recommendation here.

**Ms Thomas:** Yes, as long as the threat to the mother's life is not taken broadly and that I, as a nurse who works in obstetrics, would have the ability to not participate.

**CHAIR:** Thank you very much.

**Mr McARDLE:** Thank you, ladies, for being here today. Sections 224, 225 and 226 of the Criminal Code make abortion illegal in this state. Do you believe those sections should be repealed?

**Ms Thomas:** Is 225 the one about women being—

**Mr McARDLE:** Yes. Is it your organisation's recommendation that those sections be repealed?

**Ms Thomas:** I have read a number of the submissions and there is a lot of support for the repealing of 225. Because I believe the intentional destruction of a human life is wrong, not making it an offence to end the life of an unborn child is not consistent. However, I would not necessarily argue against it. From my perspective, I cannot sit here and say this is what I believe. However it is not a consistent argument from my point of view.

**Mr McARDLE:** Is that the position of Cherish Life as well or is it a personal position?

**Ms Purcell:** Can I clarify? Which is section 225?

**Mr McARDLE:** Section 225 says that a woman cannot cause an abortion on herself.

**Ms Purcell:** The position of Cherish Life is that we would be opposed to taking that out of the legislation simply from the point of view that we do not believe anybody should have the power to do something like that. It is obviously self-injurious that a woman would be allowed to try to commit abortion on herself. However, we were not exactly sure when we were doing the submission whether that actually was trying to cover the so-called medical abortions or not, because obviously that is part of the procedure—that they are given something to take away and take home, although some of the protocols are that they should be taking them in front of the doctor giving it to them.

**Mr McARDLE:** You mentioned also in your submission the Victorian Infant Viability Bill. How do you think that would help the debate here in Queensland regarding abortion or termination?

**Ms Thomas:** The Infant Viability Bill took a whole person approach. It looked at ensuring that women have informed consent, that they had support, that they had real choice offered, that there were palliative care options for babies who were not compatible with life. All of those kinds of things were included within it. It took a whole person and whole woman approach, and we liked those aspects of the bill.

**Mr McARDLE:** If this bill went to the House and it was passed by the House, you would recommend, however, that amendment be put into the bill to cover the issues you have raised here today and also contained in the Victorian bill. Is that right?

**Ms Thomas:** Probably aspects of them. I am not sure how you would pass the health bill while you still have it remaining in the Criminal Code.

**Mr McARDLE:** That is for the House to worry about, I have to admit. That is not for us here today. Your document also mentions the gestation periods across Europe—Germany, Belgium, France and the like. Twenty-four weeks is a fairly lengthy period of time: I think the evidence is that at 22 weeks a child is viable outside of the womb in certain circumstances. If you had to choose, what gestation time line would you be considering, bearing in mind Australian states vary as well from state to state?

**Ms Thomas:** They do. As an organisation, and as a person who believes that life begins at conception, I would not be supportive of any limits and saying that a child only becomes human at 12 weeks or something along those lines. That is from our perspective.

**Mr McARDLE:** Finally, many of the debates around this issue revolve around the right of the woman to control their own destiny. That is a fairly strong argument when it is run. Can you comment upon that, and also the rights of the unborn child and the father of the unborn child? How do you weigh up those three? Is one more important than the other, or are they all equal? The debate seems to shift into the role, obligation and rights of the woman alone.

**Ms Thomas:** It does appear that way. Personally, I believe that the highest right is right to life, because without it no other rights matter. Therefore, if the woman is elevated to the highest, then the baby is the greatest victim. We talk about the women's bodily autonomy and the control of her body. If we look at the function and purpose of the uterus, it is in her body, not for her body. It is getting ready every month to hold somebody else's body. The woman can live without her uterus; the unborn child cannot exist and continue to develop without the woman's uterus. Therefore, I can see an argument for compelling people to continue a pregnancy for the life of the child.

We also need to support women and look at the way that our society is built. We have this highly sexualised society and this expectation, and the burden is on women to almost be sexually available without the consequence of pregnancy. I do not think that is a fair burden to put on women. I think we need to look at a whole restructure of culture where we are not putting these expectations on women or bombarding them from such very young ages.

You hear a lot of stories where women are pressured by partners and the father of the unborn child to abort. If you say that abortion is okay, then men do not have to take responsibility for their actions and they just go on and do it to somebody else because abortion is easy, supposedly. All of the consequences end on the women and I think that is unfair, and then the child is sacrificed for that culture.

**Mr McARDLE:** Thank you.

**Mr HARPER:** You mentioned before that life begins at conception. What are your thoughts about the morning-after pill? It raises some questions.

**Ms Thomas:** It does raise some questions. I will let my colleague answer because I have not looked into it. I do not have a problem, personally, with people controlling whether or not they get pregnant. I think ending a pregnancy once it has been conceived is different to consciously planning to not get pregnant.

**Ms Purcell:** Essentially, the morning-after pill is supposed to be used within 72 hours of intercourse where a person suspects they could get pregnant. In that time, we do not exactly know, unless the woman might be very close to conception end at that time, and the pill may not make any difference to that event happening. On the other hand, there may have been no chance of conception from that intercourse in which case the pill is superfluous.

I suppose I am saying that I guess as an organisation we would say that if there was a chance of conception having occurred and then the composition of that pill—which is like a very strong amount of progesterone and it causes, if you like, a very quick ripening of the endometrium and then shedding—might cause a very early abortion because the conceptus cannot survive in that situation. As I said, it is a bit of a random thing. No-one really knows whether they have ended a pregnancy or not when they have taken it.

**Mr HARPER:** You mentioned before that you give some latitude or consideration to incidents where there has been incest or rape. Can you expand on that a bit because it seems to be a little bit conflicted in your views in terms of the abortion debate?

**Ms Thomas:** I am just saying, for argument's sake, if you took the view of the hard cases, such as rape and incest, then you would have legislation that totally banned abortion except in rape and incest. Even in cases of rape and incest, does the child pay the death penalty for the actions of the perpetrator, and is a second act on the woman going to make it better? That is where she needs fully informed consent. I have heard a number of stories and read in research that there are women who regret their abortions after rape, but I have not read any of women who regret keeping their baby, whether keeping it and then adopting it or keeping it and keeping it with them. I think we need to understand that, if the unborn are human, then we treat the unborn the same as we would treat the born child. How do we treat people who remind us of horrific events?

**Mr CRAMP:** Thank you ladies for attending today. I obviously know the answer to this. The member for Thuringowa mentioned the morning-after pill. At exactly what stage do you believe the foetus has human rights?

**Ms Purcell:** We believe that it has human rights from conception because it is when their life begins. Whether you call them a conceptus, a fertilised embryo, a foetus or an embryo, it is all just different names given to different sections of time within the womb. It is all the same. Life began at conception and unravels through the DNA in that baby's make-up if left undisturbed. That is what happens until birth.

**Mr CRAMP:** This committee has previously heard about informed consent, and I have heard it in my role as an MP and you have mentioned it yourself today. A big part of that would be education. Some groups seem vehemently opposed to issues such as showing the woman an actual picture, for want of a better term, of her child from an ultrasound prior to termination. Do you think that would help a woman understand at what stage her baby is at—actually seeing a picture of the stage of her foetus prior to termination?

**Ms Thomas:** I think it is the woman who has to live with the decisions. I think it is paternalistic deception to not let her see what her decision is.

**Mr CRAMP:** Do you think we as the regulators have a role to play in that? If informed consent were to happen in an unbiased manner, would we be in a position as regulators, as a government, to provide that information? Or do you think it should come from particular groups or perhaps an amalgamation of different parties from, in this instance, either side of the argument?

**Ms Purcell:** I think there would be an awful lot of fighting if it had to come from each side of the argument.

**Mr CRAMP:** Perhaps it is our role as regulators to put that forward.

**Ms Purcell:** We have always said it would have to be an independent counsellor counselling, whether that comes through a government agency or a non-government agency. Obviously, there is clearly a difficulty in what you might call freestanding or private abortion clinics because, as far as I know, there is no regulation of what they are told and what they are not told there. If it was to be accepted through commercial private abortion clinics, they also then would have to be made in some way to provide independent counselling.

**Mr CRAMP:** There was information previously provided by the ACT in the form of a booklet with information by the regulators. It did actually show, from all accounts, an unbiased approach to it to help fully inform and educate the mother. Do you think that would be beneficial?

**Ms Purcell:** I think it would be a big advance on what happens at the moment.

**Mr CRAMP:** But we see no focus on it at the moment, do we?

**Ms Thomas:** No. In the US, the Texas website has a booklet called 'Woman's right to know' and it has all stages of development. Our submission says that they have legislated in a number of states woman's right to know laws and I think that is beneficial.

**Mr CRAMP:** Would that be a way forward? A woman's right to know instead of the current route?

**Ms Thomas:** I think if you are going to legislate then women need to have all the information.

**CHAIR:** I am mindful that we have four minutes remaining for this witness.

**Mr KELLY:** You seemed to indicate in your submission that the gathering of data and statistics is important. In your assessment and analysis of the bill, can you advise whether or not this bill actually contains any provisions that facilitate that objective?

**Ms Thomas:** I read through it, and no.

**Mr KELLY:** I think we are conflating some terms here, but we are talking about informed consent and we are talking about counselling. As a health practitioner, I would consider those two things to be not necessarily one and the same. On page 17 of your submission you list a number of dot points and I think it relates to that woman's right to know. I would contend that, with the first five dot points, a medical officer would be obligated to provide that information under current Australian laws in relation to informed consent. What would be your view on that matter?

**Ms Thomas:** Likely the physician will introduce himself. He would probably not describe the abortion procedure. If you look at abortionists that have been on TV they sometimes say, 'I don't think it's relevant to the debate for us to describe how we do it'. I do not think they would do a full description. In terms of the medical risks it seems that the possible physical and psychological risks seem to be downplayed. In the US there are a number of states where it is mandatory for them to tell women about the abortion-breast cancer link and there have been women who have successfully sued their abortion clinic for not disclosing that information. I think we need to look at the most recent evidence and then put that. Perhaps having a regulated body will ensure that women would get all the information if it were a booklet or something like that as opposed to trusting somebody who is in the business of trying to sell an abortion to tell them the whole truth.

**Mr KELLY:** It is your view that the current informed consent laws in Australia do not result in this information being provided to a patient?

**Ms Thomas:** In abortion clinics?

**Mr KELLY:** Anywhere, because these procedures could happen in your general practitioner's office if you are doing a medical—

**Ms Thomas:**—if you are doing a medical abortion. From what I have heard from women, no.

**Mr KELLY:** I have a final question in relation to the women's right to know laws that you refer to here. I know that this bill does not deal with those sorts of issues. I want to relate this back to the issue of safe access to facilities that perform abortions. If there was laws that—your organisations or people who share your views—provided women with information and they were able to make a real choice, would it be reasonable then to expect that people who have made an informed decision have a right to enter and exit a facility without having people approach them and try to change their decision?

**Ms Thomas:** I do not think you can legislate the protection of a building. I do not think that if there are people who truly believe that the unborn are human, we cannot stand and pray or stand and hold signs and be actively participating in trying to expand the truth of the unborn and what abortion is and offer real support to women. There are a number of stories of women who have changed their mind because of sidewalk counsellors. I am not supportive of violence outside of clinics, but I do not think that it is right to impose a restriction around a building based on a belief that the unborn are not human.

**Mr KELLY:** You refer to the Infant Viability Bill 2015 in Victoria. What is the status of that bill?

**Ms Thomas:** It was defeated.

**Mr JANETZKI:** Thanks for being here. Today the committee is not hearing from any women who have undergone an abortion or from anybody who undertakes post-abortive counselling services. I am wondering in Cherish Life's experience—and you mentioned Madeleine Wiedemann. I am wondering what your experience is with post-abortive counselling services?

**Ms Purcell:** They are a bit difficult to come by. Do you mean the presence or how many there are?

**Mr JANETZKI:** Yes.

**Ms Purcell:** Generally, they are based upon individual people being willing to get the training and present themselves to do that sort of thing. Sometimes it is covered under pregnancy counselling services as well, so they do both before and after.

**Mr JANETZKI:** They are not readily accessible to—

**Ms Purcell:** No. There are very few dedicated ones. There are more individuals rather than any establishment.

**Ms Thomas:** Priceless House does a wonderful job. They have a full post-abortive counselling model. They would be able to enlighten more on that.

**Mr JANETZKI:** Women who have undergone abortions like Madeleine—would she have been seeking counselling services of that nature had they been available?

**Ms Thomas:** She probably would have. She said she did not know of any at the time when she started to feel depressed and sad. She did not feel like she could go back to her abortion clinic. In one of the European countries—I cannot remember which—they offer post-abortion counselling. I think it is three weeks afterwards. Then women could be provided with information if they need follow up with connection to other services and things like that so that they know they are there if they need them.

**CHAIR:** Our time has expired. Thank you both very much for coming before the committee and thank you for your submission. We will now hear from Ms Rachael Wong, who will join us by teleconference, to represent Women's Forum Australia.



**WONG, Ms Rachael, Director of Research, Policy and Advocacy, Women’s Forum Australia**

**CHAIR:** Ms Wong, this is Leanne Linard. I am the chair of the committee. Thank you for joining us on teleconference today. We have received your submission, and thank you for that. Would you like to make an opening statement of up to five minutes? Then we will open for questions from fellow committee members who are present here today.

**Ms Wong:** That would be great. Thank you very much. Good morning, everyone. I am the Director of Research, Policy and Advocacy for Women’s Forum Australia, an independent women’s think tank that strives to be a powerful and positive force for cultural change through research, education, mentoring and advocacy. Due to the shortage of time, I am going to jump straight to the parts of my written submission on the committee’s report that I feel could benefit from further elaboration.

The committee rightly rejected Mr Pyne’s first bill. However, we are concerned that some of the findings in its report indicate the desire or at least the motivation to legislate for abortion on demand as in the current bill but that such findings are based on inaccurate information. The two main areas I want to comment on are in relation to the report’s findings on international human rights law and the health risks of abortion.

The report’s finding that decriminalisation is required for Australia to effect international legal obligations is not correct. The status of abortion as a criminal offence does not in itself amount to noncompliance with conventions such as the Convention on the Elimination of All Forms of Discrimination against Women. There is no right to abortion under international human rights law and no UN treaty can accurately be cited as creating or recognising such a right. Treaty monitoring bodies such as the CEDAW committee have interpreted treaties to which they are subject as including a right to abortion have directed governments to change their laws accordingly. Such bodies have no authority to interpret these treaties in a way that creates a new set of obligations and act outside their authority in doing so.

Many states would never find such treaties had originally included a right to abortion. The European Court of Human Rights itself has consistently ruled that there is no such right to an abortion and leaves individual states to decide how they would deal with the issue. Women’s Forum are firmly of the view that abortion is an inherently harmful decision for women, so for the committee to overstate international law in support of legislating greater access to abortion is deeply concerning.

The report’s apparent acceptance that abortion is a safe procedure and one that is even safer than childbirth is certainly one part—

**CHAIR:** Ms Wong—

**Ms Wong:**—including increased risk of suicide worldwide among women who have abortions.

**CHAIR:** Ms Wong, I just interrupt you there. You do have up to five minutes to make an opening statement and you do have three minutes remaining. You are providing commentary on the committee’s first bill. The purpose of today’s hearing is the second bill introduced by the member Rob Pyne. I wonder if you could bring your comments back to the bill, please and any comments that Women’s Forum Australia would like to make on the bill before the committee inquiry today.

**Ms Wong:** The reason I am commenting on the report is that we believe that some of the information provided in the report is paving the way for legislative reform which allows for abortion on demand. We believe that some of the information that has been provided and relied upon is not correct. In our written submission we have talked about how the bill fails to address the concerns of the first bill, how there are certain concerns with the current bill and how we have certain concerns about the report itself. The point that we feel needs elaborating on at this time relates to the report, not the other parts, which I can also elaborate on later on in question time if you want me to.

**CHAIR:** You can as long as your comments are relevant to the bill before the inquiry. The terms of reference for the first inquiry were very broad, but this is a new inquiry and relates to what is provided under the bill. If you could provide practical comments or reflections on that to expand on your submission, that would be very beneficial for the committee.

**Ms Wong:** Perhaps it would be better if I submitted some more in writing. Would that be possible? The point I was going to make was in relation to the report’s commentary on the health risks of abortion. The reason that is relevant is that any changes relating to these laws need to take that into consideration. The report’s commentary that there are not really any health risks in relation to abortion, I think, is very important in relation to law reform in this area.

**CHAIR:** Thank you. We do have your submission. Were there any further comments that you would like to make in your remaining one minute with regard to the sections in the current proposed bill?

**Ms Wong:** Ultimately, what we would like to see is the committee reject the bill like it did the first one for the reasons noted in our written submission. We would like the committee to take this opportunity to make recommendations that will genuinely promote women's health and rights such as the mandatory collection of data around abortions. That way we would have proper information on which to make such important policy decisions, safeguards for informed consent which can cause women to make a real choice and initiatives to address the underlying societal issues that are leading women to seek abortions in the first place and which might make women view abortion as their only choice.

Ultimately, the consequences of changing the current law we believe are too far reaching to make on the basis of skewed studies about the data collection to show what is actually happening when it comes to abortion in Queensland and without compelling evidence that this is going to benefit women. Law changes that are going to affect one in three women—we have to do better than that.

**CHAIR:** I invite the member for Gaven to open with some questions.

**Mr CRAMP:** Thank you for coming in on this hearing today. Can I say that your submission is very well set out, very well informed and focuses on some of the issues that many people are actually concerned about in relation to this bill. Looking through your website, your focus on issues such as adoption is also very well placed. Congratulations on that. I have a couple of questions, and I recognise that time is of the essence. You mention counselling. There seems to be an absolute lack of any focus on that. What are your thoughts on not just counselling—and I understand that there is an argument that informed consent is education. I am interested in the emotional counselling of the female, both pre and post, if a woman decides to abort a foetus or a child. What are your thoughts around that and could there be at least a compulsory offering of counselling, especially post abortion for these women?

**Ms Wong:** We believe that counselling is important on both sides of a termination, so before and after. It is interesting to note that even those who would propose further reform in this area do recognise that women may need follow-up counselling or help with bereavement after an abortion. I think if we are really going to be helping women and supporting them then counselling is very important, particularly beforehand, to help them to make a truly informed decision—a decision that is voluntary and has full information. Counselling is very important on that side as well.

**Mr CRAMP:** On the issue of informed consent, I note that point 5 of your submission addresses something I asked the previous witness in terms of the opportunity to do things like view ultrasounds of their unborn child. How do you think that will assist in allowing a woman to have informed consent? How do issues like that address concerns by many people that women are not being informed appropriately before having this procedure?

**Ms Wong:** I think that is just part of providing women with full information about what is happening with their pregnancy and what is happening in relation to an abortion—to have information about foetal development and what stage their child is at and what it looks like. I think that is important for women in terms of making a genuine and informed choice at that time. You hear stories of women who have been told before they have an abortion that it is just a clump of cells, and they go through the process and they think everything is fine. Then later they see an ultrasound of someone's baby at the same stage or they hear about foetal development and they are distraught. I think it is important that this information comes in the process before the woman makes a decision.

**Mr CRAMP:** In point 8 of your submission you speak about a lack of evidence and data. Do you have any alternative way to collate that data because, as you said, there is no framework for reporting on data? We have heard previously that there seem to be large discrepancies and most reports that people rely on in this argument come from overseas. Does your organisation have any suggestion on ways forward to collect appropriate data so regulators can make informed decisions?

**Ms Wong:** In Australia there seems to be, for whatever reason, some resistance to collecting data on abortion. If we look overseas, at places like Finland or New Zealand, there is mandatory data collection that would look at how many abortions are taking place, in some cases why women are undergoing abortions, how many women are seeking counselling post abortion—those sorts of things. I think if there were practices and systems put in place to support that sort of collection that would be very helpful in determining what sort of policy changes needed to be made. That would really help women in relation to this issue.

**Mr CRAMP:** I refer to your comments in point 10 about termination up until birth and the safeguards in relation to when a foetus or child can be aborted. I wanted to know your thoughts on that. Also, do you believe that gender selection has happened in this country? Mr Pyne does not and does not believe it will happen. What are your organisation's thoughts on the possibility of gender selection coming about because of this proposed change in legislation?

**Ms Wong:** In relation to the gender selection question, I think there is anecdotal evidence that it does happen. In any society where there is a mixture of cultures, some of which are very in favour, for example, of choosing males over females, then I think that is a definite risk. To allow a situation where abortion is available on demand for any reason up until a certain gestation or even further, if you consider the fact that that limit may not really mean much at all, that certainly raises the spectre of sex selective abortion.

**Mr KELLY:** At point 7 of your submission you refer in parentheses to including much needed adoption law reform in relation to progressing real alternatives for women. What is the reform you are referring to? What are you proposing?

**Ms Wong:** It is to enable adoption to be more easily accessible. At the moment the adoption systems in place are not really that user friendly. They do not make it easy for women to make that decision, if putting their child up for adoption was going to be a possible alternative for them. The current system is just so fraught with issues. Adoptions take a long time. I think to streamline that process may make that a more viable possibility for women who are considering abortion to make that decision instead.

**Mr KELLY:** In point 8 you talk about the bill providing no regulatory framework for the mandatory collection and reporting of data on abortions. How do we collect accurate data while abortion remains subject to criminal penalties?

**Ms Wong:** There are obviously still abortions taking place, so data can be collected around that.

**Mr KELLY:** In point 19 you mention that international trends and evidence show that baby girls are by and large the targets of sex selective abortion. What is the evidence in relation to that?

**Ms Wong:** There has been a lot of evidence, especially overseas. There have been books and journal articles written and statements taken. You just need to look to China and India to see the extreme discrepancies in terms of the numbers of males and females now living. There is a huge number more men than females because of sex selective abortions in both of those countries.

**Mr JANETZKI:** Thank you, Ms Wong. I echo the comments of the member for Gaven: I thought yours was a great submission that set out the issues very clearly. You make a couple of comments, in paragraphs 11 to 14, on the arbitrary nature of the 24-week period chosen in this bill. Can you give your justification or some reasoning behind why you think 24 weeks has been chosen?

**Ms Wong:** That is the point: I guess we are not really sure. If I could hazard a guess, perhaps Mr Pyne would say that 24 weeks is the stage of viability and so after that stage we should be more restrictive, but even that is changeable depending on the child. Even at less than 24 weeks there are still risks to women in terms of physical and psychological harm. The limit is arbitrary and I would like to know from Mr Pyne himself why he has put that limit in place.

**Mr JANETZKI:** This bill proposes abortion on demand without any cooling-off periods, any counselling or right-to-know requirements. Beyond those mentioned briefly in your submission, what measures would you like to see in those areas?

**Ms Wong:** Sorry, could you repeat that?

**Mr JANETZKI:** We have a bill that has no cooling-off periods, no counselling and no right-to-know requirements. What measures would you like to see in those regards?

**Ms Wong:** I think those are some of the more important measures. Aside from ensuring informed consent—that would include prescribed information such as alternatives, information about foetal development and the things you have mentioned—what is also really important is to ensure there is support for women. Even if they do have this information, they may still be facing other challenges in their life which are making them go down this track, which they might not otherwise if there were those supports in place. I think even before coming to a bill where you are trying to increase access to abortion, you need to look at why women are seeking abortions in the first place and potentially try to look at those things rather than just address the symptoms of these women's situations.

**Mr HARPER:** In section 32 you mention that the committee's report dismissed and downplayed the impact of abortion on women's health. I think it was a significant body of work that looked at a range of different points—counselling, gestational periods and a range of other points that were raised during that inquiry. Could you expand on that?

**Ms Wong:** Sorry, I am finding it quite difficult to hear you. Did you ask me to expand on what our concerns were with regard to the health risks in the report?

**Mr HARPER:** Yes, number 32, where you say the committee's report has dismissed and downplayed the impact of abortion on women's health. Can you expand upon that a little more?

**Ms Wong:** We think that the report's apparent acceptance that abortion is a safe procedure and one that is even safer than childbirth is a one-sided view of the research and that it fails to acknowledge the psychological risks inherent in abortion, including the increased risk of suicide worldwide among women who have abortions, which the Queensland government itself has recognised.

The report noted that a majority of systematic analyses concluded that rates of mental health problems were the same for women with an unwanted pregnancy, whether they had an abortion or gave birth, and that abortion rarely causes lasting negative psychological consequences in healthy women. However, the report only listed six analyses and one-third stated otherwise. We believe that the fact that a third of the studies cited in the report give evidence that abortion does lead to an increased risk of mental health problems is not something trivial just to be pushed aside and that it is far from clear that, as stated in the report, there is no established causal relationship between abortion and mental health outcomes. We believe that there is a multitude of research to state otherwise.

The report also emphasises that a prior history of mental health issues is the most reliable predictor of a post-abortion mental health issue. While this may be so, it does not follow that all women who suffer mental health issues post abortion therefore had a prior history of mental health issues. We do not believe there is anything in the evidence to support this.

Of course there are negative factors which are going to make mental health problems after an abortion more likely, which, as the report mentioned, includes childhood adversity, intimate partner violence, coercion, drug use, poverty, social disadvantage et cetera. Given what we know about such factors being reason some women seek abortion in the first place, we believe it is even more imperative that we address these factors rather than simply provide women with more abortion.

**CHAIR:** The time for questions has expired. Ms Wong, thank you very much for joining us by teleconference today. On behalf of the committee, thank you to Women's Forum Australia for making a submission.

**Ms Wong:** Thank you very much for the opportunity to present.

**JOSEPH, Ms Rita, Private capacity, via teleconference**

**CHAIR:** Thank you very much, Ms Joseph, for joining us by teleconference, and thank you for the submission you have made. Would you like to make an opening statement of up to five minutes and then we will open to committee members' questions.

**Ms Joseph:** Good morning to my fellow Queenslanders. I was born in Queensland, and my family and the old homestead are still there on the farm. I did my first degree at the University of Queensland back in the sixties and I went on to work in the philosophy of language of human rights. My book on human rights and the unborn child sets out the historical evidence that right from the beginning of modern human rights the unborn child was formally recognised as a member of the human family with equal and inalienable human rights. I was on the Australian delegation to the children's summit in New York and for years I have been on the UN human rights mega conference circuit, working in committee rooms advising delegations in negotiating the language of human rights documents, mostly at the UN in New York but also at the Hague, Geneva, Rome, Istanbul, Cairo, Beijing and other places.

I still retain my Queensland accent and the true Queenslander's down-to-earth, common-sense approach to problems. This bill is a problem—a problem of timing. It is about 30 years too late. This bill is to catch up, we are told, with similar legislation in other states, but now is precisely the time for the Queensland parliament to hold its nerve, to keep in place the legal protections for unborn children being nurtured in their mother's wombs. In doing so, Queenslanders will be honoured for holding their stand and will find themselves in the lead of the return to a just restoration of human rights of little daughters and sons at risk of procured abortion. We Queenslanders, I believe, have always been more fortunate in that we are endowed with a natural scepticism that makes us less susceptible to the urgent whims of ideological propaganda. Not for us the easy embrace of the absurd dogma that pregnancies are childless, that a stork named 'reproductive health' brings the child fully formed from some nearby cabbage patch to be granted instantaneous rights only at the moment of birth.

I think the real irony here—and the point I want to make—is that the tide is turning. The fierce pull of a rapidly ageing 50-year-old ideology is beginning to falter. As we all become better educated and able to see on ultrasound the humanity of little daughters and sons in their mothers' wombs, the tide is changing. Two nights ago on television news we saw pictures from Texas of a little daughter, LynLee, at 23 weeks being taken out of her mother's womb for 20 minutes to perform surgery on her spine and then more pictures of her being born bright and beautiful three months later. Look at the language in clause 21 of this bill—'Abortion on woman more than 24 weeks pregnant'. Why is there no recognition of the daughter older than LynLee, or the little son? Why has the little targeted victim of abortion disappeared from this bill?

For many years I studied the history and the language of ideologies: communism, Nazism and others. I came to understand the role that new language played in dehumanising those human beings who were deemed socially unwanted. I look at the wording of this bill and I immediately ask myself: 'What is this language hiding? What protections are missing?' The answer is clear: it is hiding the deliberate killing of a small defenceless human being older than LynLee. This bill is exclusively about a woman who is more than 24 weeks pregnant. Their child is not worth a mention—just deleted. The bill is pretending that the pregnancy is childless.

I shall finish with just two examples of how the tide is turning. Think back to restoring legal protection for unborn children. The first development is that I am currently involved in an advisory capacity with the UN Human Rights Committee in Vienna, which, under pressure from extreme feminist ideologues in high places, has been exploring the possibility of extending the right to life article 6 of the International Covenant on Civil and Political Rights to include a new exception to the right to life, or abortion. There have been three sessions so far with no agreement reached. A fourth session is coming up soon, but it is looking like it is in the too-hard basket. You will not hear this from the media or read this in academic journals yet, but I can tell you that the significance of this stalemate is immense. Here is an admission that there is still at present no right to abortion to be found in this foundation convention on which the whole architecture of international human rights law has been built.

The second development is on behalf of Saving Downs, a group of families with children with Down syndrome in New Zealand. My colleagues and I have made a number of submissions to the International Criminal Court. We are currently in negotiations with the Office of the Prosecutor. Our main argument is based on the verifiable fact that, in New Zealand—as in the USA, the UK, Australia and many other countries—more than 90 per cent of children detected prenatally to have Down

syndrome are aborted. We say that this amounts to a form of genocide where measures intended to prevent births within the group are being endorsed. We say that the failure of the states to provide appropriate legal protection is part of this crime. We say that the states' provisioning and/or funding of health systems that facilitate measures intended to prevent births within the group constitutes complicity in genocide. We say that these abortion programs are being carried out in a widespread and systematic way and thus constitutes acts of extermination as defined in the Nuremberg judgement and a crime against humanity. A preliminary examination of the complaint was launched in June 2012. The prosecutor at the International Criminal Court has invited us to provide an additional submission on the antenatal screening programs—

**CHAIR:** Ms Joseph, I will have to stop you there, sorry. That brings the five minutes to a close. We want to ensure that members have an opportunity to ask questions.

**Ms Joseph:** Fine. That is good. I would conclude by saying that, really, my advice on this bill is to just tear it up. Be brave and innovative. Bring on a new bill that can do real good—a bill that will protect unborn children from lethal discrimination. Thank you.

**CHAIR:** Thank you, Ms Joseph. I invite the member for Toowoomba South to open questioning.

**Mr JANETZKI:** Ms Joseph, thank you for your contribution from the international human rights law perspective and a philosophical perspective. It is very important to the committee that we get all kinds of perspectives in this consideration. I want to take you to the various sources of international law. Obviously, you have relied on the universal declaration. It is quite compelling evidence when you talk about the International Covenant on Civil and Political Rights in respect of mothers who are sentenced to death. That particular document recognises the rights of the unborn as well. In this debate, those in support of the bill would also rely on international law principles to justify their position. Can you take us through a couple of the arguments that those supporting the bill would draw from international law and how you would distinguish them in your opinion?

**Ms Joseph:** Yes. I think one of the problems is that, when the human rights committees, for the committee system, begin to put out arguments for bringing in abortion laws they just fail to understand that they have no role. They really do not have any authority to do that. One of the important things to understand is that the abortion law movement is driven by committees that are dominated by an ideology and that the Human Rights Committee has no authority to remove legal protection from the unborn or from the suicidal, which is part of the approach at the moment.

The proposed changes do not comply with article 51, rules for amendment. That says that to amend something like the right to life requires that at least one-third of the state parties have to come together and have a conference. It has to be accepted by a two-thirds majority of state parties to the present conventions. It is a very complex process. It is just not there. We have to understand that human rights committees have no mandate to create new rights. Contrary to the Vienna convention rules of interpretation, abortion rights, like suicide rights, contradict the ordinary meaning of the right to life. Other than specific provisions for the death penalty, no other limitation on the right to life is permitted under article 5 of the International Covenant on Civil and Political Rights. There is no provision for the legalised killing of unborn children or suicidal persons. For 50 years the international community has now worked hard to abolish the death penalty—the single exception to the duty to protect every life by law. It is strange, because we cannot see the irony of now introducing two new exceptions—to remove protections from the suicidal and from children targeted for abortion. This is not an expansion of rights, but a contraction of rights.

**Mr JANETZKI:** Thank you. In view of the time for the other committee members, I will move on to my next question. Can you briefly explain for the committee the relationship between international law and a range of the principles and documents and their interaction with the law of Queensland?

**Ms Joseph:** Yes, I think—

**Mr JANETZKI:** More accurately, probably Australia, because it would ratify treaties at a federal level.

**Ms Joseph:** Exactly.

**Mr JANETZKI:** How would it impact on Queensland?

**Ms Joseph:** We have already made commitments on behalf of Australia and we are part of that. We are part of Australia, a federation. Queensland is obliged to provide that, because article 50 of the International Covenant on Civil and Political Rights states—

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

Really, the Queensland government has to follow what we agreed to in the international covenant. The federation of Australia has ratified the International Covenant on Civil and Political Rights, which protects the right to life. This bill is proposing a broad, undifferentiated decriminalisation of abortion. It would introduce and comprise invalid limitations or exceptions to the right to life.

**Mr JANETZKI:** Thank you. I just want to turn briefly to the common law—Blackstone, that great English jurist the 1700s. The earliest abortion laws related to basically protecting the unborn child at which point movement could be felt in the mother's womb. That was the initial abortion law in the 1700s. As medical science advanced, that fundamental legal principle was changed to reflect what we knew about the unborn child's development and conception. In a world where medical science continues to make advances, where do you see international law progress? You touched on it in your initial comments. In a world where we know evermore various aspects of an unborn child's development, where do you see international law progressing in the years ahead?

**Ms Joseph:** I believe that international law is very rapidly coming towards understanding that the child in the mother's womb has human rights and they have the same human rights as every other human being. We don't allow for prejudice in terms of size or prejudice in regard to disability or any of those things, and that is really the way it is going. Back in Blackstone's day there was not much known about the early days of pregnancy, but in this day and age there is no excuse for ignorance. We understand that pregnancy is a continuum, that it begins at conception, and that these human rights for human beings begin at the time of conception.

**Mr KELLY:** Thank you, Ms Joseph. I could not quite pick it up from your introductory statement, what is your actual profession? Are you a lawyer or a linguist?

**Ms Joseph:** I am a philosopher. My expertise is in the philosophy of human rights law. My book is called *Human Rights and the Unborn Child* and it has been published around the world and it is really the definitive text on the human rights of the unborn child. I go through the history very carefully and I establish all the things that we have agreed to as an international community.

**Mr KELLY:** Just to be clear, you are a human rights law philosopher rather than a human rights lawyer.

**Ms Joseph:** That's correct. No, not a lawyer, I am a philosopher, but I have consulted internationally on many cases.

**Mr KELLY:** I do not ask those questions to diminish your profession and your standing.

**Ms Joseph:** No, I understand that. Thank you.

**Mr KELLY:** Just to clarify my questioning from here on in. On the first page of your submission in the fourth paragraph you say—

The child before birth having been recognized by the *Universal Declaration of Human Rights* as being included in "all the members of the human family" cannot be excluded by any subsequent human rights instrument or committee or judiciary or legislature without undermining the very foundation principles of modern international human rights law.

I am not a lawyer either. I am a nurse. That comment to me suggests that once something is passed into law in this place it can never be changed. I would wonder what your thoughts are on that. I have never heard of this Blackstone before, but I have heard of the 1700s. In Blackstone's time it was perfectly legal, argued on the basis of science and the Bible, for people to go to Africa, acquire other human beings as property and sell them between themselves, a premise that today we would feel is not acceptable from a legal perspective. My question to you is: this notion that the law is never changeable, what are you basing that on?

**Ms Joseph:** I am basing it on the fact that the basis for human rights law is deontological, it is on principles, it is not according to our changing ideas. It is deontological, it is on principle, that is the important thing. We just do not have that capacity to change from human rights based on principles to human rights based on convenience or on other factors. These principles are very deeply ingrained into our law now and we cannot change them. We cannot change from one kind of law to another kind of law without prejudicing our protection of the weak and of those with lesser power than we have. I think this is very important to understand.

**Mr KELLY:** Thank you for that. Often during your submission and in some of the things you have said today you reference the importance of language and linguistics and I agree that that is very, very important. I just want to take you section 21 of the bill. This section of the bill is something you have talked about in your earlier opening statements and you have made reference in the submission to the language that is used around abortion being a language that disappears the foetus from the process.

**Ms Joseph:** Yes.

**Mr KELLY:** I know you will not necessarily have a copy of this in front of you but I refer to some of the stories that were included in submission 849, Maternity Choices Australia's submission to the first inquiry. You suggested that the language that is used is there, and I am sorry if I am paraphrasing you incorrectly, to justify the killing of a baby. I refer to two statements made in this statement from two different women. One described her experience of falling pregnant, being extremely happy about having another child and then being diagnosed with a cancer that would require significant amounts of chemo and radiation and making the agonising decision to terminate the pregnancy because of the concerns about what that would do to the foetus. The second refers to a woman that had the foetus diagnosed with a fatal abnormality and describes her extremely distressing decision around seeking a termination at 22 weeks. In both of these statements the foetus and their sentiments as a mother are obvious and are clear. I don't think about these things necessarily from that perspective, I think about them from a clinician's perspective. I guess my question to you is, is this language really about trying to help clinicians assist patients to make a very difficult decision in very difficult circumstances rather than about the killing of an unborn child?

**Ms Joseph:** I think there is always an alternative to the direct killing of an unborn child. It is important to understand that our duty is always to heal and to help and to alleviate pain, but not to kill the child. That is the difference. Killing is just not an acceptable approach to a problem in pregnancy. Killing the child is not an acceptable approach. The unborn child is a real person with real rights and with needs that need to be met and the argument that abortions are necessary is becoming more and more out of date. The necessity isn't there. There have been immense improvements in prenatal surgery, in prenatal care, and none of these are dependent on killing the child. Everything in medicine is directed towards amelioration of the condition or trying to help, trying to make it least painful, and the amazing thing is that in this day and age prenatal medicine is just advancing in leaps and bounds. The wonderful thing is, too, as some great experts have pointed out who deal in neonatal surgery and medicine, in prenatal—

**CHAIR:** I am sorry to interrupt you, but I am mindful we only have five minutes left and I know there are other members who have questions. I will hand now to the deputy chair.

**Mr McARDLE:** Thank you, Ms Joseph, for being available to the committee. Can I take you to page 13 of your document and the heading 'Protecting human beings targeted for abortion is primarily a Human Rights Issue'. You make the comment at the start of the second paragraph of that subheading that reads—

International human rights law overrides Queensland law where Queensland law fails to provide appropriate legal protection for the child before birth.

Do you recall that?

**Ms Joseph:** Yes, that's right.

**Mr McARDLE:** Are you saying that the declaration of the rights of the child, the declaration of human rights in the ICCPR, are law in this state and in this nation at this point in time? The reason I raise that is that, and if I am wrong here please let me know, I understood that simply affirming the rights by a nation such as Australia does not give it domestic status as law, it then has to be incorporated into law in this nation to be binding upon the various courts and tribunals. Are you looking at that as saying that they exist—that is, the declarations I have referred to—as principles under which we should govern as a parliament the way we move forward or are you saying that they are, in fact, law in this nation?

**Ms Joseph:** I am saying that we have an obligation certainly under the covenant. We signed that covenant, we ratified that covenant and we did it in good faith. Article 50 of that covenant, the International Covenant on Civil and Political Rights, states that provisions of the present covenant shall extend to all parts of federal states without any limitations or exceptions. The Federation of Australia has ratified that covenant, therefore decriminalisation of arbitrary deprivation of life for a particular class of human beings—that is, children before birth—is inadmissible under international human rights law. Such a broad undifferentiated decriminalisation of all abortions would introduce and comprise invalid limitations or exceptions to the right to life.

**Mr McARDLE:** Would you agree with me that the declarations I have referred to, and you have as well, have not been passed into domestic law in this nation, however, rather, it is international law you are saying applies to Australia as principles or guiding principles?

**Ms Joseph:** Discrimination in the application of the right to life is without distinction of any kind and this is what we are talking about. This bill is discriminatory.



**Mr McARDLE:** Thank you very much, Ms Joseph, I appreciate your time.

**CHAIR:** Thank you very much, Ms Joseph, that brings our questioning to an end. Thank you for the submission that you made and thank you also for making yourself available to join us on teleconference today.

**CAMPBELL, Dr Ray, Director, Queensland Bioethics Centre**

**CHAIR:** Thank you for joining us again for our second inquiry. Can I invite you to make up to a five-minute opening statement and we will open for questions

**Dr Campbell:** Thank you to the committee for the opportunity to once again address you and to respond to your questions. As before, I appear on behalf of the Catholic Archdiocese of Brisbane and particularly our archbishop, the Most Reverend Mark Coleridge, who has been following this discussion with great interest.

As the bill in question seeks to amend the Health Act, I would like to open this time with some general comments relating to the church's involvement in health care in the state of Queensland as relevant to the bill. The Catholic Church is heavily involved in health care throughout Queensland, as I am sure you are well aware. In particular, the church is involved in the care of pregnant women through its various maternity hospitals. The service offered by those hospitals is highly regarded. In particular, the Mater Hospital here in Brisbane is a world leader in the care of difficult pregnancies and premature babies, which is something we can be very rightly proud of. We care for babies of the same age as those who would be destroyed under the present proposed legislation.

Furthermore, the church, through its own agencies and through supporting other voluntary organisations, cares for pregnant women who need support of different kinds throughout their pregnancies. Those voluntary organisations receive virtually no if any assistance from the government, although sometimes the people they care for are referred to them by our public hospitals. Through their great work, many women have been assisted to bring their children to term and now rejoice in the children they have born when they were previously tempted to terminate their pregnancy.

The church also assists organisations that assist women who have been through the trauma of abortion. Some might deny the existence of such women, but believe me they exist and they are deserving of our care. They should not be dismissed simply to serve someone else's ideological objective.

I mention all this just to highlight that the church is not on the sidelines of these issues, nor is the church simply seeking to be some kind of moral arbiter. The church, through its individual members and institutions, is involved at the coalface of these issues. The church is involved in the care and health of women and their children. Of course, many of the institutions I refer to were founded by women to serve women.

I turn very briefly to the bill. As I note in the beginning, the bill wishes to amend the Health Act, so one would presume the bill is about improving health for women, but just exactly where does this bill address itself to the health of anyone? The only protections it offers seem to be to abortion clinics. The current clinical guidelines from Queensland Health over therapeutic termination are much more a model of displaying care for the health of women than this bill is. I can think of many ways to describe this bill, but one thing it is not is a bill aimed at protecting and enhancing the health of women or their children. I am happy to leave my opening comments there and to take questions.

**CHAIR:** Thank you, Dr Campbell. I would like to acknowledge the great service of Mater Mothers, where I had my two babies. I am sure everyone on the committee acknowledges their great work and service.

**Dr Campbell:** I should declare an interest. I am the chair of the Mercy Partners Council, which is now the canonical sponsor for the Mater.

**CHAIR:** In your submission, you talk about health and state of the bill—

Indeed it treats abortion as a trivial procedure. Abortion is a procedure with surgical risks and great personal significance.

In a legal and policy sense, how do we do that statement justice? You are talking about the health of women. As the state, separate to the church, how do we balance some of the interests and issues?

**Dr Campbell:** Can you unpack that a little more for me?

**CHAIR:** What I am trying to get at is that there are surgical risks and it does have great personal significance, yet there would still be women in situations who may make the decision to seek a termination. My recollection of your verbal submission last time and your written submission is that the Catholic Church does not support a decision to terminate. Your submission makes a number of statements such as—

It is true that the majority of the population believe that women should have access to abortion—

And I am interested know what you are basing that statement on—

but it is also true that there is preference for women to have real and immediate access to alternatives to abortion.

As the state, as the government, how do we best balance the tensions of all of those issues to make sure that we are protecting the health of women?

**Dr Campbell:** As I already suggested during the first inquiry and make some reference to here, and I have just referred to your own guidelines from Queensland health at the moment, if someone is going to have an abortion these are some of the things that should happen: proper information; information about alternatives; good counselling to make sure that they are making a well-informed decision and also an uncoerced decision, so pre-decision kind of counselling. Making it mandatory that those things be at least offered is one of the ways that you help to dress those issues. Similarly, I am very pleased that those guidelines refer to follow-up after termination. Anecdotally, our clinics are not renowned for following those guidelines. I am not talking about our hospitals. I think you have some of the answers to your questions in the guidelines that actually exist at the moment for therapeutic termination.

**CHAIR:** Do you feel that the current legislative regime within which Queensland women are operating is giving justice and doing justice to putting the health of women first, given that many witnesses have argued that many terminations are operating outside of the terms of those guidelines in public hospital systems?

**Dr Campbell:** I am not so sure. I think that the public hospital systems—and this is only anecdotal evidence—generally try to operate within those guidelines. It is those who are outside the hospitals. If you wanted to look at how you do more to enhance and protect the health of women, you look at how you regulate those clinics and, indeed as I suggested in my submission, do we even need those clinics?

**CHAIR:** That leads to my next question. You state—

Doing away with “abortion facilities” and ensuring that abortions took place in the same way as other medical procedures would do more for the protection and health of women than what is proposed here.

Is it your position that only women who present with fatal foetal abnormality should be allowed to access terminations in a public health facility?

**Dr Campbell:** I do not want to be drawn into—

**CHAIR:** When I say ‘you’, of course I do mean the Bioethics Centre.

**Dr Campbell:** As I said, the church’s position regarding abortion as such is clear and I articulated that last time. I do not want to be drawn into saying that these are the kinds of conditions that the government might consider. At least, I do not want to go too far down that line. I suggested as a fall-back position, if you like, codifying McGuire would clarify the position and give a range of where legally those abortions might occur in a hospital.

**CHAIR:** The current bill proposes to move termination into a health bill, as proposed by the member for Cairns. Particular views in your submission make mention of conscientious objection, that is, you do not feel that the provisions that are included provide adequately in the area of conscientious objection. Also, some limitations are included, such as—

The condition that a second doctor be consulted by the first doctor, does not give one grounds for confidence.

Can you expand on those two points?

**Dr Campbell:** If we take the two-doctor rule, the second doctor does not even have to examine the patient. It can be a phone call. There is no protocol given as to how that doctor gives their view. It could be two doctors from the same clinic. It just opens itself, in my mind, to subterfuge or just having a nice way out of it. Normally when you seek a second opinion regarding something, you at least see the doctor who is giving the second opinion. I think that is a token thing. What was the other part?

**CHAIR:** In regard to conscientious objection?

**Dr Campbell:** I did not think this bill was as bad as some others regarding the area of conscientious objection, but it still leaves it open. As I mentioned in my submission, I am left with the query: why are we legislating in this area of conscientious objection when for years the professional associations have handled it? The AMA has its rule on conscientious objection. Why are we buying into it and not leaving it to the AMA, which in a sense has what I would call a sounder approach to conscientious objection than some of the legislation passed in other states?

**CHAIR:** Some have argued that they feel we would need legislative protection for those who would seek to conscientiously object.

**Dr Campbell:** If you are legislating, you would accept the role played by the professional organisations.

**CHAIR:** Thank you.

**Mr CRAMP:** In regards to your submission, the bill offers no health care for women, even though it purports to address that. This is an interesting quote, which has been touched on but you have certainly gone straight to the core. There is a concern that this is far too simplistic for a complex issue and really it should be more about women's rights. What are the areas of concern for the Bioethics Centre and perhaps the church in ensuring not only that the baby is protected but I am also concerned about the woman holistically—emotionally, mentally, physically? Are there any particular avenues that your centre would see so that we could move forward to ensure women are protected?

**Dr Campbell:** I give all due credit to Queensland Health. Obviously I am not advocating therapeutic termination, but their guidelines that have been prepared cover very well a wide range of areas that show genuine concern for women's health. If those guidelines were followed and implemented, we would greatly improve the situation for women's health around this area in Queensland. As I said, the more I studied those guidelines, and I went back to read them in light of this submission, frankly I was not quite sure why, if someone wanted to change the regulation on abortion, they were not using that as a model.

**Mr CRAMP:** You mentioned in your report a reference to Clause 21 of the bill, which deals with two options: one is to end pregnancy and the other is to kill the child through feticide. Would removing sections 224, 225 and 226 of the code mean there would be no recourse for feticide as such as it would no longer be a criminal offence; is that what you are saying? I know it is obvious, but what are your concerns around that? Is it that basically it will be no longer a criminal offence?

**Dr Campbell:** If you go back to the first bill, yes. It virtually removes it. If you follow it up with a paragraph like this where you expand it beyond 24 weeks, that is exactly what you have.

**Mr CRAMP:** My last question is around conscientious objection. Having spent 14 years in the ambulance service prior to this job, I am very well aware of the great work of the Mater services, especially in Brisbane in their special care nursery. How concerned is the Mater organisation with regards to conscientious objection? I do not need to know the legal advice, but have you gone so far as to take legal advice on how this bill or the previous bill could impact on your services? Would you still refuse termination at the hospital?

**Dr Campbell:** I will give a generic answer. I am not going to speak on behalf of the Mater, but I was involved in discussions relating to legislation in Victoria, et cetera. Generally speaking, where a Catholic facility operates a healthcare facility, it does so on a covenant that it operates it according to the Catholic ethos. That is something that is signed off when agreed upon. Should you want to change those terms as a government, then you are into a different contract. No matter what happens to the law, the Mater's contract is that it can continue to administer health care according to its ethos.

It is not the institution that is most caught under the conscientious objection or lack thereof provisions; it is the individual doctor. No-one has gone after the Catholic hospitals in Victoria on this issue, but they have gone after individual doctors. They are the ones who do not enjoy the protection. I would be more concerned about the individual doctor in a private practice who does not want to refer on for abortion. They are the ones who I see are under threat.

If you come to an institution, my understanding of the arrangement between government and Catholic institutions in running health care is that we run them according to the Catholic ethos. That is part of the contract. If you want to change that contract then we would probably pull out of health care. I am not going to speak for the bishops on that one.

**Mr CRAMP:** It certainly was not to jump to those conclusions. It is interesting that the concerns are that heightened that there are considerations and deliberations taking place. You did mention other states where doctors have been subject to legal proceedings around their conscientious objection. Do you believe that this bill will lead to the possibly of that occurring in Queensland for individual doctors?

**Dr Campbell:** As I said, I do not think what is proposed here is as, what I would call, draconian as in Victoria. There is probably only a very limited range for it to become an issue here—whether you decide what is an emergency in that situation et cetera. Realistically, I do not know that it would become an issue under this proposed bill, the way I see it at the moment. Lawyers might have a different view on that.

**Mr KELLY:** In terms of your submission I was interested in what you say about paragraph 20. You say that this flies in the face of common law grounds which sought to make limited abortion legal in Queensland and contradicts society's expectations. Does that suggest to me that if the common law approach was codified that the organisations you represent would be supportive of that approach?

**Dr Campbell:** If it were a choice between that and something worse—in other words, complete liberalisation of abortion—then we might support that as a lesser evil, to use the technical language. It is not something that we support in a generic sense because we think there is an injustice involved in termination of pregnancy full stop, as I outlined at our first meeting. That is our position. If we have a choice between one piece of legislation and another piece of legislation, we might advise people that this one seems to have more fences around it than that one.

**Mr KELLY:** I am you glad you brought up the Queensland Health guidelines which seem to be written trying to interpret the common law and the code and also incorporate the case of Q as well. If this bill were unsuccessful but the previous bill was successful—that is, the matter was decriminalised so there is no guidance under law—would it be your understanding then that effectively not just Queensland Health but through the licensing arrangements any organisation or individual who performs terminations would rely effectively on that document to guide their practice?

**Dr Campbell:** On those guidelines?

**Mr KELLY:** Yes.

**Dr Campbell:** I would have to investigate that, Mr Kelly. I am really not in a position to give you an answer and try to understand the ins and outs of that. If it was totally decriminalised it would depend upon your understanding of the Queensland Health guidelines.

**Mr KELLY:** If it were totally decriminalised and we were not able to put other health regulations in place and we were relying on the Queensland Health guidelines, would your organisations have concerns that future health bureaucracies or governments of the state could simply change those guidelines without a legislative requirement?

**Dr Campbell:** I would have two concerns. One would be that one—that is, that they could. The second one would be that once you went down that path to what extent would the guidelines be followed when we have said that anecdotally we do not believe they are followed in a lot of our facilities—not our public hospitals, but other facilities—at the moment.

**Mr KELLY:** That leads me to my next question. Your solution to safe access is not to have anywhere to access this. That is on the basis that these procedures should be done in organisations that provide a full range of services. I put it to you that as health care and medicine becomes more and more specialised there are numerous clinics that specialise in one procedure or even subprocedures. Why should we treat the termination of a pregnancy and, say, other women's health services any differently to other sections of health care?

**Dr Campbell:** I take your point, although I would like to go more into that and know exactly how many specialised clinics there are. I am certain we have skin cancer clinics. Most of them do not have the kind of possible repercussions surgically as perhaps a surgical termination of pregnancy does. I take your point there. Given what I have heard about our public hospitals sometimes having to fix up what has happened in abortion clinics, it seems to me to indicate that it would be wiser to have those procedures, because of the surgical side effects that can happen and can be quite disastrous, done in a tertiary hospital.

**Mr KELLY:** I am aware of problems related to procedures performed in dental clinics and orthodontic clinics and other specialised procedures that have had to be fixed up in hospitals. Should we shut down orthodontists and dentists and prevent them from performing—

**Dr Campbell:** I take your point.

**Mr KELLY:** You mention that division 3 would become obsolete if abortions followed the normal process for surgery. This section suggests that there is no system at the moment in terms of licensing and regulating clinics where abortions are performed. Based on previous evidence and submissions, it would seem to me that to perform surgical abortions or surgical terminations there is a requirement to go through a licensing process. Is that your understanding?

**Dr Campbell:** That is my understanding, but I am not an expert. That was in relation to a particular issue. I am talking about the anecdotal evidence of the lack of follow-up sometimes after a termination in a clinic. That would be my greater concern.

**Mr McARDLE:** You make the comment in your paper about those who object based upon conscience and that the AMA would have a code of ethics to deal with that point. You made that point several times. You referred to the issues around clause 21 and the doctor forming an opinion post 24 weeks gestation and then a second doctor being consulted and there being no requirement around that consultation as to what is required to be done or cannot be done. Would the AMA code of ethics not govern that as well? Would their ethical standards not require certain things to be achieved or consultation to be accepted by the professional body as true consultation?

**Dr Campbell:** I have not looked at that. I would be very interested to have a look at it for you. I dare say it would, but, once again, how is it policed and regulated? I do not know. I take your point. It would be interesting to have a look at.

**Mr McARDLE:** The issue of the AMA code of ethics would not cover a nurse, which is detailed in clause 21 as well. A doctor can direct an RN to do something. That would not cover the nurse. It could well be important that that be covered off in this bill as well.

**Dr Campbell:** I am not against covering conscientious objection properly in the bill, in the sense of making sure that is allowed for.

**Mr McARDLE:** One of the things that worries me about clause 21 is that, as you correctly point out, the patient or woman may never see the second doctor because it is the first doctor who has to consult, as I read the terms of the bill, the second doctor. That doctor may have a biased point of view, not deliberately, but we are all human beings. We adapt and adopt to our circumstances based upon our prior life experiences. Would you be concerned about the fact that even if you accepted the terms of the bill that a woman does not see the second doctor to express her own opinion and that doctor form their own independent opinion upon seeing the reports and assessing the woman in front of them?

**Dr Campbell:** I definitely would. I believe that getting a second opinion is required because it is supposed to be a termination in light of a serious threat to the woman's physical or mental health. I do not think that can be established simply through the sharing of records or one doctor sharing his point of view. I think that it takes a patient-to-doctor examination. That is something we see in various other areas of medicine all the time. If you go for a second opinion it is normal that it involves a face-to-face meeting.

**Mr McARDLE:** The other point that has been raised in other submissions on this exact issue is that it could well be the doctor in the next office, in the same complex. It could be a pro-choice establishment. That doctor could be a colleague of the first doctor. That would also be a concern to you, would it not, in that it is not an independent or seen to be independent doctor?

**Dr Campbell:** Definitely. I raised in my evidence that that would be the case if there is no protocol around this second opinion. I think we need to establish something around it if you want to make it something more than dressing.

**Mr McARDLE:** Would you be concerned that the code of ethics of the AMA or the QNU, for that matter, may not cover this situation to a standard that is required to be met to satisfy the test that we are talking about here today?

**Dr Campbell:** As I say, I have not looked at it from that point of view, but I think that I would be concerned.

**Mr HARPER:** Somebody has to fly the flag for the Townsville Mater where my children were born.

**Dr Campbell:** Very good. I am up there tomorrow actually.

**Mr HARPER:** At the very core of this bill is the amendments to Health Act. The commentary in your submission notes that it displays very little concern for the health of women and that division 3 entitled 'patient protection' ignores the various ways in which women's health might be more sufficiently addressed with regard to abortion. You touched on proper information and mandatory counselling and follow-up. Are there any other aspects that you would consider should come under the women's health portion?

**Dr Campbell:** The mandatory part is the mandatory offering of counselling. I do not think it is mandatory counselling. I think there is a problem with mandating counselling.

**Mr HARPER:** What are your views on the mandating of counselling?

**Dr Campbell:** Forcing someone into counselling has already destroyed the counselling relationship. Counselling relationships are very special kinds of relationships. I think that you can mandate that it has to be offered and genuinely offered, but I do not think that you can mandate that it actually takes place. That would undermine the very counselling process by doing that. That is what I mean by that.

**Mr HARPER:** Were there any other aspects of women's health that you wanted to touch on?

**Dr Campbell:** Nothing that is coming to mind. That assessment should take in the woman's physical condition, emotional condition and her social condition, all of which might be having a bearing on her decision, and help her to explore those things.

**Mr HARPER:** You touched on earlier in your oral submission the fact that this only protects women around the centres themselves. Can you articulate on that any further?

**Dr Campbell:** Personally I think it is huge overkill. There was talk in here about images and photographs being taken. I have never heard of that happening? Has anyone ever actually witnessed or had evidence of that actually taking place?

**Mr KELLY:** Yes, every year in Greenslopes there are people holding up images—

**Dr Campbell:** No, taking images; taking photos of people coming and going.

**Mr KELLY:** Sorry, I misunderstood you.

**Dr Campbell:** I am not talking about people holding images. People are generally trying to say that there is something wrong here. I know of women who have been walking to have a termination and walked up to these people and walked away and had their child. I think there is a way of doing it that is respectful and is still saying something. I know that there are people who simply stand outside and pray. I do not have any problems with that.

**Mr HARPER:** As a committee we need to address all aspects of the bill. I did note earlier when someone raised foetal abnormalities that you were reluctant to go into that area and make comment on that in terms of the 24-week gestational period. I think that we need to look at all aspects. I am wondering if you could touch on that?

**Dr Campbell:** I do not consider foetal abnormality in itself to be grounds for terminating life. I do not consider adult abnormality to be grounds in itself for terminating an adult life. Ms Joseph talked about the Down syndrome situation. I could tell you some stories of Down syndrome children watching commentary and turning to their mother saying, 'Why do they want to kill me?' I think there is something for us to think about as to what we are saying about people with disabilities when we are so focused on the disabled child in utero.

Having said that, there are occasions—this is where 24 weeks becomes significant—when the foetal abnormality is such that it is going to be lethal either at term or pre term and it is also aggravating a condition of the woman. That is where an early induction might be called for, and you still do the best you can for the child even though you know the child is going to die. That, in my mind, would not be a direct termination or a direct attack on the life of the child. You are doing something therapeutic. The principle of double effect, as we refer to it, would often come into play in those situations.

Madam Chair, I think you referred to some of my comments about the views of the population. Some years ago two colleagues of mine wrote a book called *Common Ground?*, which I refer to in my first submission and the archbishop also referred to it. I think that book is one of the most extensive attempts not just to poll people but also to drill down by having focus groups. It was quite honest in its answers even though the people were themselves not in favour of abortion. They admitted that most of the population believe there should be access to abortion. One of the startling things that came out of that process was that the area where quite a large number agreed on termination was over abnormality, and we were quite shocked. I was shocked by the result and I was not part of it, but even those who were part of it were quite shocked by that result. I am not quite sure what it says.

**Mr JANETZKI:** Can you indulge me in giving an ethical perspective? I have no connection with Mater Health Services. If this bill were passed, what ethical challenges would you foresee if terminations are being conducted at 24 weeks in one part of a health facility and in another part of the same health facility all efforts are being undertaken to save the life of an unborn child at 22 or 23 weeks? Without being specific, what ethical or philosophical challenges do you foresee?

**Dr Campbell:** I think you will find the staff are very conflicted, and I have noted this from an experience in Sydney, not at a Catholic hospital. I would hope that the scenario you are talking about would not happen in a Catholic hospital. It will not happen in the Mater.

**Mr JANETZKI:** That is why I did not go there.

**Dr Campbell:** But I do know of other private hospitals where it has happened. I cannot quote you things, but I think, first of all, you are going to find that the staff are conflicted because we need a rational consistency. As you say, you are terminating one child which could be a quite healthy child while you are fighting to save an unhealthy child of a similar gestation period. I think it raises a whole lot of issues regarding expenditure of resources for the hospital to think through. 'We are terminating here; why are we spending money here?' I think it raises through the whole establishment a question of rational consistency. When you come up against radical inconsistency like that, you start to undermine things in all kinds of ways.

**CHAIR:** Dr Campbell, our time for questions has expired. Thank you very much for coming before the committee.

**Dr Campbell:** Thank you, Madam Chair, and all members of the committee for the opportunity to talk to you today. All the best with your deliberations.



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

**DUFF, Ms Angela, State Vice-President, Australian Family Association**

**Mr Baker:** Before Angela starts with her opening statement, I might point out that she is a great walking advertisement for our cause.

**Ms Duff:** Good morning. The Health (Abortion Law Reform) Amendment Bill would be a joke if the issue were not so serious. Mr Pyne's bill includes an unenforceable 24-week limit which lets late-term abortionists do their worst without any penalty. This is an attempted con job on the public. A law without consequences is no law at all, besides which there is no medical reason to perform abortion after 24 weeks of pregnancy as there is never a situation in which a viable, unborn baby needs to be killed to save the mother's life.

At the same time, the bill would establish so-called protected areas near abortion facilities in order to criminalise peaceful protesters who are praying and footpath counsellors who are standing to help vulnerable women who may request assistance or an alternative. It is scandalous that the Pyne bill states specifically that the killing of viable babies would not be an offence, yet peaceful protest would be. These so-called protected areas would protect only profit-making abortion businesses, certainly not women and their unborn babies.

A number of submitters have argued that abortion should be treated like any other medical procedure and regulated through the Health Act rather than the Criminal Code, but abortion is only a medical procedure in the same way that execution by lethal injection is a medical procedure. Indeed, that is exactly the way one abortion technique—foeticide—is done. Abortion is in the Criminal Code for good reason, because it is the killing of an innocent human life. American abortionist Dr Warren Hern at a meeting of the Association of Planned Parenthood Physicians in 1978 described midtrimester dilation and extraction abortion—a common practice in Queensland—in this way:

We have reached a point in this particular technology where there is no possibility of denial of an act of destruction by the operator. It is before one's eyes. The sensations of dismemberment flow through the forceps like an electric current.

This bill should be rejected by the committee because it is poorly drafted hotchpotch legislation which serves no purpose given the committee already has recommended that Mr Pyne's first bill not be passed. Also, this bill is not in line with current community attitudes and expectations, as demonstrated by the comprehensive market research undertaken by Galaxy for the Australian Family Association in May this year. We draw the committee's attention to our written submission to this inquiry in which we conclusively refuted ANU's flawed attempt to discredit this poll.

As 53 per cent of Queenslanders either think the current law is about right or is not restrictive enough, parliament clearly should keep abortion in the Criminal Code. At the same time, Queenslanders want safeguards for women to sit beside the current law. Ninety-four per cent of Queenslanders want women considering abortion to receive free independent counselling and information on the development of the unborn baby, the nature of the procedure, the physical and psychological risks of the operation, and the alternatives of keeping the baby or adoption so they can make a fully informed decision.

Other safeguards the public wants are a cooling-off period of two to three days for women before an abortion—supported by 87 per cent of Queenslanders—and parental consent requirements for girls under 16—supported by 75 per cent of Queenslanders. The reason these safeguards are so desperately needed is that abortion harms women. Besides the physical risks of infection, haemorrhage, infertility, breast cancer and even death, abortion can have a huge impact on a woman's psyche—on her emotional, mental, psychological and spiritual health. American psychiatrist Dr Julius Fogel, who was also an obstetrician who performed many abortions, said it best:

Every woman ... has a trauma at destroying a pregnancy ... A level of humanness is touched. This is a part of her own life. She destroys a pregnancy, she is destroying herself. There is no way it can be innocuous ... often the trauma may sink into the unconscious and never surface in a woman's lifetime. But it is not as harmless and casual event as many in the pro-abortion crowd insist. A psychological price is paid, I can't say exactly what. It may be alienation, it may be a pushing away from human warmth, perhaps a hardening of the maternal instinct. Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist ...

We are appalled at the claims made by medical bodies to this committee that abortion is not harmful to women. Their attitude is, 'Move along folks; nothing to see here,' but then why would we expect those who have no respect for innocent human life to have respect for the truth? We call on the committee to examine the ample evidence of the harm that abortion does to a woman which we

provided in hard copy format with our submission to this inquiry. We provided seven copies of each of the following: three research reports 'Really a choice?'; 'Women and abortion: an evidence-based review'—

**CHAIR:** Ms Duff, that brings your five minutes to a close. I invite the member for Thuringowa to open questions.

**Mr HARPER:** Thank you both for your submissions and for being here today. Are there any aspects of the bill in terms of the health amendments that you think should be included in reviewing the bill as it sits? I wanted to get some commentary in regards to counselling and your thoughts on the 24-week gestational period.

**Ms Duff:** I believe that there should be a limit right throughout pregnancy, because a life is a life at conception. In terms of 24 weeks, you are pregnant all the way through. There is no amazing point at 24 weeks. I think what we are probably referring to is viability outside the womb, but you need huge medical support even after 24 weeks.

I believe there should be mandatory counselling because a lot of women do not have the information. Abortion is just bandied around as an option, but there are risks associated with it. A lot of women do not know how the medical procedure is done, so I think the information should be given. Perhaps Alan can point to what happened in Adelaide.

**Mr Baker:** We mentioned this in our presentation at the public hearing for the last inquiry. We tabled an article in the *Sunday Mail* in Adelaide and gave the committee a copy of it. This was a report in the *Sunday Mail* about the Women's and Children's Hospital in Adelaide which in 2003 had a policy change and made counselling mandatory for termination of pregnancy by social workers at that hospital. In South Australia there are no private abortion clinics. All the abortions in South Australia are done in public hospitals. A total of 584 women made appointments for termination. Only 473 turned up for the talk and then only 417 went through with the termination after discussing their options. There is a level of unwanted abortion and that reduced the number of abortions by 25 per cent as a result of that requirement for mandatory counselling by independent counsellors.

**Ms Duff:** With any major medical procedure, you need information to sign off that you understand and you are willing to take on the risks.

**Mr Baker:** As far as the 24-week limit is concerned, if you are going to have a 24-week limit consistent with viability—although it is generally accepted that the age of viability in Australia is about 23 weeks and in America about 22 weeks—then let us have a limit that is enforceable and real; that is going to be observed because it has a penalty attached to it. There should be a total prohibition on late-term abortion, which is a trade in human misery.

There is no medical reason, as Angela said in the introduction, for a late-term abortion because, if a mother has a medical condition, an emergency or her life is at risk, the doctors who are treating her are not going to perform foeticide and wait three days for that baby to be delivered dead. They will terminate the pregnancy by going in with a caesarean section, removing the child and immediately giving it active treatment, resuscitation, and taking care of the mother. That is the quickest way of solving the medical problem for the mother—to induce, in some cases, but if it is an emergency with preeclampsia to go in with a caesarean section. You do not need to kill the child. The child is viable and the child has legal rights once it is born.

**Mr JANETZKI:** I want to pick up on your point you have just raised, Mr Baker, in respect of late-term abortions. What evidence does the Australian Family Association have in respect of children being born alive as a result of late-term abortions?

**Mr Baker:** There were some figures recently released in Queensland where I think the number was 28 in the last year who were born alive. Most of them were probably babies who had lethal abnormalities and the doctors and mothers had decided to induce early labour. They were born with a heartbeat so they are recorded as being born alive. They might have lived for a few minutes or a few hours. In most cases that was probably the cause of that. If they had a foetal abnormality which was not lethal, the truth of the matter is that they would perform foeticide and that is why 95 per cent of Down syndrome babies are killed by abortion. Those are not lethal abnormalities. Spina bifida is not a lethal abnormality but most of these babies with those conditions are knocked off in the womb. Foeticide is performed on them so there is no risk of them being born alive. That is totally immoral.

They now have a test for Down syndrome early in pregnancy. October is Down Syndrome Awareness Month. It is so hypocritical that we already kill 95 per cent of Down syndrome babies in the womb in search-and-destroy missions. That is what happens. There is a lot of pressure put on mothers by their doctors to get rid of the Down syndrome or spina bifida child. We recently had an

Australian first in the Mater Hospital here with Dr Glenn Gardener, who appeared before your committee recently. He performed that groundbreaking surgery on a spina bifida child in utero in the Mater. How fortunate is that child that he or she was not aborted.

**Mr JANETZKI:** The Galaxy research that the association commissioned found pretty overwhelmingly that Queenslanders wanted to see not necessarily legislative change but social programs changed to address the abortion question. I do not know whether you heard me ask this question before. This bill is now being proposed and there is no cooling-off period and there is no compulsory counselling. In terms of social program changes, what would the Australian Family Association recommend? What is your preference?

**Ms Duff:** As we were saying, mandatory counselling because there is no information. Abortion is just given as an option but not what the procedure is, what the risks are associated with it and what other alternatives there are. The cooling-off period is important.

**Mr Baker:** Informed consent is different from independent counselling. I think there needs to be an informed consent booklet like the ACT had until, unfortunately, the Labor Party and Greens got into power three years later and repealed it, revealing themselves to be pro-abortion rather than pro-choice. How on earth can you remove an informed consent provision in the legislation to protect women and say you are pro-choice? That is what happened in the ACT.

With late-term abortions, we are fearful if Mr Pyne's legislation is enacted by parliament that we would have the same level of demand for late-term abortions as they have in Victoria, where in the last year for which we have figures, 2013, there were 179 late-term abortions performed for foetal abnormalities and 179 performed for psychosocial reasons—that is, the partner of the woman has left, there are financial difficulties or there is some other psychosocial reason for killing a child who is probably at the age of viability.

**Mr JANETZKI:** I presume the association would have discussions with post-abortion counselling services, although I think Cherish Life mentioned there were very few. What is the feedback from those counselling services that you have received, if any?

**Mr Baker:** Are you talking about the counselling services offered—

**Mr JANETZKI:** Priceless was mentioned.

**Mr Baker:** The Priceless Life Centre, or Priceless House as they are now known, are all volunteers. You heard from them at the last public hearings.

**Mr JANETZKI:** My apologies. I was not present at those.

**Mr Baker:** It is unfortunate that they were not able to be included on this today, but perhaps there is a possibility that the committee may look at having another half day of hearings to hear from Priceless Life again, given that I noticed Children by Choice is being invited again tomorrow. That would be good if you did have the opportunity to hear from Priceless Life. They are volunteers. None of them are paid. They do not get any government funding. They do a wonderful job in the highest standard of independent counselling. Of course they have a pro-life ethic but it is not directive; it is finding out what the woman wants and needs. No doubt some women will go ahead and have a termination. I think they said that in their evidence before you last time. They also provide post-abortion counselling.

Emma Morris, who sent a submission in I believe, also did an opinion piece in the *Courier-Mail*. Her story is recounted in a video on the Abortion Rethink site. She sought counselling from Priceless Life, and after years and years of mental anguish and all kinds of emotional problems she found healing. There are many women who—

**CHAIR:** I am mindful that we have eight minutes to go and I know that the member for Greenslopes and Gaven would like to ask questions.

**Mr KELLY:** Mr Baker, you made the statement that there are no medical reasons for a late-term termination. I put the situation to you where a woman is carrying a foetus which is diagnosed to have no brain, no kidneys or no heart—no capacity to survive outside of the uterus. As a clinician, if I was going to be responsible in providing the options to that particular individual, the options would be that we can terminate that pregnancy or you can carry that pregnancy to full term. The outcome for that foetus will be exactly the same in both of those situations. It is foreseeable as a clinician that a woman who goes through, say, 16 weeks additional time—where they are very visibly pregnant, where they have people congratulating them, where people are actually suggesting that they are about to face a very happy time when they know there is a very sad thing about to occur to them—would suffer great psychological trauma through that process. In fact that situation is described in one of the case studies in Maternity Choices Australia's submission to the last inquiry.

I would say to you that, in my view as a clinician, there is a clinical reason in that particular instance whereby a termination would be a choice that individual could rightly make. I would not suggest that I as a clinician would say which is the choice to make, but it would certainly be, from a health perspective, something that that person should have access to.

**Ms Duff:** For the psychological health of the mother?

**Mr KELLY:** Absolutely.

**Mr Baker:** We would agree. To be pro-life is not necessarily to be pro-full-term.

**Mr KELLY:** How does that then accord with your statement that there can be no medical reason for a late-term termination?

**Mr Baker:** In that situation, what is best for the mother invariably is that the baby is born. I have a friend where this happened to her and her family. She delivered a baby with anencephaly. The women invariably choose to have the baby delivered, whether the baby lives for a few minutes or a few hours, and the family cuddles that baby. It is a sad experience but it is much, much more preferable to have that happen than to have the baby destroyed in the womb.

**Ms Duff:** It also promotes the emotional hearing. I know you say that it is traumatic for the woman to hear that news and to be given that choice but the support should be given for full term. I had a nephew that was only given two years to live because his heart would not be able to sustain that. Do we make the choice that we should cut his life because we do not want his life continuing on and living with the knowledge that he is going to die anyway? It is very sensitive.

I have a friend who experienced that she would know that her child would be dead a few hours after giving birth, but there is a great emotional and psychological healing with carrying that full term and giving that child a chance, even if it is a few minutes. It is still life. It promotes the healing. When you say that everyone is excited, usually the woman is able to explain to her friends and family that this child is not going to be viable outside the womb and then they can get the support around that. There is not necessarily any support after an abortion, after that unnatural ending of a life.

**Mr Baker:** Ethically, there is a distinction between actually destroying a child in the womb with foeticide or some other destructive procedure and allowing that child to be born early. If it is past the age of viability, there is no ethical problem with that, having an early induction and labour of a child that has a lethal condition which is incompatible with life outside the womb. What kills that child is not the early termination; it is the lethal condition.

**Mr KELLY:** You quoted a whole range of statistics that related to mandatory counselling in South Australia. The bill does not deal with counselling—mandatory or otherwise. You quoted some numbers and I am trying to remember what you said. It was something like 580 made an appointment for a termination, something like 470 or 480 showed up and then 417 went on with the termination. Does that study know what happened to those women who did not keep the appointment for the mandatory counselling?

**Mr Baker:** No. They could have gone elsewhere. They could have gone to Victoria to get an abortion there. We do not know.

**Mr KELLY:** Are you concerned that, by implementing mandatory counselling, a significant number of women will not seek any medical assistance at all in relation to their decisions around termination or continuing that pregnancy?

**Mr Baker:** One of the sayings that those on the other side of the debate use is that abortion is a matter between a woman and her doctor, as if there was a doctor-patient relationship, but the vast majority of abortions in Queensland are done in private abortion clinics to which a woman makes an appointment directly—or maybe goes through Children by Choice. Typically, there is not a relationship between the woman and her doctor. She sees someone, fills out some forms, goes to the operating room and is in there for five minutes with the doctor performing the procedure, and then she is out. There is no relationship. She is not given any help or counselling by the doctor.

**Mr KELLY:** In terms of the number who did not go on to have a termination, we do not know how many of those women went on to have children who may have been born into situations of domestic violence or other long-term problems that put those families who were vulnerable already—we do not have any understanding of what has happened to those women at all, do we?

**Mr Baker:** No.

**Mr KELLY:** Just a final question, in relation to the protected areas in the bill that you have commented on—and thank you for that. You talk about the government's role in terms of not controlling how and where people protest. I put it to you that, in fact, we quite frequently control

people's capacity and the manner in which they protest—and I will give you an example. Any trade unionist will tell you that if they want to stage a form of industrial action or a protest they generally have to seek approval from the Industrial Relations Commissioner for that action to be protected, that is, for them not to be liable for any legal penalties. Given that we control the manner of protest in a number of situations, why is it unreasonable that a bill seeks to control the manner in which a protest occurs?

**Ms Duff:** If the clauses under proposed section 24 were passed into law by parliament in the quiet hours of the night, then the vast majority of Queenslanders who currently disapprove of abortion up to nine months for any reason would be committing an offence if they showed their disapproval in any peaceful manner anywhere near a place where abortions are performed. I realise they are restrictions around a peaceful protest and currently there are restrictions, and I think they are appropriate. I am a footpath prayer/counsellor and have been for 20 years. My standard procedure of going outside an abortion clinic is to ring the police and say to them, 'I'm standing here. I'm not blocking the footpath. I'm not blocking the entrance. I am not harassing the woman. I just want to let you know.' Usually with profit-making businesses behind me, they are wanting to push ahead; they do not want any disagreement or any alternative put in front of their business. I am usually the one who gets harassed by the staff and so that is why I call the police. If the police do turn up, they usually say, 'We've got better things to do with our time.'

The question the committee must investigate is to what extent the for-profit clinics which are operating in Queensland lobbied to have this clause placed in Rob Pyne's private member's bill—whether any promise was made. No other business receives special sanctions to make protesters criminals. Why single out a business that profits from killing babies? Usually—

**CHAIR:** I am mindful that our time has expired, but do I want to give the member for Gaven time to ask questions.

**Mr CRAMP:** I refer to your comments around adoptions and the fact that there is a very small pool of eligible children currently to be adopted and quite a large number of eligible potential parents or couples waiting to adopt. Do you think that should form a part of that informed decision-making process? You talk about an independent and non-biased approach. Should adoption be an option? I want to hear your thoughts on that because there is a supplementary question to that.

**Mr Baker:** Adoption is an option which should be discussed. A woman who is contemplating an abortion should be aware of all her alternatives. Perhaps there are some reforms that need to be made in the adoption area to make it a choice that more women would choose to take up. I think 54 is the number of 'stranger' adoptions in the last year in Australia of Australian born children.

**Mr CRAMP:** There were 10 or 11 in Queensland. We have heard previous witnesses effectively state that adoption should be the very last option put on the table. My personal belief is that it is almost seen as a negative option. Whilst we are talking about abortion, do you think that would have some impact—viewing it as negative option?

**Ms Duff:** I do not know whether it is a social agenda through sociology departments, but adoption is considered a negative and it is considered to be cruel to be giving your child away. Then we have this diabolical issue on the other side that it is okay to take your child away, to kill your child, but not to give your child away.

**Mr CRAMP:** I was very interested to see your thoughts about that because we have not had many people come up and say in their submissions that it is a positive option. You said there were 179 psychosocial reasons for abortions performed in Victoria last year. Was that correct?

**Mr Baker:** The last year for which we have figures, 2013. That is late-term abortions.

**Mr CRAMP:** I keep hearing evidence that having this form of legislation come in where you can terminate up to the date of giving natural birth does not promote any increase in abortion rates. Overall, was there an increase or was the abortion rate still the same in Victoria that you know of and it is just that now they are providing reasoning for that?

**Mr Baker:** We know that at one hospital, which is the royal women's in Melbourne, there was a sixfold increase in two years between 2008 when abortion was decriminalised in Victoria and 2010. The number of late-term abortions performed at that hospital went up from one a fortnight to two a week. There was a sixfold increase. We do not have any figures for any other hospitals, but that is the main hospital that does late-term abortions in Melbourne.

**Mr CRAMP:** You do have some evidence which is a start because I have not been provided with it previously.

**Mr Baker:** That was in a Channel Seven news report in 2010. The only article I could find in the print media to verify that was this article in the *Age*, which I can table.

**Mr CRAMP:** In relation to the words 'psychosocial reasons' and the specifics you gave—it could have been social economic circumstances, financial circumstances—were they your words, or were they actually in a report or a dataset of some kind?

**Mr Baker:** They are in the dataset. We can provide you with that information.

**Mr CRAMP:** Can you table that?

**Mr Baker:** Yes, I will forward that to the committee.

**Mr CRAMP:** Is that okay, Madam Chair? I have just about Mr Baker's commentary around psychosocial reasons for terminations in Victoria. I asked were the words he used part of a dataset and statistics or were they his words and he said they were data and statistics. I have asked can we table that.

**CHAIR:** He can take it on notice and provide it.

**Mr CRAMP:** Can you take it on notice?

**Mr Baker:** Yes. Could I table something else, too? I know we do are running out of time.

**CHAIR:** Yes, we have. I think the deputy chair has a final question that he would like to ask before we move on.

**Mr McARDLE:** Ms Duff, a few moments ago you spoke about the relationship between those organisations that provide termination and Mr Rob Pyne. Am I right in saying you were suggesting we ask him about whether or not there was—in my words—an inducement of some sort to include something or not include something in the bill? If that is your comment, are you making that based upon fact or because the bill did not do something or did do something you believe there may be a relationship?

**Ms Duff:** There may be a relationship.

**Mr McARDLE:** There is no evidence of that statement, is there?

**Ms Duff:** No.

**Mr Baker:** It is just a question.

**Ms Duff:** It is a rhetorical question.

**Mr McARDLE:** I think it is a question that is not based on fact, not based on any evidence, but simply put into the air today to create some sort of idea in the mind of the committee. Is that right or wrong?

**Ms Duff:** No, it is not just to cloud the issue. I just know from experience—from 20 years of being outside an abortion clinic—that they do not like peaceful protests. In the last couple of years I have been part of a group that just prays peacefully—not blocking any entrance—but we get very harassed by the staff.

**Mr McARDLE:** Let's get this very clear, though. You are not saying there is any evidence you have got in any way, shape or form of inducement; correct?

**Mr Baker:** No.

**Mr McARDLE:** However, you are saying there that we should investigate if one does exist; is that right?

**Ms Duff:** Yes, to consider.

**Mr McARDLE:** Based upon what?

**Ms Duff:** That these clinics are profit making and that they do not want any objection to their practices.

**Mr McARDLE:** We are supposed to take that on board without any evidence?

**Ms Duff:** As I said, that is from my experience, not from evidence. That is from my experience.

**CHAIR:** Thank you. Our time for questions has expired. Thank you for coming before the committee today. We will now hear from Dr Katrina Haller, who joins us by teleconference to represent Right To Life Australia.

**HALLER, Dr Katrina, Senior Executive Officer, Right To Life Australia**

**CHAIR:** Dr Haller, it is Leanne Linard, chair of the committee and member for Nudgee. Thank you for joining us today. We would like to give you an opportunity to make a brief opening statement of up to five minutes before opening to questions from the committee.

**Dr Haller:** I would firstly like to say that everything these days seems to be a fundamental human right, but I would like to reject the concept that abortion is a fundamental human right. No international instruments can be interpreted to provide that. As a matter of scientific fact, a new human being begins at conception. So every human life is a continuum, beginning at conception and advancing in stages until death. There are different names for these stages including a zygote or the fertilised ovum, blastocyst, embryo, foetus, infant, child, adolescent and adult. You were once a child; you were once a baby; you were once an unborn child. It does not change the scientific consensus that at all points of development each individual is a living member of the human species.

Everyone has inherent dignity and protection for their inalienable human rights, and this is recognised in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and other international instruments. I note in your report No. 24 to the 55th Parliament you quote the CEDAW committee wanting to establish a right to abortion and you say the international Convention on the Rights of the Child looks at—bearing in mind that as indicated in the Declaration of the Rights of the Child, the child, by reason of his physical and mental immaturity, needs special safeguards and care including appropriate legal protection before as well as after birth. This is dismissed as being only the preamble, but I would like to draw your attention to article 17 (2) which provides that every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child. The definition of 'child' in the international Convention on the Rights of the Child is being someone under the age of 18. It does not specify a beginning age of birth or anything else, just the definition of child as being under the age of 18. We see abortion as a human rights issue that denies the child his or her right to life.

Of course, the mother has a right to life, too, but we live in a first world country in Australia and doctors can save both the mother and the child. They monitor the mother's health and they grow the baby as long as they can and then there comes a point where the doctors decide to induce the birth early but give the child every protection available to try to save the child's life. Children who have been born after 20 weeks gestation can survive. Over 24 weeks gestation they have more than a 50 per cent chance of survival and that decreases the younger they get, but babies have been born and survived over 20 weeks.

I see abortion as a very violent act against a woman and her child. Our social system is set up to make these two enemies—that the woman has to see the child as her enemy, as stopping her from working, as stopping her from studying. We should be able to do both. We should be able to offer women something better than to say that she cannot survive and live her life as she wishes to and have her baby as well. We have to do better than that so that women can do both. The whole philosophy of abortion teaches us that you can use violence to get what you want for any reason.

A woman never forgets how many times she has been pregnant. It is a very significant event for her. Her body has to be respected. Her biology and her sexuality have to be respected. Abortion trivialises that and does not really solve the problem. If you have an economic problem, you need an economic solution. If you have a social problem, you need a social solution. If you have a medical problem, you need a medical solution. Abortion is using a medical procedure to solve what can be a social problem or an economic problem. If the woman is homeless, we suggest she be given help to find accommodation support. If the woman is in a domestic violence situation, we suggest she be given help for counselling and to resolve that problem. Abortion does not solve social or economic problems; it will often entrench those social and economic problems. It is really a refusal to help her and it is a failure to seek a solution to her problems. I would just like to expand on—

**CHAIR:** Dr Haller, I note that your five minutes has expired. We will move now to questions. Thank you for your opening statement. The explanatory notes to the bill state that the policy objective of the bill before the committee is that there currently exists a lack of clarity around to what point during gestation and for what reasons a termination of pregnancy may be performed in Queensland. How do you feel that the bill before the committee, the Health (Abortion Law Reform) Amendment Bill 2016, does or does not address that?

**Dr Haller:** The law is that abortion can be performed to save the life or the physical or mental health of the mother. That is quite clear. The Rob Pyne bill does not seek to clarify that; it seeks to expand it. It seeks to have abortion on demand for social and economic reasons. If it were to clarify

it, it would be a bill to say that abortion is legal to save the life or the physical or mental health of the mother. To me, that is quite clear. It is a medical decision; it is a medical procedure to respond to a medical condition. The Rob Pyne bill does not confine itself to medical problems.

**CHAIR:** Dr Haller, your submission does not make any direct reference to or provide commentary on the different sections of the bill. Do you have any comments to make with regard to conscientious objection contained in the bill?

**Dr Haller:** I believe in conscientious objection, that no doctor should be forced to be part of an abortion. They are trained to save lives, and here they are being asked to destroy a life. They would see the mother and the baby as two patients, but now they are being asked by the woman to destroy the life of her preborn child. Doctors should not be forced to be part of that. In Victoria they do not have to do an abortion unless it is an emergency—I do not think that would ever happen—but they have to refer the woman to an abortionist if she wants an abortion. Many of our doctors are very upset about that because they see that as being complicit in obtaining the abortion. We agree with conscientious objection, that doctors should not have to be complicit in obtaining an abortion.

**CHAIR:** Would it be fair to say that you feel the bill, with regard to conscientious objection, strikes the right balance as it currently is worded?

**Dr Haller:** No, it does not, because it requires a doctor to refer a woman to an abortionist.

**CHAIR:** The Queensland bill as proposed does not require that.

**Dr Haller:** We would agree that doctors and nurses should not be required to be complicit in obtaining the abortion.

**CHAIR:** Dr Haller, do you have any specific comments to make with regard to what is proposed in the bill around termination and abortion facilities, that an area of 50 metres should be declared a protected area? Do you have any specific comments to make with regard to that?

**Dr Haller:** I know that in Victoria the Fertility Control Clinic had a court case against people who were outside their clinic who were offering help to the women who were going inside. These people were saying things like, 'We can offer you something better than this place can offer you,' or, 'How can we help you?' or, 'Do you really want to do this?' Some girls would say, 'No, I don't really want to do this.' The Fertility Control Clinic were losing business so they asked the police to arrest these people for harassment. It was found that there was no harassment. Then they got behind the Sex Party person, Fiona Patten, in the Victorian parliament to introduce a bill. They were saying, 'This will stop women being harassed,' but that was all a huge lie because the people outside the abortion clinic were merely offering to help the women going in. Once women go into that clinic, nobody gets paid unless the abortion is done, so any counselling they would get would be ridiculous. The cleaner does not get paid, the receptionist does not get paid—nobody gets paid unless the abortion is done, so they have a vested interest.

**CHAIR:** Dr Haller, you have made the comment, as some other submitters have, that this element of the bill has come about because of clinics. You have talked about the profit motive there. What would be your comment to others who would say that it is the women themselves who would raise that this is not supportive or a positive experience for them but in fact makes a difficult decision, which they may have made on informed information, very painful and even more difficult? What would be your comment in regard to their voices as well as, as you say, feeling that it is coming from clinics themselves?

**Dr Haller:** We believe that women should have independent counselling—not provided by the abortion clinic, because they have a vested interest in the outcome, but completely independent counselling. We hear from girls who say, 'I was coerced into this. My boyfriend put a lot of pressure on me,' or, 'His parents put a lot of pressure on me,' and they regret it. After the abortion they feel very down, very depressed.

**CHAIR:** I totally agree with you that independent, impartial counselling is very important. If a woman was to undergo such counselling—I appreciate that that is not contained in the bill as it is—would you still say that it would be fair for a woman under those circumstances to be approaching a facility and have people standing there with pictures and so on? Do you feel that is still supportive of that woman?

**Dr Haller:** Yes. We think women have a right to know. If they are going to make a so-called choice, they need to have an informed choice. They need to know what they are doing before they do it. Often they find out after they do it, especially if they have RU486. They expel a little sack with a little baby in it and they are often horrified to see how very well developed that little baby is. I think women have a right to know what they are doing.



**Mr CRAMP:** At the very beginning of your opening statement you said that it was scientific fact that life begins at conception. Were they your words or do you have some factual evidence that you are relying on to make that statement?

**Dr Haller:** I did a PhD in physiology. At the time of conception, when the DNA from the sperm unites with the DNA from the ovum, you have 23 chromosomes from the sperm and 23 chromosomes from the ovum. They join together to form 46 chromosomes, so there you have a genetically unique individual. Never before in the history of mankind has that individual existed and never in the future will it exist. That is unrepeatably. That DNA, those 46 chromosomes, determines the characteristics of the person—whether they have blue eyes or brown eyes, how tall they are going to be and their characteristics. That cell divides into two cells, four cells et cetera and continually grows. The beginning of that genetically unique individual is at fertilisation of the ovum. You were once a child. You were once a baby. You were once an unborn child. You were once a fertilised ovum. You were once that one cell that was the union of a sperm and an ovum and the DNA from each combining. They are the 46 chromosomes you have in every cell of your body.

**Mr CRAMP:** Great answer—very scientific, although many people have stated to me that they do not know where I come from! You made a statement in part 3 of your submission about modernising and clarifying the law, that women have a right to know that abortionists are careful to shield them from the truth. Talking about modern ultrasound technology—I brought it up to a previous witness—this committee heard previously that there are lengths taken by pro-choice clinics, or abortion clinics, to not show that. Do you think it should be legislated that that should form part of informed consent, that women should be provided an ultrasound or a picture of their unborn child or foetus to help them make informed consent? You obviously have a scientific background. How should that be done and in what setting, from an emotional standpoint, for the protection of the woman's emotional state?

**Dr Haller:** These are done, I think, to determine the exact stage of the pregnancy. The woman should be invited to hear the baby's heartbeat. Women are often told that it is just a bunch of cells, that it is nothing, that it is a piece of tissue. That is incorrect. If they see the ultrasound of the baby, they then see the baby's head and the baby's arms and the baby's legs. The baby develops very quickly in the first trimester and in the second and third trimesters it more or less merely grows. It finishes development, but all of the development really is done in that first trimester.

**Mr CRAMP:** Dr Haller, does your organisation see any opportunity for abortion or do you oppose all abortion? I know that some people—some of my colleagues and myself included—put up medical arguments, but I am very interested to hear about women who are the victims of rape or incest and especially those at a very young age who fall pregnant. I am not after your thoughts; I am after the organisation's standpoint on what occurs in that instance. Should they be allowed to have abortion as an option?

**Dr Haller:** We do sympathise with victims of rape or very young girls, but we do not see that the solution is to abort their babies. We do not kill children because their father is a criminal, so why should the child lose his or her life because the circumstance surrounding the conception was that of rape? That woman does need a lot of help and support. We would try to help and support her as much as we could. It is similar with a young girl. Pregnancy is a symptom of what is happening. We do not agree with abortion in any circumstance.

**Mr CRAMP:** Not even if it is a father who rapes his young daughter of 12 or 13 years of age and impregnates her? I gave that example to a previous witness.

**Dr Haller:** When I was a lawyer at the community legal centre we had a case like that of incest. The girl would continually have abortions and go back to the father. If there is a pregnancy, at least that would get the girl away from the father. The authorities would take the girl away from the father so she would not be subject to that continual incest, which is covered up by repeated abortions.

**Mr HARPER:** In your opening statement you said that life begins at conception. You have just gone on with the chromosome counts. Do you consider the morning-after pill a form of abortion?

**Dr Haller:** I do not know. I think the idea of the morning-after pill is to prevent conception, but I think it may be abortifacient if conception has already occurred. It might prevent conception if conception has not occurred, but it might be abortifacient if conception has already occurred.

**Mr McARDLE:** Dr Haller, thank you very kindly for being with us today. Earlier you said that you endorsed the idea of having the right to attend outside a clinic to offer alternative advice in relation to abortion. If the procedure involved independent counselling before and post, and also a booklet of

some form being given to the woman in regard to all the options, why would there need to be a continuing presence outside of the clinic to offer alternatives, if those stages had already been gone through prior to the decision by the woman, pre and post?

**Dr Haller:** That is right: there would be no need for those people to offer assistance and information. Presumably the counsellor would have a referral list—for example, if the woman was homeless an accommodation support service or if the woman was a victim of domestic violence a referral to counselling.

**Mr McARDLE:** There would then be no need to protest outside, because all of those issues are dealt with appropriately at the front end, shall we say—independently as well?

**Dr Haller:** Yes. We would agree with independent counselling.

**CHAIR:** The time for questions has expired. Thank you again, Dr Haller, for joining the committee today and for assisting us with our inquiry.

**Dr Haller:** Thank you very much for inviting me.

**Proceedings suspended from 12.30 pm to 1.02 pm**

**FRANCIS, Ms Wendy, Queensland State Director, Australian Christian Lobby**

**CHAIR:** As we resume our hearing today of the Health (Abortion Law Reform) Amendment Bill 2016, I would like to welcome Ms Wendy Francis, the State Director of the Australian Christian Lobby. Ms Francis, would you like to make an opening statement of up to five minutes and then we will open for questions? Thank you.

**Ms Francis:** That would be great. Thank you very much. Thank you for the opportunity to address you today and to contribute to this very important discussion. You are all, I know, very aware of the huge community concern in relation to this bill. This is evidenced by the large response to both the call for submissions and also the number of signatures that have been gathered by the Queensland parliament e-petition. Pyne bill No. 1's call for submissions received over 1,400 responses and over 82 per cent of these responses opposed the Pyne bill. The first e-petition against the bill attracted over 23,800 submitters, which was one of the largest e-petitions in Queensland's history. The second inquiry into yet another Pyne bill has, I understand, received over 1,300 submissions. Out of those that have been uploaded, which I think is around about a third, 83 per cent are opposed to the Pyne bill version 2. There is also a new e-petition against the second bill which has, so far, attracted over 12,100 signatures.

The people of Queensland take abortion very seriously and I want to take this opportunity to thank you, the committee, for the attention and the gravity with which you are also treating this issue. I believe that this is in stark contrast to the approach that Mr Pyne has adopted, which I would describe personally as almost flippant. His first bill was, at best, irresponsible in its lack of consideration in detail. You, the committee, on behalf of the committee and for all Queenslanders, examined evidence and presented a detailed report in response to his first bill, recommending that it fail along with many other considered recommendations, but before your report could even be tabled and examined by Mr Pyne he presented his second bill without any benefit of the work done by the committee. For the onlooker and many people who talk to me, this lack of due process appeared most disrespectful of our committee system, which is so important here in Queensland, particularly because this is our quasi-upper house.

I was here and I listened to Mr Pyne when he appeared before the committee last month. It certainly appeared to me at that time that he was not well versed at all as to what was even contained in your report, which involved considerable deliberation and research. Mr Pyne called to speak with me personally. He appeared to be quite angry and agitated on the phone, saying that he was going to look at legal avenues to stop me from saying the things I am saying about the bill. He told me I was to stop calling it the 'Pyne' bill and that he intended to take information to the police. At the time I responded to him calmly and, I believe, quite kindly. I have not heard anything more from him.

Mr Pyne's ill-conceived second bill has done nothing to allay the concerns of Queenslanders. The bill specifies that women can conduct their own abortions on themselves. Whether this is a reference to chemical abortions with RU486 or something else, it is incredibly irresponsible, anti-woman and, indeed, dangerous and contrary to medical advice.

In regard to the restrictions on freedom of speech that Mr Pyne has included in this bill, I would question whether this will pass the constitutional test. This aspect is also absolutely anti-woman, anti-family and would effectively restrict medical staff in a hospital or clinic where abortions are provided from providing full information and would silence them from providing advice to patients other than to proceed with an abortion. It prohibits anyone in the facility from even speaking to a family member to try to talk them out of having an abortion. A mother wishing to speak to her daughter to tell her that she will support her in an unexpected pregnancy and encourage her to continue; a partner, wanting to reassure a loved one that they do not want them abort the baby; a doctor able to provide all the information to a patient that is available or encourage them to look into all other options, this would be breaking Mr Pyne's law. Women who find themselves with an unwanted pregnancy deserve so much more than what Mr Pyne would want us to believe is an easy fix. It is not. Women deserve to be given all information about all options as well as appropriate support.

Lest we forget that we are considering human life, I want to end my comments with the following quote from the preamble to the Convention on the Rights of the Child—

... the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

I thank you for listening to me today and also to the tens of thousands of Queenslanders who ask you to reject Mr Pyne's profoundly anti-woman second abortion bill. Thank you very much.

**CHAIR:** Thank you, Ms Francis. Can I get some clarity on your comments about a mother not being able to talk to her daughter—I think you also mentioned something about this in the bill—and a doctor not being able to talk to his patients. Can you clarify what you are referring to?

**Ms Francis:** In Mr Pyne's bill, he talks of 'Prohibited behaviour in relation to abortion' meaning—

An act that can be seen or heard by a person during the protected period for the facility, and intended to stop a person from—  
...having... an abortion in the facility.

That is anything that is heard by a person that is intended to stop that person from having an abortion in the facility. If we are talking about abortions happening in hospitals, that is exactly what we are talking about.

**CHAIR:** I am not sure about the interpretation that you have applied there, but I will not take the time up now with you going back to the bill. I want to have a look at that. You make the point in your submission that, contrary to the claims of Mr Pyne, abortion is already easily accessible in Queensland. You have been very clear that you feel that this bill is inadequate. Do you feel that there is a case, given that statement, for a health bill of some sort?

**Ms Francis:** I still do not believe that abortion should be put wholly in the Health Act. I believe that, as in other states, at least portions of it need to remain in the criminal act, because there are so many dangers for women surrounding the issue of abortion. I believe that many of the recommendations that your committee even looked at—you were looking at different suggestions from different community groups and also pro-life groups of appropriate counselling, appropriate options given to women, not necessarily then trying to coerce them into keeping the baby either. There are a number of ways that I think that we could improve the current situation in Queensland. I do not believe that our current system is perfect at all, but I believe that Mr Pyne's remedy for it is very dangerous.

**CHAIR:** Following on from that, I am interested in your comments in the submission that you made about cooling-off periods. Would you like to speak to that? You draw a comparison between safeguards that are place for consumers and the fact that on such a significant decision as this they are not. Can you talk to that?

**Ms Francis:** Many people who talk about abortion who are very pro-choice—friends of mine who are pro-choice—would talk about it the same as any other operation, the same as an appendectomy. You would not go into a doctor's surgery to have an appendectomy and have the appendectomy on that day. You are given all of the potential dangers and the options—if there are any other options. If there was an emergent situation we would want a woman to be attended to immediately. Unless it is an emergency—your tonsils, your appendix—nothing else is removed on that day. You go away, you are given forms to sign, there is time for you to consider all options. Yet on this very important issue, one that I think research would back up that there are many issues for women post and pre, we do not have any sort of time frame of them having an option just to sit back and then think.

**CHAIR:** In giving the example of a medical procedure, do you think that the reason there is that space is that there has been some thinking or desire to incorporate a cooling-off period or is it really just about how those operations are scheduled in the health system?

**Ms Francis:** No, I would think that it is giving time to consider in most of those issues.

**CHAIR:** Okay. Thank you. I am interested in the comments that you make about late-term abortions. I recall clearly that you gave us a table in the first hearing and you were talking about what occurs in Europe.

**Ms Francis:** Yes.

**CHAIR:** They have access to terminations up to 12 weeks in most instances. You make the following comment in your submission on page 8 that new approaches to abortion in the US specify a 20-week limit. Can you make a comment on the adequacy or otherwise of Mr Pyne's bill that chooses 24 weeks?

**Ms Francis:** It is an interesting figure. He has just chosen an arbitrary 24 weeks. I think it is really very important that, when we in Australia or anywhere around the world are looking at creating new legislation, we look at what is the best practice globally in any area. Certainly, when you look at best practice in Europe, 12 weeks seems to occur time after time. In Germany, Belgium—I have it in front of me so I am just quoting from my head—France and Denmark, without any need to go through any hoops it is much lower. For Mr Payne, 24 weeks, I do not believe that it still prohibits late-term

abortions either. I think that is an important point. Certainly, I think the European model is something that we should seriously consider looking at. Again, this is one of the reasons I do not feel—and it might be my own interpretation—as if there is gravity from Mr Pyne in a true examination of best practice.

**CHAIR:** By virtue of providing the table of those jurisdictions overseas in the last inquiry and referring to it again in your submission here, obviously, you think that those models are working better. They allow terminations up to the end of the first trimester, which is the situation that is not currently in place in legislation in Queensland. Is it your position that that would be preferable to the current system that we have?

**Ms Francis:** I am profoundly pro-life. Personally, I believe that life commences at conception and I think there is good reason to believe that. But when Mr Pyne would throw out any restriction at all, then I think that it is incumbent on me, and particularly working for the Australian Christian Lobby, to look around the world to see what other jurisdictions are doing. I would certainly see what is happening in Europe is much preferable to what Mr Pyne has suggested.

**CHAIR:** Taking the example of Europe and looking at the average rate of termination there, do you think that, because they have a different legislative scheme that looks at termination differently and perhaps is more able to get statistics because it is not considered a criminal act, that is preferable so that we at least have data to further inform some of the additional social supports that many witnesses, including the ACL, argue for?

**Ms Francis:** I think data is vitally important. At the moment, South Australia is really the only state that is providing any data that we can look at. I think there is some coming from Western Australia as well. I think the collection of data is really very important not only for surgical terminations but also for RU486. We need to know what is happening so that we can understand more fully why women are choosing to have abortions—whether there are social reasons even. We need to have data. I totally agree with that.

**CHAIR:** Do you think that the current legislative environment in Queensland allows the collection of that data?

**Ms Francis:** No.

**CHAIR:** Do you think that the bill as proposed by Mr Pyne would provide for better data?

**Ms Francis:** I don't see that in this bill, no.

**Mr McARDLE:** Thank you, Ms Francis. Leaving aside the issue of ACL's preferred option—that is, it not proceeding in any way, shape or form—if a bill of this nature did proceed, you would prefer the 24 weeks to be 12 weeks or one of those lesser week periods referred to or used in Europe, is that right?

**Ms Francis:** I don't believe that Mr Pyne's bill is redeemable. I don't believe there is any part of his bill that is actually redeemable.

**Mr McARDLE:** Let us just say not 24 weeks but a bill was to go ahead you would say the best of the worst options would be 12 weeks or a period like a jurisdiction in Europe?

**Ms Francis:** I think if we reduce the time frame to 12 weeks such as in Europe we would at the very least be acknowledging viability of babies and I think that that would be a good step towards acknowledging the humanity of the foetus.

**Mr McARDLE:** Clause 21 of the bill refers to 24 weeks and what has to happen for a termination to occur post that time. A doctor has to form an opinion that the termination is required for stated reasons. It then says that that doctor himself has to consult with a second doctor. Leaving aside the issue of the code of ethics that doctors practice under, my concern is that the patient does not see the second doctor necessarily under the terms of clause 21 so that a doctor, the second doctor, could form an opinion based upon what he or she is advised in writing or otherwise by the first doctor. Do you see a problem with that?

**Ms Francis:** I see a big problem with that because of what you just said, but also because both doctors can be part of the abortion clinic.

**Mr McARDLE:** They can be sitting side by side in the same office let alone the same building.

**Ms Francis:** There is potentially a conflict of interest. I am not putting any doubt on the ethical standards of our doctors but I think there is a conflict of interest when you are in an abortion clinic and you are looking for a second opinion.

**Mr McARDLE:** It has been raised in submissions that counselling should be, one, mandatory, pre and post as well, and also a booklet used like the one that was used in I think it was Victoria or South Australia some years ago.

**CHAIR:** ACT.

**Mr McARDLE:** ACT—to outline what are the alternatives available. Do you see that as a way forward as well?

**Ms Francis:** I see it as a great way forward and to work with our child minister, Shannon Fentiman. Because one of the options that should be provided for women is an availability to adopt. I know that this is a very difficult area, but we need to look at this area if women are going to have truly full options. Yes, a booklet such as that is really good. It is very difficult to actually get into that adoption stream at the moment.

**Mr McARDLE:** I will not talk about the adoption issue at this point in time for obvious reasons. My last question is this: you made the comment that you do not believe the bill would survive a legal challenge. Why is that the case?

**Ms Francis:** Well, I didn't know that Professor Nick Aroney was actually submitting but in going through the submissions I wanted to—because for my own sake I wanted to see the percentage again of people, because I wanted to gauge how Queenslanders were feeling again, and I came across Professor Nicholas Aroney's and so I clicked on that from interest because I know him and I was really amazed by his arguments there because I personally felt, from a completely novice point of view, I felt that it was an attack on my freedoms and I was interested to read in his very detailed and learned submission that it indeed could be not constitutional.

**Mr McARDLE:** Thank you very much indeed.

**Mr HARPER:** Thank you, Ms Francis, for your submission. I do actually appreciate all the different European countries you pointed out and I took note of the particular reference to when buying a house there is a cooling off period. Obviously quite a few other countries do do that. In terms of the current Queensland Health clinical guidelines, do you believe they are adequate in terms of informing and supporting women who choose therapeutic termination given that they lean towards conscientious objection?

**Ms Francis:** I think it would probably vary from health professional to health professional how effective the counselling is and I think we should be perhaps more prescriptive on making sure that women are given all options.

**Mr HARPER:** But the clinical guidelines themselves are set within terms of gestational periods. I don't know if you have looked at the guidelines themselves.

**Ms Francis:** You are talking about our current legislation?

**Mr HARPER:** Yes.

**Ms Francis:** Our current legislation, is that what you are meaning?

**Mr HARPER:** The clinical guidelines that exist within Queensland Health.

**Ms Francis:** I am confusing the two issues. Our current situation at the moment, for me the current guidelines would work if they were working, but it obviously is not working because we still have so many abortions in Queensland. I would say that there are issues that we need to look at in the guidelines, if that makes sense. I am not sure if I am on the same wavelength as you, sorry.

**Mr JANETZKI:** A few of us have already mentioned the European abortion laws and it may be unfair of me to ask you this question, but do you have any understanding of why European abortion laws are more restrictive than other jurisdictions throughout the world? Do you have any background information?

**Ms Francis:** I don't really, because it is interesting when you look at them, you could try and come from a religious point of view, but that doesn't fit with them all across the board so I don't think it is a religious point of view. I think for me it is just a more progressive—if I can use that in the true sense of the word—understanding of human life. I think as the years have gone on and we have more and more access to ultrasonic equipment we are seeing operations being done on babies very, very young in the womb. We are acknowledging their humanity and so it is difficult then in the same hospital to deny that humanity.

**Mr JANETZKI:** Again it may be a little unfair of me to ask, but I asked an earlier witness today in respect of international law principles which you have raised persuasively here. Some supporters of the bill would also draw on international legal principles. Can you possibly distinguish the reliance of people supporting the bill on those provisions of international law, distinguish that from the reliance you place on these principles?

**Ms Francis:** There is nowhere in the United Nations treaty that contains the word abortion so there is no direct reference and there is no right to abortion that I believe can be inferred in any of the treaties. If we were to look at it objectively, there's very few areas that we could even try and extrapolate. One of them would be that a woman who is pregnant cannot have the death sentence so there are very clear areas where the reason why she can't have a death sentence is because it would be killing two humans. I think whichever side of the international human rights law that we look at, it is an extrapolation from it, but I do not believe that in any way a right to abortion can be inferred from it.

**Mr CRAMP:** Ms Francis, it was mentioned before about cooling off periods and you have noted in your report that adoption consent is at least 30 days. There were previous witnesses who stated that having a cooling off period may actually make it even harder for a woman to abort a child in the early stages because it obviously prolongs it. What is your organisation's thoughts towards that? How do you validate having a cooling off period?

**Ms Francis:** This is a really important decision that a woman is making. This is something that is potentially life changing. There is a lot of research about the potential problems post abortion and I think that it is only reasonable that we would allow time for a decision of this magnitude to be made. If indeed it is having just an operation and there is nothing to be concerned about then there is no problem in having a wait. If there is no issue of any trauma or any concern then why would there be an issue of waiting a couple of days?

**Mr CRAMP:** That was my next question: does the organisation have a position about what an appropriate cooling off period would be?

**Ms Francis:** We don't, but I would imagine two or three days.

**Mr CRAMP:** So it is not extensive?

**Ms Francis:** It is a chance to pause, a chance to consider all of the options and to make sure that you do have full information. One of the travesties that I see is that a young girl can have an abortion, even without her parents' approval. A young girl can go through this very traumatic—and it is traumatic—operation without the support of her parents, can return home without them knowing and they have no understanding as to why she is withdrawn or sad.

**Mr CRAMP:** That leads me to my next and last question: mention was made of the ACT's booklet which was then withdrawn by the next government. I have asked this several times and I don't recall asking you on behalf of your organisation: there are obviously some very divided views on this issue and I have suggested several times to many witnesses would it be our place as a regulator to set this information and, if so, who would we take that information from? For the record, many of the pro-life organisations have agreed that the government as the regulator could promote that independently. Many of the pro-choicers have detailed that that is their organisation's role and responsibility. What are the ACL's thoughts on that?

**Ms Francis:** I don't believe that pressure should be put on a woman from either group, if we are going to talk about either side. I believe that a woman should be able to be given full information and that role should not come with bias. That role should come with full information for her to be able to look at.

**Mr CRAMP:** Do you think the regulator, the state government, could have a role doing that?

**Ms Francis:** I believe that certainly information could be given to the state government to look at and then the regulators could decide what is appropriate and what is not. The last thing we want to do is add any extra trauma or sadness to anybody, but they should have full information.

**Mr KELLY:** Thank you, Ms Francis, for your submission and your attendance here today. Am I to take it from your opening statements that you have attempted to engage with the member for Cairns in terms of both the first and the second bill?

**Ms Francis:** Yes. I tried to meet with him and was unable to, but then my comments from my opening statement were he contacted our office wanting to speak to me.

**Mr KELLY:** I know you have recently engaged in consultation processes in relation to other bills and I know that you are deeply connected with many people who share similar views to yourself. How would you characterise the consultation process in relation to this private member's bill compared to others that you have recently made submissions and appeared as a witness in relation to?

**Ms Francis:** In relation to with the committee?

**Mr KELLY:** How would you compare the two consultation processes?

**Ms Francis:** One of the things that surprised me with the adoption consultation was that it was very quick. It was handled very quickly. I think that I have found this consultation process to be handled really very well across the parties. I have been really thrilled with the way I feel as if the committee is working as a Senate committee would. Senate committees, you know better than I, work very collaboratively and I feel as if that has been happening. I feel as if the committee has not handled this in a political manner. I am not sure if that is what you were asking.

**Mr KELLY:** I guess what I am interested in is your feeling of being able to talk to the actual legislator, the person initiating the legislation rather than the committee.

**Ms Francis:** No, it was impossible. It was impossible. I felt offended by his phone conversation. He was very accusatory. He was quite unkind. He said things that I believed were not true. I asked him to clarify and he didn't. When I sat here and listened to him at the inquiry, there was no even opening statement. I suppose that's okay, that's his right, but this issue deserves more. I am not personally offended. I am actually very difficult to offend because I know that I am not right all the time. I am happy to debate anything with anybody, but I felt personally offended because of the gravity of this issue. The way that the committee has actually addressed it and then his response to the committee, I personally felt quite frustrated.

**Mr KELLY:** In your assessment, does the second bill contain some significant deficiencies and may have benefitted from further consideration of the report of the first committee?

**Ms Francis:** Without doubt. Not only did he not wait until the report came from the committee; I felt unsure that he had actually got himself across the report.

**Mr KELLY:** I could ask you a lot more questions, but I believe we have hit time.

**CHAIR:** Yes. Thank you very much, Ms Francis. Time has expired. Thank you for your submission and for coming today. We appreciate it.



### **HOBART, Dr Mark, Private capacity, via teleconference**

**CHAIR:** Dr Hobart, I welcome you and thank you for joining us via teleconference. Would you like to make a brief opening statement of up to five minutes, before members ask questions?

**Dr Hobart:** Thank you for inviting, honourable members. My main concern is that in this legislation there is no protection for women before 25 weeks of pregnancy, for example, from coercion by partners or unscrupulous doctors. In my submission, I detailed the case of a woman who was in a mid-pregnancy. She had a gender selection abortion carried out eventually, after I had refused to refer her. Subsequently, I reported the doctor who did the abortion to the medical board for unprofessional conduct, because he had not performed the abortion for medical reasons but for gender selection. After their investigation, they wrote to me that they had decided not to take any action because the Abortion Law Reform Act 2008 allows a medical practitioner to perform an abortion on a woman who is not more than 24 weeks pregnant and, based on the information provided, it was not unprofessional for the doctor to have performed a legal abortion for a woman who was in a mid-pregnancy. Subsequent to that I received a letter from the medical board stating that I was under investigation myself. Subsequently, after an investigation of eight months, the medical board formally cautioned me. I have full documentation of all this. My main concern is that, if this legislation goes ahead as it is, women in Queensland will not be protected. Thank you.

**CHAIR:** Thank you very much for your opening statement. I invite the member for Greenslopes, Mr Joe Kelly, to open questions.

**Mr KELLY:** Dr Hobart, we have heard evidence from previous witnesses in the last inquiry that doctors simply would not perform a termination at any stage in pregnancy based on the gender of the foetus. It would seem that you are presenting at least one example where that may have been the case.

**Dr Hobart:** Yes, that was the reason it was done. The exact wording from the medical board was that it considered, based on the information provided, it was not unprofessional for Dr—and they named him—to have performed a legal abortion for a woman who was at that stage of pregnancy.

**Mr KELLY:** If other witnesses are telling us that this would not happen and that it would offend your code of ethics, are there legal protections that could be put in place to prevent terminations happening for this specific reason?

**Dr Hobart:** Yes, there should be as you would for any other medical procedure. For example, if you are having your gall bladder out, you would have to have an indication to have your gall bladder out. First of all, you would have to have gallstones that are causing some pain, et cetera. It would be unethical for a doctor to take out your gall bladder just because you wanted your gall bladder out. That is the analogy I would make. Here we have the situation where there is no basic work-up of the patient using standard medical history and examination to determine if the procedure is appropriate or not.

**Mr KELLY:** Doctor, even if we created a law that said you cannot seek an abortion for this particular reason, would there be any practical way to prevent a person presenting another reason that they would want to have a termination?

**Dr Hobart:** They could always get around it by telling lies, but at least attempt is made to make sure that it is being done for the correct reasons. Patients can present to doctors and make up their symptoms and so forth, and sometimes have unnecessary operations based on that. At least there is the necessity for the doctor to try his best to make sure that the procedure that is proposed is appropriate.

**Mr KELLY:** Would clause 21 of the current bill, which requires, say, a doctor to consult with her or his colleague, provide any protection in this particular issue that you are raising here?

**Dr Hobart:** That is for over 24 weeks, isn't it?

**Mr KELLY:** That is correct.

**Dr Hobart:** That is correct. That is the bare minimum amount of protection. It could be the abortionist and the anaesthetist who are the two doctors involved, for example. The other doctor does not actually have to, by the look of it, have examined the patient. All he would have to go by is what the other doctor told him, sort of thing. That would not be sufficient protection, in my view. There should be perhaps an independent doctor. There should be some procedure that needs to be gone through to make sure that everything is being done that is possible to safeguard the woman, especially in cases of coercion, which may be difficult to pick up.

**Mr JANETZKI:** Dr Hobart, bearing in mind that these proceedings are on the public record, please feel free to say if you feel uncomfortable answering any of my questions.

**Dr Hobart:** Yes.

**Mr JANETZKI:** I wanted to investigate a little more the matter that had you investigated by the medical board. Were the couple who came to you up front in asking you to conduct the procedure on the basis of gender selection? They were up front in asking you that?

**Dr Hobart:** Yes.

**Mr JANETZKI:** When referred to the medical board, did the medical board in its final determination make any findings against you or was it simply a caution with no findings being made and no admission of liability?

**Dr Hobart:** It was a caution, which is the lowest form of penalty. It is not publicly recorded and that sort of thing.

**Mr JANETZKI:** On the allegations made against you, as articulated in your public submission, the board was concerned that you may have failed in your obligation or demonstrated disregard, but they made no findings ultimately in those regards?

**Dr Hobart:** No, they did not make findings in those regards.

**Mr JANETZKI:** Have you heard or been aware of other medical practitioners with whom you have spoken in Victoria or elsewhere who have seen similar requests from members of the community?

**Dr Hobart:** For gender selection?

**Mr JANETZKI:** Yes.

**Dr Hobart:** I have only heard anecdotal reports via another party, so not directly from doctors.

**Mr JANETZKI:** Obviously there is information on the public record and in newspaper reports that across the world there may be one hundred million girl babies who have never been born due to gender selection abortions. What is your feeling on gender selection abortions generally in Victoria? Obviously you have limited anecdotal evidence. What is your opinion? Is it common, in your view?

**Dr Hobart:** I have to say that I do not know. I only know what is reported in the newspapers and things such as that. I do not have any special knowledge about that. I would imagine, going by what I have read, it must occur.

**Mr JANETZKI:** Has the medical board of Victoria, AHPRA or any other medical regulatory body issued any guidelines or directives in relation generally to this issue that you were faced with?

**Dr Hobart:** No. They did not issue any directions as to what a doctor should do when faced with this situation

**Mr JANETZKI:** Presumably, you would have viewed your actions in this matter as a matter of conscience?

**Dr Hobart:** Absolutely, yes.

**Mr HARPER:** Thank you, Dr Hobart, for your submission. If there is one thing that has certainly raised eyebrows for me going through this particular bill and the bill before it, it is the issue of gender selection. I thank you for articulating in your submission the issues around that. I would like to get your views around foetal abnormalities. We are talking about 24 weeks, in terms of gestational periods. Do you have any issues with that? Secondly, are you aware of the current clinical guidelines that Queensland Health uses for therapeutic terminations and do you have any commentary around that?

**Dr Hobart:** As far as foetal abnormalities go, there can be a very broad spectrum of abnormalities. Are you asking me what my personal views are?

**Mr HARPER:** Yes, what your opinion is.

**Dr Hobart:** I think a human life is a human life whether there is an abnormality or not. We do not discriminate when it comes to people who are born in terms of their abnormalities or medical problems. There are laws against that. I do not understand why it should be any different as far as the unborn are concerned.

**Mr HARPER:** Maybe I can articulate that a bit better myself. When I talk about foetal abnormalities I am talking about fatal foetal abnormalities—that is, where the baby has no chance of survival. As far as I understand it, there is a procedure where two doctors will review the situation before making a decision to terminate the pregnancy. Maybe you could articulate on what happens in Victoria?

**Dr Hobart:** There is no law against terminating a pregnancy for foetal abnormality in Victorian law, as far as I understand it. It is perfectly legal right up until the end of the pregnancy.

**Mr HARPER:** Just to remind you of the second part of my question. Do you have any commentary on the current Queensland guidelines around therapeutic termination?

**Dr Hobart:** If the pregnancy is posing a risk to the mother's health then it falls within the lawful termination of pregnancy, as I understand it. I suppose it is where you draw the line as to the threat to the mother's health. Certainly if the threats to the mother's health are grave ones—for example, if it were severe pre-eclampsia or an intrauterine infection—then, of course, the pregnancy has to be terminated otherwise the mother may die. There is no question there.

I suppose there are other areas which are not as severe but are very tricky where there is a lot of danger to the mother. That would be up to the specialist doctors to assess the risk to the mother if she were to continue the pregnancy, bearing in mind the viability of the foetus. That would be best left up to specialists, the obstetrician concerned, perhaps other doctors who are looking after whatever is her problem, whether it is renal disease or heart disease or whatever condition she may be suffering from.

**Mr HARPER:** Just to conclude, you think that the current clinical guidelines are adequate enough in Queensland?

**Dr Hobart:** Provided they are followed. In Victoria a lot of abortions were done for social reasons and not really medical reasons. They were classified as falling under the guidelines. No, generally speaking I would agree that the current law should be adequate if followed correctly.

**Mr CRAMP:** I noted the commentary in your submission that this law reform gives no protection to women who are up to 24 weeks pregnant. A lot of argument has been around protection after the 24-week period. If these changes were brought into effect, abortion could happen up until the day of natural birth.

**Dr Hobart:** Yes.

**Mr CRAMP:** We did touch on this previously. With protection to all women who are up to 24 weeks pregnant, are you really focussing on the fact that they need to be fully informed—it is not so much a physical protection but making sure they are adequately equipped to make the right decision?

**Dr Hobart:** Yes. Sometimes they may need to be physically protect. Sometimes they need to be fully informed. Sometimes a woman will have a termination because she is not fully informed. For example, I had a patient who thought she was carrying an abnormal baby, but she had not been adequately sorted out. She should have really seen a genetics physician to explain to her what the risks were, which were pretty small, rather than just panicking. She ended up having a termination. They are the sort of things that can happen if the woman is not fully informed.

**Mr CRAMP:** So it is about looking at the possibility of legislating so that there are certain safeguards in place, especially medically, so that every women has the right to seek professional advice that is adequate to her situation, such as a genetic specialist if required?

**Dr Hobart:** Absolutely. They have to be fully informed just like with any other medical procedure. They have to be screened for depression, for mental illness et cetera. They may be quite depressed. The decision you make when you are depressed might be completely different to the one you would make if you were in your normal state. These are the sorts of things that really need to be looked at carefully.

**Mr CRAMP:** I touch on something the member for Toowoomba South noted before about the UN estimates of 100 million girls technically missing, having never been born. According to the information that I have, Australia registered 1,395 missing female births between 2003 and 2013. As noted before, it has been dismissed—and to the best of my knowledge even by Mr Pyne—that gender selection is really not an issue in this country. To make sure that it is not an issue, should we be looking at safeguards in terms of matters like gender selection to be enshrined in legislation to ensure that, as in your case, an abortion cannot be generically dismissed when it is really about a gender selection issue? As regulators should we be looking at some form of legislation to protect those unborn children and, in many cases, to protect mothers who would like to have them but are not based on other people having gender selection issues?

**Dr Hobart:** Yes, women should be protected against having to have a gender selection abortion. All the other things we talked about such as having full information, making sure she is not depressed or mentally ill herself should be put into legislation to try to protect women so that they do not end up looking back on it and saying 'Oh, my goodness me, what did I do. If only I had known that,' or that sort of thing.

**Mr CRAMP:** Do you think that that sort of legislation could also be extrapolated to issues such as Down syndrome and disabilities? Would it fall into the category that it is just another form of discrimination or should we be looking at the fact that gender selection is a social issue and then we

have medical issues such as disabilities and abnormalities? Should we just be looking to enshrine the fact that all of those sorts of issues cannot come up? Should we separate issues or should it be legislated across-the-board?

**Dr Hobart:** You cannot discriminate against people because they have a disability, whether they are born or unborn.

**Mr CRAMP:** I guess my point was: is gender selection as important as disabilities?

**Dr Hobart:** A disabled person has just as much right to be born as a woman does or a man does. Unless there is a severe threat to the mother, all these people should be given a chance.

**Mr CRAMP:** I agree with you. I just wanted to hear your opinion.

**Mr McARDLE:** Dr Hobart, I want to go back to your submission. You filed a complaint with the board because the doctor who performed the termination terminated the child because of gender selection. Do you know what the couple said to him was the basis for seeking a termination? Secondly, were you informed by the board as to the response by the second doctor as to your complaint?

**Dr Hobart:** First of all, I do not know what the conversation was between the parties at that time. In their letter to me the Medical Board did not say what conversation or correspondence they had had with the doctor concerned.

**Mr McARDLE:** So it might well have been the couple, on seeing the second doctor, did not indicate what they indicated to you was the basis for the termination?

**Dr Hobart:** I do not know what they said. I can only tell you what they said to me.

**Mr McARDLE:** The Medical Board then wrote to you after making the determination regarding your complaint. They wrote to you saying they were concerned about three things. One was you failed to refer the patient on. Who filed the complaint, the doctor or the couple?

**Dr Hobart:** Where did they get the complaint from? They filed what is called an own motion. They took it upon themselves to investigate me after there was a newspaper article about me. There was no complaint by anyone against me, it was on the basis of a newspaper article.

**Mr McARDLE:** Based upon that, the Medical Board, AHPRA took it upon themselves to launch an investigation?

**Dr Hobart:** That is correct.

**Mr McARDLE:** I take it in Victoria the legislation requires that a doctor who has an objection to undertake a termination based upon conscience is required to refer to a doctor who will terminate, is that right?

**Dr Hobart:** Who they know does not have a conscientious objection to abortion, yes.

**Mr McARDLE:** The way that the Medical Board approached the complaint or launched the complaint against you to my way of thinking is quite startling because they are looking not at an investigation by way of contacting you to begin with to talk it through but by saying, 'We are now launching an investigation.' Do you find that heavy handed?

**Dr Hobart:** Incredibly heavy handed, especially after I had reported to them what I thought was a very bad thing that had happened. To find that I am the one who has to defend himself I found very upsetting at the time.

**Mr McARDLE:** Thank you, Dr Hobart.

**CHAIR:** Dr Hobart, I have one question with regard to the bill before the committee. Do you have any comment to make about whether such a situation could arise in Queensland under the provisions currently contained in the proposed bill around conscientious objection?

**Dr Hobart:** Could this happen with the proposed bill?

**CHAIR:** Yes.

**Dr Hobart:** Well, yes, it could because there is no safeguard for the woman in this situation. There is no need for counselling or investigation of the woman's situation, as you would in a normal medical condition. They could just have the procedure with virtually no questions asked as to the reasons why they want to have the procedure which—

**CHAIR:** Dr Hobart, I was more asking from the point of view of yourself as the medical practitioner.

**Dr Hobart:** Could you repeat the question?

**CHAIR:** I was more asking about yourself as a medical practitioner. Under the proposed section in the Health (Abortion Law Reform) Amendment Bill as it relates to conscientious objection, do you feel that a similar situation could arise for a medical practitioner operating in Queensland, or do you feel that the drafting—

**Dr Hobart:** You are talking about whether the medical practitioner would be investigated by the Medical Board for refusing to refer; is that what you are saying?

**CHAIR:** Do you feel that the bill would preclude it because of its current wording around conscientious objection?

**Dr Hobart:** If you refuse to refer for an abortion, under the proposed bill that should not be a problem, as far as I understand it.

**CHAIR:** So it is your position that the wording in the proposed section of the bill that we are considering would have provided protection to you had you been operating in Queensland under that legislation, or does it not go far enough?

**Dr Hobart:** I should have looked at that part more closely. What section is that? Here it is; it is section 22—

No-one is under a duty ... to perform or assist in performing an abortion.

It does not actually specify that you do not have to refer for an abortion. I suppose that comes under 'assist'—maybe. Anyway, it is certainly some protection, and I would expect that I would not have been investigated had I been operating under that legislation. Section 8 in the legislation in Victoria is very bad from that point of view.

**CHAIR:** It was my reading of it that section 22 as proposed is not as restrictive or prescriptive as the Victorian legislation, but I was interested in your interpretation of that as a medical practitioner. Dr Hobart, thank you very much for being willing to make yourself available to the committee. Thank you for your submission. We appreciate it.

**Dr Hobart:** Thank you very much indeed.

**QUINLAN, Professor Michael, Dean, School of Law, University of Notre Dame**

**CHAIR:** Professor, welcome. Would you like to make an opening statement of up to five minutes before we ask you some questions?

**Prof. Quinlan:** Yes, I would. Could I first begin by thanking the committee for the opportunity to provide a written submission and for the opportunity to speak to the committee now. My submission deals with three aspects. It deals with the need for greater support to be provided for women, it deals with the question of the proposed provisions in relation to the prohibition of behaviour in relation to abortion facilities, and it deals with the proposed provision which seeks to provide a legislative difference in the treatment that might be provided depending upon the period of gestation of the pregnancy. I will deal with each of those briefly in this five-minute period, and some of these relate to each other.

The first point is that I think it is very valuable for the state parliament to be looking at the question of the termination of pregnancy. I think the most important thing that states can do to help women in an unwanted or unexpected pregnancy is to provide them with a lot of information and to provide them with opportunities to fully consider the different choices they might have to make. Critical to that being a real choice is to provide women with adequate financial assistance, emergency housing, counselling and information about alternatives to abortion and not allow them to be funnelled into a process where that appears to be the only option for them. That is the first point that I would like to make.

The second point I would like to make is in relation to the proposed prohibition of behaviour in relation to abortion facilities. This proposed legislation is part of a trend which I think is a very unfortunate trend that we have seen in a couple of states and territories in Australia, starting with Tasmania, then the ACT and Victoria, and now being considered in Queensland. To me, provisions of this kind are a significant infringement on the political liberty of Australian citizens and deal with an issue about which there will always be and there definitely are—it is hard to see how that will change—different opinions in the community about this particular procedure.

Some people feel so strongly about this particular issue that they wish to be present near termination facilities in order to pray for those who are making that decision and to pray for those who are the victims of that decision, or to seek to discourage people from proceeding. The reason why people engage in this practice is that it feeds in a bit to the first proposition I made which is that people actually do change their mind at the last minute when they are provided with additional information, which rather demonstrates that there is a lack of sufficient information being provided before the decision to approach one of those facilities is made.

The third point I wanted to make is in relation to legislation which seeks to differentiate between the treatment and protections or availability of termination procedures depending upon the period of gestation of the pregnancy. This proposed legislation ticks the period of 24 weeks. If there is time in questions, I would like to expand on this point because one of the sets of material which I referred to in my submission is a video and a publication which is distributed by National Geographic produced by The Endowment for Human Development on the biology of prenatal development. What that demonstrates very clearly is the different stages of development in a typical pregnancy, the surprising level of development at very early stages and the substantial amount of development at the period of 24 weeks, which is what is proposed in this legislation.

**CHAIR:** Professor Quinlan, you did mention that you wanted to expand on a point. You have 1½ minutes left. You have been very precise. Was there something else you wanted to say? We are happy to go to questions if you prefer.

**Prof. Quinlan:** Yes. Very quickly and in very brief summary, according to that paper and that video, in a typical pregnancy at four weeks the heart of the embryo is beating at 113 times per minute. At six weeks the cerebral hemispheres are growing disproportionately faster than other sections of the brain and the embryo begins to move spontaneously and to have reflex movement. By seven weeks, hiccups can be observed and leg movements can be seen, including a startle response. At eight weeks the brain is highly complex and constitutes almost half of the embryo's total body weight, and growth continues at an extraordinary rate. The foetal period continues until birth, but by nine weeks thumb sucking begins, the foetus can swallow amniotic fluid, the foetus can also grasp an object, move their head forward and back, open and close their jaw, move their tongue, sigh and stretch. At three to four months—that is, 12 to 16 weeks—distinct tastebuds now cover the inside of the mouth. Although movement begins in an embryo at six weeks, a pregnant woman first senses foetal movement between 14 and 18 weeks. This is traditionally the event called the quickening, which is mentioned in my paper.

**CHAIR:** Thank you, Professor Quinlan. The time for your five-minute statement is up. Thank you for those comments and thank you for the submission. The first point that you extrapolated on from your submission was alternatives to abortion rather than, to use your words, 'being funnelled into termination'. What the committee has heard both in our earlier inquiry and in submissions is that, although those alternatives may be put on the table, a woman may be informed of those alternatives and they may be readily accessible, rather than being funnelled into a decision to terminate they may feel that is the right decision for them. What do you say in situations such as that?

**Prof. Quinlan:** This is a very difficult problem and a very difficult issue for the legislature to deal with. As I make the point in the submission, the more we know about the stages of foetal development and the more that we are able to see—and the extraordinary 3D imagery that we are able to see—the more difficult the decision and the more concerning the decision to terminate a pregnancy at any stage. In Queensland at the moment, as I understand it, and as is the position across most of Australia, abortion is readily available. What we are talking about in the context of this proposed bill is to make some alterations to the existing position. The existing position is essentially as I have described it. What we are talking about here is a proposal to alter the existing position.

**CHAIR:** To follow on from that point, Professor Quinlan, the explanatory notes, which I am sure you have read yourself, being dean of the school of law there, state that there currently exists a lack of clarity around what point of gestation and for what reasons a termination of pregnancy can be performed in Queensland. There has been much debate around whether, firstly, such a lack of clarity exists and, secondly, whether the bill will assist in reducing that clarity. Can you make a comment about that statement?

**Prof. Quinlan:** Sure. I think the question of whether there is a lack of clarity or not really turns on the extent of access that is available. My understanding in all states and certainly in Queensland is that there is ready availability. This legislation, as I understand it, is not really directed at reducing availability. The question of the clarity of the law really turns upon not only the words of the law but also the way it has been interpreted judicially and the way that it is prosecuted. It is probably that last point which provides a situation where we have ready accessibility of abortion in Australia. Unless the government or the police prosecutors' approach were to change, that is likely to remain the position.

When people look to the law, to the written words of the relevant legislation, that can produce an unfounded criticism of what the actual position is because the reality is quite different from what the words of the present legislation say. The proposal to make these amendments will not clarify anything. It will provide for new provisions to deal only with that extraordinary and terrifying situation where terminations occur at 24 weeks, at a very advanced stage of gestation, but it will leave in exactly the same position the rest of the laws.

**CHAIR:** Professor Quinlan, proposed sections 23, 24 and 25 deal with what can and cannot occur around an abortion facility. The second point that you raised was infringement on political liberties.

**Prof. Quinlan:** Yes.

**CHAIR:** The opposite argument to that is that individuals in making a difficult decision have a right to privacy. To use words that are contained in the explanatory notes, these provisions from proposed sections 23, 24 and 25 are about preventing or protecting patients from harassment, hindering, intimidation and interference. Obviously you feel that the bill does not balance or protect those interests, but how do we as a legislature look at balancing both an individual's political liberty and an individual's right to privacy?

**Prof. Quinlan:** I do not think the words in the legislation and the explanatory memorandum that you have just read really encapsulate what the legislation provides. It goes much further than dealing with questions of harassment, hindering or intimidating which would already be, I am sure, unlawful under other provisions in Queensland. It goes further than that, as does the legislation in Tasmania, Victoria and the ACT, to prohibit 'a protest, by any means, during the protected period for the facility relating to the performance of abortions in the facility'.

A protest can be perfectly peaceful and perfectly quiet. The instances which we have seen since the legislation has been enforced where charges have been brought have been exactly of that nature. In Tasmania, Mr and Mrs Stallard and Mr Preston were charged under their legislation for standing quietly, holding a picture and having some leaflets which were available for anyone to come and collect if they wished to. In fact there was no evidence in that case, which was heard in Tasmanian police v Preston, of Mr Preston or the Stallards actually approaching anyone, harassing anyone, intimidating anyone or behaving in any nature like that. The only evidence of them interacting with any individual was of a person approaching them and challenging them.

As I explain in the submission, some people do feel very strongly about this issue—and I would put myself in that category—but some people not only feel strongly about this position but also feel strongly that they want to assist people in making a different decision to the decision which they have embarked upon. As I mentioned at the outset, a major driver for people to be in the vicinity of a facility to pray or to silently protest or to provide counselling or other information is to give women information that has not otherwise been provided to them. The fact that that does happen is evidenced by the number of people who actually change their mind at that moment.

**CHAIR:** The deputy chair asked an earlier witness about the fact that the bill does not deal with providing information, counselling and things like that. If it did deal with those issues and an individual was provided with all relevant information before being able to make a decision, do you feel there would be a need for people to be standing outside these facilities with additional information still seeking to change the mind of someone who essentially has taken an informed position, from your point of view?

**Prof. Quinlan:** It is a question of need and a question of what people feel they are obliged to do by their religious beliefs or by their conscience. What you would really be doing if you were to pass this legislation would be setting Queensland up to criminalise behaviour by citizens who would not otherwise act in a criminal way. That is the situation we have seen where it has been enacted. Mr Preston is an elderly gentleman. It is worth going online, if you get an opportunity, to have a look at a photograph of the Stallards. They are two elderly people. Mrs Stallard suffers from a disability. In the ACT, a fine was levied on a person who was standing quietly outside an office block, which is the only facility where terminations occur in the ACT, and he was not issued with a fine until his rosary beads were evident in his pocket. If that is the sort of behaviour you wish to criminalise, then I think that is quite extraordinary. You would be setting Queensland up to a situation where people feel so strongly about this that they will continue in their peaceful behaviour but be criminals for doing so.

**CHAIR:** Thank you. I will hand you now to the deputy chair, Mr Mark McArdle.

**Mr McARDLE:** Thank you very kindly for your time today and your submission. I refer to clause 24—that is, actions around the complex itself. In your submission, you refer to two sections of the Criminal Code. They do not actually deal with action that takes place around the premises; they take place in regard to entering the premises or threatening to enter the premises.

**Prof. Quinlan:** In the legislation which is proposed?

**Mr McARDLE:** No. In the legislation proposed, there is a skirt, shall we say, around the premises where people cannot enter into, but the Criminal Code provisions you refer to in your submission deal with either 'enters on land' or 'threatens to enter or damage a dwelling or other premises'. It is not quite the same thing, is it? This is a curtilage area that you cannot enter into, or you cannot conduct yourself in a manner.

**Prof. Quinlan:** I think there are a couple of questions built in there. The first proposition which I would make is that the Queensland parliament has decided that it will provide for certain protections; they are in sections 70 and 75. They go as far as they go, but that is what has been decided in relation to all premises in Queensland and that is a position that has been taken.

The question then arises as to whether there is any particular reason for particularly special legislation to be introduced in relation to one particular type of property in Queensland. That is the question which I would really urge the committee to very carefully consider. If the committee forms the view that there is some need for some specific legislation which goes beyond section 70 and 75 of the Criminal Code, then the question is how far that legislation should actually go. It is my very strong submission that prohibiting protests is going well beyond what is appropriate for a democratic government to do.

**Mr McARDLE:** In answer to the chair's question regarding mandatory counselling, the bill is silent on that. There is no requirement in the bill to have pre or post counselling, or both for that matter, nor for information to be given to the woman as to what the alternatives are, what it means to go through an abortion and, more importantly, what could be the outcomes of an abortion. Leaving aside the issue of reports about mental disability et cetera flowing from an abortion, would you say that that information should be incorporated into a bill of this nature?

**Prof. Quinlan:** If there was going to be legislation in this area, certainly that is information which would be extremely helpful for people to be provided with. For those who advocate the need for free access to the termination of pregnancies on the basis of choice, it is a false proposition unless women are actually given information to enable them to really make a choice. That is not just information; that is also access to real alternatives if that is what they choose.



**Mr McARDLE:** The other point with that of course is that the counselling must be independent of the body who will perform the termination.

**Prof. Quinlan:** Yes, that is right. I think others have pointed out that one of the drawbacks with the proposed provisions in relation to the dealing with abortion for women over 24 weeks is that the language which is used—the actual provisions of that section 21—does not actually provide any real protection for the foetus, if that is what the intention of the legislation is. There is no indication there that the doctors who are involved in the consultation would not be involved in the procedure itself.

**Mr McARDLE:** Should the post-abortion counselling also be independent?

**Prof. Quinlan:** Yes. There is this whole area of the risk that is posed to women through the termination procedures. As my paper is clear on, there is disagreement amongst experts as to the extent to which this problem arises, but it is clear that it does arise for some women. It is also clear from the material that I have read about this topic that this particular problem can arise for women who have had a termination irrespective of the stage of gestation of the termination. I think it is very important that as much information as can be provided is provided to people before they make this decision. Making a decision of this kind, knowing exactly what it is you are doing, should make it more unlikely that those facts will become known to you at a later stage and trigger an unfortunate reaction.

**Mr McARDLE:** The submissions across the board in this inquiry and the earlier inquiry focus on the rights of the woman. Little regard is had to the rights of the father in this case. Leaving aside the obvious examples of incest and rape, is there a role for the father in this process from your perspective?

**Prof. Quinlan:** I think that is a very good question and a very important one because that is the position across Australia—that the interests of the father are not taken into account and they have no relevance at all to any decision-making. That is not to say that there are not situations, because there certainly are, where women are pressured into having terminations by the father of the child. That is clearly a problem. If there was legislation to deal with this problem in a more coherent way, it could perhaps address that particular issue as well. Certainly, fathers who are concerned about the life of their growing embryo ought to be able to be heard about their own interest in that life.

**Mr McARDLE:** Thank you.

**Mr KELLY:** In relation to the issue of prohibiting political freedom or protest around abortion clinics, there are other examples in Australia where we manage and regulate the manner in which people can express themselves politically and protest. As someone who has had experience in the trade union movement, I think of the restrictions that are put around the collective actions of union members that are regulated and managed by various industrial relations commissions. That is done, in my understanding, because there is a recognition that there are times when, even while you might be trying to make a legitimate point, you are actually making it in a way that is damaging to society overall. It would be my contention that this is another example where an attempt is being made not to stop people protesting legitimately but to regulate it in a manner that is not harmful to sections of society. I would be interested in your thoughts on that.

**Prof. Quinlan:** I think people do have a right to freedom of expression. In this particular issue, many people are motivated by religious motivations in their activities. I think people of integrity, people who have strong convictions and people who are law-abiding citizens are not the sorts of people we want to be prosecuting. That is the experience we have seen so far in the use of similar legislation in other places. I would really urge the committee to read that police v Preston case in the Magistrate's Court in Tasmania. You should also look online because it is very powerful to see Mr and Mrs Stallard when you are considering the fact because they have been arrested and charged in relation to an offence when they were acting in a way which was completely consistent with their own world view and completely consistent with their own understanding of the value of life.

**Mr KELLY:** If a group of people who either had been sexually molested by members of a church or supported people who had been sexually molested by a church gathered together and chose to stand at a place of worship every Sunday—say, a Catholic Church, an Anglican Church or a Salvation Army hall—and wave placards, hold up pictures of people who may have committed suicide because of that molestation—

**Mr CRAMP:** Chair, I ask your direction on the member for Greenslopes using a molestation by a church. I would like some more specific terminology on that—if there is a member of a church but not a church group as itself or an organisation.

**CHAIR:** What point of order are you raising?

**Mr KELLY:** I am happy to rephrase.

**CHAIR:** If my understanding of your question is correct—

**Mr CRAMP:** I think it is a generalisation. I would like to hear a rephrasing and some more appropriate terminology.

**Mr KELLY:** As we have a royal commission into institutional child sexual abuse at the present time which has revealed many confirmed cases of child sexual abuse by not just members of the church but many other institutions in our society, my question of the professor is: if a group chose to attend a local church every Sunday to make their political point every single week and cause great discomfort and disease to members of that congregation, would we as legislators have some role to play in terms of managing the manner in which that group was exercising their democratic rights to freedom of speech and protest?

**Prof. Quinlan:** I think that would depend on exactly what they were doing. If they were entering the church and disrupting the religious service, that may be one thing. We are not dealing here with situations where people are entering termination facilities and actually disrupting what is going on inside—the proceeding there. If people wish to stand outside a church and quietly protest, then it would be their democratic right to do so.

**Mr KELLY:** What if the administrators of that particular church, facility, community or building appealed for assistance to prevent that from happening? What should occur in that situation?

**Prof. Quinlan:** I think that people have a freedom of political communication. If they want to stand outside a church and make their point, then they can stand outside a church and make their point.

**Mr CRAMP:** I think you answered adequately regarding the fact that sections 70 and 75 of our Criminal Code Act already set adequate rulings for people who wish to conduct protests. I put on record that I have seen plenty of union based protests that do, in fact, hinder society and groups. I think you adequately answered the other questions surrounding that. I would contend that you very adequately answered the fact we do not really need to see a change in rules, especially in this instance, for people standing outside any clinics, churches or anything like that. I think it would open up a larger issue. There is a question that I am interested in hearing your thoughts on. If we went down that track and sought to put restrictions on this particular group of people, from a legal point of view would that open up the doorway for other groups to start seeking to restrict political protests which is people's legislated right?

**Prof. Quinlan:** Two things: first it would open up Queensland to litigation because there would be an inevitable claim that the legislation was infringing upon the implied right for political communication which has been found by the High Court. On the second point, infringing upon the rights of political communication in this way would be certain to be used by other pressure groups to argue that there should be similar legislation to prevent protesting in other circumstances where people might be offended by other people's activity.

**Mr CRAMP:** I have a last question, and I know time is limited. If you do not want to give a short answer, that is fine; you do not have to answer. I notice you spoke around the stages of a foetus and the different life signs. We noted in a previous witness statement and their submission about some European countries and different stages of a foetus where it is no longer permissible for a termination. Do you see that as an appropriate avenue that we should look at? Should it be 12 or eight weeks based on life signs or any legal precedence? I understand you are not medical, but is that a precedent set by other countries?

**Prof. Quinlan:** Can I answer that in two ways? Firstly, from my own personal position there is no difference in the quality of life of an embryo from the time of conception to the time of birth to the time of death. From my perspective, I would not be recommending—because I could not—that the committee recommend any particular period of gestation as being a cut-off point. The point that I make in my submission is that whatever cut-off point you might choose if you were to go down that path, that is assuming that the gestation period of that particular embryo that is subject to the termination is in exactly the same way as is normal, which is not always the case. Like any life form, some embryos develop faster than others and some develop slower. The bigger question and the reason why I was mentioning some of the information from that National Geographic publication is where do you draw the line? If it is when the heart starts beating, that is in week 4. Some people would be quite surprised to learn that terminations are very regularly happening from that stage, let alone at all the later stages of gestation. I think if parliamentarians wish to enact legislation which draws gestational periods or if courts do, as the United States Supreme Court did in *Roe v Wade*, then that is a very difficult proposition to defend.

**CHAIR:** Thank you very much. Professor Quinlan, thank you for making yourself available to the committee today. We certainly appreciate your time and expertise.

**Prof. Quinlan:** It is my great pleasure. Thank you for the opportunity.

**CHAIR:** I now invite Professor Nicholas Aroney to come to the table.

**ARONEY, Professor Nicholas, Professor of Constitutional Law, School of Law, University of Queensland**

**CHAIR:** Professor Aroney, would you like to make an opening statement of up to five minutes and then we will open for questions when you are ready.

**Prof. Aroney:** Thank you for the opportunity to appear before the committee. I am a professor of constitutional law at the University of Queensland. I have been there since 1995 and have taught constitutional law for that many years. One of my areas of particular expertise is the implied freedom of political communication. If I may say so, I have published a total of 14 books, book chapters and journal articles on the topic.

There are three important propositions that I would like to submit to the committee on this issue of the protest law in the proposed law: first, that the proposed new paragraph 24(2) (c) of the Health Act is almost certainly unconstitutional because it contravenes the implied freedom of political communication; second, all of the elements in the proposed paragraphs (a) and (b) of section 24(2) are essential to their constitutionality; and, thirdly, there are significant doubts about the constitutionality of several similar laws in other states such as those in Victoria and especially Tasmania and the ACT.

If I may go to that first point, if enacted, paragraph (c) would in conjunction with section 24(1) make it an offence to engage in a protest by any means during the protected period for the facility relating to the performance of abortions in that facility. Paragraph (c) is specifically aimed at protesting. The act of protesting lies at the very heart of freedom of political communication. While free speech can be appropriately regulated, restrictions on political speech and protesting must be subjected to rigorous scrutiny. Paragraph (c) goes much further than general workplace antiprotest laws enacted in other states. I note that the law in Tasmania is the subject of a constitutional challenge and paragraph (c) goes a lot further than that. It also goes much further than anything enacted in any of the other states in relation to abortion protesting except for the ACT.

In *McCloy v New South Wales* the High Court of Australia set out a three-stage test to be applied when considering whether a law impermissibly interferes with freedom of political communication. The questions to be asked are threefold: first, does the law effectively burden the freedom in terms of its terms, operation or effect; secondly, is the law compatible with the constitutional system of representative government; and, thirdly, is the law reasonably appropriate in securing a legitimate objective? On the first point, there is little doubt that paragraph (c) would place an effective burden, indeed a very substantial burden, on freedom of speech. In terms of compatibility, in my opinion, paragraph (c) is not compatible with the Constitution. This is because, as I mentioned, it is directed at protests per se whether or not such protests are intended to stop a person from entering an abortion facility or from having an abortion. The prohibition on protesting per se is not a purpose which is compatible with the Constitution. For this reason alone paragraph (c) is unconstitutional, but that is not the only problem with paragraph (c).

In my respectful submission, even if a legitimate purpose for paragraph (a) could be found, the law is not a reasonable means to achieve such a purpose. We might speculate that the purpose of paragraph (c) is to enable people to enter abortion facilities without undue interference and to preserve their privacy. These are legitimate objectives. However, paragraph (c) lacks any rational relationship to these goals. It does not prevent people who are not protesting from interfering with people accessing abortion clinics. Paragraphs (a) and (b) do this. There are entirely effective ways of achieving these goals without imposing a blanket ban on protesting. Again, paragraphs (a) and (b) are obvious examples. While these goals are important, because paragraph (c) does little, if anything, to achieve them and while it places a very heavy burden on political communication, it is not a balanced law. That makes it disproportionate and unconstitutional as well.

Here it is important to recognise the well-known fact that protest activities are most effective when undertaken where the action is, that is, where the activities being protested against are actually occurring. For example, environmentalists routinely protest at places where they say environmental damage is occurring such as forests that are being logged, factories that are polluting or mines that are said to be damaging the environment. Preventing protesters from protesting where the activity is occurring is to place a very significant restriction on political communication.

In summary, there are four separate and independent reasons why paragraph (c) is unconstitutional. It is aimed at protesting. It lacks a rational connection to any legitimate objective and there are many less restrictive laws that would enable persons to be protected legitimately in terms of accessing medical services.

My second point is that in terms of the proposed paragraphs (a) and (b) of section 24(1), all of the elements of those provisions are essential to their constitutional validity. The reason for that is this. Paragraph (a) prohibits behaviour that is harassing, hindering, intimidating, interfering, threatening or obstructing. Paragraph (b) prohibits acts that can be seen or heard by a person such as someone accessing an abortion facility. As alarming as the notion that you might harass someone might be, the constitutional validity of paragraphs (a) and (b) turn on the other element in the proposed bill, and that is that such actions must be 'intended to stop a person from entering the facility or performing an abortion'. In my submission those extra qualifications are essential to make paragraphs (a) and (b) constitutional. I would also note that even these provisions would need to be interpreted in a way that is compatible with the implied freedom so as not to unduly interfere with political protesting.

The third and final matter that I would like to submit to the committee is that this last observation reveals why there are significant doubts about the constitutionality of several other similar laws in other states such as those in Victoria and especially Tasmania and the ACT, but perhaps my five minutes is up and you would like to ask me questions about that.

**CHAIR:** Spot on. Thank you very much. I invite the deputy chair to start questions.

**Mr McARDLE:** It was a very succinct paper as well. Can I summarise it in that subparagraph (c) would not survive a challenge in your opinion?

**Prof. Aroney:** That is my submission.

**Mr McARDLE:** In part 12 of your submission you say subparagraph (a) and (b)—you have not really addressed that question fully, but today you would say you suspect more likely than not they would survive a challenge?

**Prof. Aroney:** I did not consider them fully because I thought (c) was so plainly unconstitutional. My strong point is that (a) and (b) require all of those elements to pass constitutional muster. Further, I did intimate in that final paragraph that it would still need to receive an interpretation that protected freedom of speech. This is something the High Court has insisted on doing in a lot of the cases.

**Mr McARDLE:** Do I take your commentary to be that there is still a shadow of doubt in your mind as to (a) and (b) but no doubt as to (c)?

**Prof. Aroney:** I would not use the term 'doubt' in relation to (a) and (b). There is not much doubt in my mind about (c), if I can put it elliptically, because for the reasons I gave it goes so much further than anything else except the equivalent clause in the ACT.

**Mr McARDLE:** If paragraph (c) could be severed it would not defeat the bill, would it? Would finding that unconstitutional defeat the whole bill or could it be severed by the court retaining the balance of the bill?

**Prof. Aroney:** The general rule is that the court will conclude that an offending provision can be severed where removing those words does not affect the substantive effect and operation of the other provisions. I would have thought that it could be severed for that reason.

**Mr McARDLE:** I take you to clause 23, 'Declarations for abortion facility'. It talks about an area of 50 metres around the facility itself. Have you turned your mind to that particular provision?

**Prof. Aroney:** Fifty metres?

**Mr McARDLE:** Yes. Clause 23 provides that an area declared to be protected must be at least 50 metres as a prohibited area. You cannot protest, you cannot harass et cetera. Is there a question mark in your mind about having an area defined around a facility of such a nebulous nature—around 50?

**Prof. Aroney:** I think certainly in relation to paragraph (c), but because paragraphs (a) and (b) restrict what is prohibited in the ways I have suggested that is not so much of a problem. An artificial boundary, together with a blanket prohibition on protesting—as I say, where the action is, where things are happening; sorry to have used that expression—is quite objectionable.

**Mr McARDLE:** Let us say for example that we have in time to come three or four facilities across Queensland. The clause says that it is an area of 'at least 50 metres at any point'. You could have facilities at 100 or 150 metres. Does that raise a concern in your mind about an arbitrary boundary being placed upon where you can and cannot do a certain thing, or should it be uniform?

**Prof. Aroney:** It is more the substantive restrictions or definition of the offence that is the more critical factor, in my opinion. The breadth of that zone is relevant where those other qualifications are perhaps less stringent, or if they were less stringent. I have not addressed my mind carefully to this question, but there are other provisions in other states which lie somewhere between the tenor of paragraphs (a) and (b) on the one hand and paragraph (c) on the other. It could well be relevant to considering the constitutionality about the breadth or the size of the protected zone.

**Mr McARDLE:** Could you save paragraph (c)? Would you amend it in a manner that could sustain it in the act?

**Prof. Aroney:** In my submission you could not. That is really the third point I was coming to. You could amend it to make it look like the provision in Tasmania, but, in my respectful submission, that would be still insufficient. I could walk you through that, if you would like, in answer to that question.

**Mr McARDLE:** We would not have time, I do not think, Professor.

**Prof. Aroney:** It would only take about two minutes.

**Mr McARDLE:** I will not do that, but I think the word 'protest' is what you are concerned about most of all?

**Prof. Aroney:** Yes, it is.

**Mr McARDLE:** The fact of a protest taking place implies a reduction on the rights we all have as citizens of this nation?

**Prof. Aroney:** Yes. If I may say, you could amend paragraph (c) so that it says 'a protest which is able to be seen or heard by a person accessing an abortion facility'. That is what some of the other statutes say. In my respectful submission, that would still not rescue the provision from the problem of constitutionality, because a protest, by its very nature, is going to be able to be seen by someone entering an abortion facility.

**Mr McARDLE:** Otherwise why protest?

**Prof. Aroney:** So it would not in substance make a difference to the reach of the provision.

**Mr HARPER:** This is probably the only day I will say that I am happy to have lawyers in the room, dealing with someone who is obviously an expert in constitutional law. I refer to the provisions within the bill dealing with protests. In dealing with such a sensitive matter, where an individual woman makes a decision to have a surgical or medical abortion, do you think their rights to privacy should be given due consideration rather than having to go through that process of a protest and people around? Just putting the law aside for a second, what about the right to privacy?

**Prof. Aroney:** I think the other aspects of the bill that I have made no submission on do attempt to protect the privacy of persons accessing abortion facilities, in terms of those prohibitions on recording them and so forth, as well as paragraphs (a) and (b). I would agree that the privacy of people does need to be protected, but I would not regard a blanket prohibition on protesting as necessary to protect people's privacy when it is protected by paragraphs (a) and (b) and those other provisions prohibiting recording and so forth.

**Mr HARPER:** I was wondering if you could articulate those alternatives. I have not quite caught up with what (a) and (b) are, but I will have a read. I note that, interestingly, Q Health conduct therapeutic terminations in Queensland hospitals. We do not see those protests outside public hospitals but we do see them outside private facilities. Why is that the case? Is it because it is on state land?

**Prof. Aroney:** I could not answer that question.

**Mr HARPER:** It is an interesting observation, I think, at this point.

**Mr JANETZKI:** Thanks, Professor, for your submission. When I was an undergraduate constitutional law student of yours in 1998—I was underwhelming; I flew under the radar—we spent a lot of time talking about political communication. Certainly it was a relatively new area of constitutional law. What is your reading these days of the High Court and their willingness to strike down provisions of this nature, particularly when we have a number of other cases that you have referred to in your submission?

**Prof. Aroney:** To generalise, in 1992, when the implied freedom was first constructed, the court applied it to Commonwealth legislation which was struck down. A lot of commentators said at the time that, even if they agreed with the implied freedom and its derivation from the Constitution, the High Court was taking a very stringent approach to what it would mean and it struck down legislation that could have been justifiable. Possibly in response to a lot of discussion and criticism that occurred at that time through the 1990s, I think most observers would say that the High Court

found ways to develop its understanding of the implied freedom that constrained its application somewhat, but I would say that the High Court has now entered into a third phase where it is becoming more expansive about that. It seems that proportionality tests have now won a majority of the court. That is why in my submission I applied the proportionality test that a majority the court adopted in *McCloy*.

**Mr JANETZKI:** You mention there is a Tasmanian piece of legislation. Is that the Workplaces (Protection from Protesters) Act that is currently before the High Court?

**Prof. Aroney:** It is not before the High Court, I do not believe, but it was the subject of a magistrates court decision and I understand that it is the subject of appeal to the Tasmanian Supreme Court.

**Mr JANETZKI:** The previous submission from the dean talked about section 78 of the Criminal Code in Queensland, which makes it a criminal offence to restrict political liberty. You have not gone to section 78 of the code in your submission. Do you have any thoughts on that provision and its application in this instance?

**Prof. Aroney:** I do not have anything to add to my submissions on that point.

**Mr JANETZKI:** Constitutional law is extremely complicated and hosts a divergent range of views. Would you expect that your view put to us today would receive wide support from constitutional lawyers? Have you spoken with others in respect of this proposed law?

**Prof. Aroney:** I have to some extent but not very widely. In fact, as it happens I am working on a major research project on this whole question of protest laws, because it is not just the abortion laws but also the environmental protest laws which are also in some respects the subject of challenge. What is quite remarkable about that is that the environmental protest laws are much more carefully constrained than the abortion protesting laws, yet the environmentalist movement is pretty strong on the view that it is unconstitutional. The difference is quite extraordinary, so I think it is really important to draw attention to, in a balanced way, the way in which environmental protesting is regulated as well as abortion protesting. I think I heard evidence in discussion, prior to me appearing before you, about trade unions as well. I think one has to, in a balanced way, consider how protesting is regulated across-the-board in order to come to a principled approach to that question.

**Mr KELLY:** Professor, when I think of a political protest I think of an individual or a group of individuals gathering together to try to influence the decision-making of generally some sort of a corporate body—a government or an organisation. The actions that have been described in this instance are people being footpath counsellors, trying to change the decision of an individual woman. How does that constitute political communication and protest? What corporate body are they trying to influence in that situation?

**Prof. Aroney:** I cannot comment on any specifics about people's motivations or actions, but I would say that political communication, as well as communications that have the objectives you just described, can often exist at the same time in respect of conduct. I think that happens, as I mentioned, in relation to environmental protesting and other forms of protest as well. For example, environmentalists might protest about what is actually happening in a forest, and their interest is in placing pressure upon the company that is undertaking the forestry engagement and also placing pressure on the people who work there who are engaged in those activities. They are also simultaneously making a political point and hoping that, I would surmise, this will affect government policy and legislation. I would say that the same sort of reasoning applies to all forms of protesting, including abortion protesting.

The important thing to remember is that this legislation might well apply to people who do not profess to be entirely concerned for the political issue and might be interested in counselling, but that is not the constitutional question that has to be addressed. The constitutional question is about the scope of the legislation and its effect on political communication. I would probably say that the sorts of behaviours or actions that protestors typically do, according to reports outside abortion clinics, involve often holding up signs or pictures which are clearly making claims about the nature of abortion which is a contribution to political discussion, even if that might not be, in one particular case or another, the primary motive that person has.

**Mr KELLY:** Does your answer change if the person does not have dual intentions—if their only reason for being there is to pass on information, supposedly to bridge an information gap, that may not have an accepted clinical basis to change that individual's decision? Is that still a political action, to stand there to try to change one person's view without any other intention?

**Prof. Aroney:** That would be a question of evidence before the court. If the legislation, as it often does, uses the term ‘protest’ then the court would have to interpret the meaning of ‘protest’. I would have thought that the natural meaning of the word ‘protest’ involves both political and also just direct disagreement with what is being done. The whole point would be whether the person is engaging in protest as defined by the court in its interpretation of that clause.

**Mr KELLY:** Knowing the stated objectives in the explanatory notes and the introductory speech, is there, in your opinion as a constitutional lawyer, any way that these amendments can be changed so they would stand the test of constitutionality and also achieve the policy objectives that have been stated?

**Prof. Aroney:** Yes, I think by the removal of paragraph (c).

**Mr CRAMP:** Professor, my understanding, from what you have been saying, is that it is a matter for the courts what people’s real intentions are, but what would be judged in protesting would be how you go about it—your actions, and whether you obstruct a person and stop them from, in this instance, going into the clinic. Previous witnesses have said that they question the person going in simply by asking, ‘Is this what you really want?’ Would that be seen, in your opinion, as an obstruction to that person entering? There is no physical obstruction. They are standing away from the footpath and asking, ‘Is this what you really want?’ Is this something that would be considered an obstruction?

**Prof. Aroney:** The words used in paragraph (a)—

Harassing, hindering, intimidating, interfering with, threatening or obstructing...

Your question is about obstructing in particular?

**Mr CRAMP:** No. Sorry, my apologies.

**Prof. Aroney:** Or is it about all of those?

**Mr CRAMP:** You can go to the whole wording. I am just interested because, if I am asked a question, even on the street, do I suddenly think, ‘That’s somebody obstructing, hindering, harassing or intimidating me?’ I would always feel that it is the very nature of how they went about that and their actions. Is that not how the law would see it? What would that law see that person standing there praying and then asking that person? It is not just in relation to this issue; I am very interested to make sure that people’s civil liberties are protected. I would be interested in your opinion.

**Prof. Aroney:** I think it would, as you suggest, depend on a careful analysis of the context. Arguably, a simple polite, courteous and non-threatening question might not of itself constitute harassing, hindering et cetera, but a single question delivered in a certain sort of way would. A second and a third and a fourth question, depending on how they were delivered, would make it more and more likely that the behaviour was harassing and so forth. I think it would depend on the circumstances, because the terms ‘harassing, hindering, intimidating’ et cetera are not words like, ‘questioning,’ or ‘communicating with,’ or ‘speaking with’—terms that describe language or communication that is more moderate and peaceable than those words connote. It would depend on the context.

**Mr CRAMP:** Thank you.

**CHAIR:** Professor Aroney, thank you very much for coming before the committee today. I know that the committee appreciates the significant expertise that you have brought around constitutional law. Thank you very much.

**Prof. Aroney:** My pleasure. Thank you.

**CHAIR:** The committee will now take a short break and resume at 3.30 pm

**Proceedings suspended from 3.01 pm to 3.31 pm**

**CHAIR:** The hearing into the Health (Abortion Law Reform) Amendment Bill 2016 will now resume. I invite Dr Joseph Thomas and Dr Anthony Herbert to come forward.



**HERBERT, Dr Anthony, Private capacity**

**THOMAS, Dr Joseph, Private capacity**

**CHAIR:** Thank you for joining us. I understand that each of you will contribute to a brief opening statement of up to five minutes and then we will open for questions. Would you like to commence?

**Dr Thomas:** Thank you. Chair and honourable members of the committee, in an ideal world there would be no unwanted pregnancy and there would be no foetal abnormality. However, in this real world where we live our lives are both complex and messy and there is a need for an abortion law. However, this abortion law being enshrined in the Criminal Code does not make sense. In any society, laws are enshrined so that the rights of individuals are linked with the responsibilities that they should have. The freedom that is given to all of us is defined with limitations. If we do not have these laws that regulate our rights and define our freedom there will be anarchy and chaos. This is true for abortions as well.

An abortion seen simplistically involves a woman, a foetus and a medical practitioner but, clearly, there is much more that is involved. As we can see here, the parliament, the government and the public is also involved. The woman has the right to choose. However, this right should be after she has been given unbiased information on all of her options and the risks and benefits that are involved in the choices that she might make. It is a reductionist view to see it only as the woman's right to choose when there is another life involved and many other stakeholders.

It is granted that the foetus has no legal right and no legal status attributed to it. However, this does not mean that the foetus has no value. Each of us sitting here started as a fertilised ovum and we were once an embryonic foetus. The potential of the ovum becomes a reality once viability is crossed. That is when a value should be attributed to a foetus.

In addition, moral and ethical issues are the foundations on which any society is built and cannot and should not be ignored. The medical practitioners involved have moral obligations and are bound by their registering bodies and the colleges to which they belong to adhere to guidelines and protocols and practise in a modern and ethical manner. A duty of care to the persons who come to the practitioner and to firstly do no harm is enshrined in all colleges and in medical boards. In any law that is passed, provision should be made to protect doctors who uphold human values, human life in all its form and to practise with a clear conscience.

In my practice, I see women with multiple foetal abnormalities who struggle with the decision, and the dilemma that it causes, that they have to make and they are thrown into greater disarray when they are told that there is no law in Queensland that they could go to if they need a termination based on foetal abnormality. They are then required to find a reason, either based on mental health or a physical reason, for the mother to request a termination. Of course, some of them would choose a perinatal palliative care pathway.

**Dr Herbert:** Thank you, Joseph. I am speaking on behalf of my own personal professional opinion and not on behalf of any particular organisation. We need to approach women in this difficult situation in a compassionate and non-judgemental way. We believe that perinatal palliative care is one option that should be offered to women who are carrying a pregnancy where the foetus has been diagnosed with a life-limiting condition as an alternative to late-term abortion.

Perinatal palliative care programs are being established throughout the world. Perinatal palliative care is a compassionate model of support that can be offered to parents who find out during pregnancy that their baby has a life-limiting condition. As prenatal testing continues to advance, more families are finding themselves in this heartbreaking situation. Perinatal palliative care incorporates the philosophy and expertise of palliative care into the care of this new population of patients.

For parents who receive a life-limiting prenatal diagnosis and wish to continue their pregnancies, perinatal palliative care helps them embrace whatever life their baby might have before and after death. This support begins at the time of diagnosis, not just after the baby is born. It can be thought of as hospice in the womb, including birth planning and preliminary medical decision-making before the baby is born as well as more traditional palliative care in the postnatal ward or at home after birth—that is if the baby lives longer than a few minutes or hours. This approach supports families through the rest of the pregnancy, through decision-making before and after birth and through their grief. Perinatal palliative care empowers families to make meaningful plans for their baby's birth, life and death and offers dignity to a vulnerable baby and their family.

**CHAIR:** I thank you both very much for your opening statements. I also thank you both for coming today. I appreciate that you have significant expertise that is of great assistance to the committee in examining this bill. In looking through your submission you make joint recommendations?

**Dr Thomas:** Yes.

**CHAIR:** In relation to the recommendation relating to terminations on demand you state—

... (social terminations) be limited to the first trimester (up to 13 weeks...

You also make a recommendation of what would be required should termination be sought after 22 weeks and six days of gestation. Do you have a view on what legal or procedures should oversee a termination after 14 weeks and up to 22 weeks should someone seek a termination in that time?

**Dr Thomas:** Right. That is just on demand—social, without any medical reasons?

**CHAIR:** In both situations.

**Dr Thomas:** This is my personal opinion. If there is foetal abnormality found between 14 and 22 weeks, I think that it is the family's decision that they decide whether they want to bring the life into the world and look after the baby, which means a commitment from their side, from society's side, from supporting structures' side, or they do not want to do it. These are babies who are dearly wanted. They are not pregnancies that have just been unplanned due to a lack of contraception and they are a social inconvenience. Sometimes they have gone through IVF pregnancies. They have come through prenatal scanning and they find that there is something wrong. They do not take this decision lightly. If they do, we have to bear the consequences—they have and we as a society have to. I think that freedom should be given to them to 22 weeks if there is a medical indication for a termination.

**CHAIR:** And if there is not? In the other circumstance?

**Dr Thomas:** That is a difficult question for me to answer, because anybody who thinks that a pregnancy is an inconvenience, or there is no indication to end the pregnancy, they should be able to have that processed before 13 or 14 weeks. Of course, there would be instances where they did not know they were pregnant and exceptions would come up but, overall, my own feeling is that social terminations should be limited to the first trimester of pregnancy. There are medical complications as well if terminations are undertaken after 14 weeks.

**Dr Herbert:** In focusing on pregnancies where there has been a diagnosis of a severe condition, there is a variety that may be diagnosed from very severely life-threatening conditions such as trisomy 18 and 13 to other conditions that may be less life threatening but still associated with disabilities, such as spina bifida or trisomy 21. I think the condition itself needs to be considered.

There is also the timing of when the diagnosis is made. Some diagnoses may be picked up on early scanning—at eight or 10 weeks—and some confirmatory genetic testing, but sometimes the diagnosis may not be made until the 18- or 20-week scan. Sometimes it is more challenging to get prognostic certainty earlier in the pregnancy. I think it is a complex decision to make for the parents and for the health professionals to give accurate information to the parents. As a risk minimisation, it is preferable to avoid late terminations if we can.

**CHAIR:** Thank you. The explanatory notes state—

There currently exists a lack of clarity around what point during gestation and for reasons a termination of pregnancy may be performed in Queensland. The bill seeks to clarify when care can be imparted and to avoid prolonged approval and ethics processes, not conducted for the benefit of patients' wellbeing but to substantiate lawfulness.

From your point of view as medical practitioners, do you feel that the bill as proposed achieves that aim—that in some way it would provide clarity in cases where a woman did present for a late-term abortion due to fatal foetal abnormality?

**Dr Thomas:** In a sense, the pathway now is tortuous, because they have to go to an ethics committee at the Royal. They have to pretend to be a little bit unable to cope and have psychiatric grounds on mental health or physical reasons, not based on foetal abnormality. I think that is hiding behind the facts. If there is a foetal abnormality that the parents are needing a termination for, that should be stated as such and not a termination occurring based on a maternal condition. I think if the bill would provide a pathway for—if I can use the term—late-term abortions for a serious foetal condition, then I would be supportive of that if the parents do not want to go down the palliative pathway, which is an alternative for them.

**CHAIR:** In your view, does the bill as it is worded now provide adequate protections for somebody seeking a termination post 24 weeks as it relates to foetal abnormality?

**Mr Thomas:** As related to foetal abnormalities, yes.

**CHAIR:** That is, that a doctor reasonably believes the continuation of the woman's pregnancy would involve greater risk of injury to the physical or mental health of the woman than if it was terminated and has consulted at least one other doctor who also reasonably believes continuation of the pregnancy would involve greater risk of injury. Do you feel that they are appropriate safeguards?

**Dr Herbert:** In our submission we recommend the approval from a hospital ethics committee be required for exceptional circumstances where a family may request a termination beyond 22 weeks and six days of gestation based on a later diagnosis of a foetal or genetic condition. I think some sort of ethics process, if it can be done in a timely way, is perhaps more transparent than maybe two particular clinicians.

**Dr Thomas:** Yes, some sort of a regulatory body or a registry to keep an eye on what is going on would be needed because a sixth digit could be considered an abnormality. A cleft lip is a highly repairable abnormality regardless. A parent may say I want a termination for that. Where do we draw the line? That is the difficulty when we talk about foetal abnormalities without any qualification.

**CHAIR:** Reading on from that, you would say the bill currently is deficient in that it should be 22 weeks and six days not 24 weeks and an ethics committee would be preferable to what is proposed?

**Dr Thomas:** Yes. Because where do you draw the line? Some would argue what is the difference between 22 weeks and six days and 24 weeks. I think for me it is an important line and that is the line of viability. We resuscitate babies from 23 weeks onwards and therefore that is why we suggested 22 weeks and six days.

**CHAIR:** Thank you. I could ask many more questions, but I know my colleagues would like to ask some questions.

**Mr McARDLE:** Thank you, doctors, for being here today. If I understand your submission, up to 13 weeks the mother determines.

**Dr Thomas:** Yes.

**Mr McARDLE:** Post 22 weeks and six days the committee determines.

**Dr Thomas:** Or a regulatory body of some sort or however the law can be defined to make it a little bit more watertight.

**Mr McARDLE:** Who determines between 14 weeks and 22 weeks and six days? Who has the right there to make a determination?

**Dr Thomas:** It will have to be a foetal medicine specialist or a tertiary scan, based on that. It is a medical practitioner who is qualified in the area of foetal abnormalities who defines what the abnormality is. He does not decide whether the woman should have a termination or not.

**Mr McARDLE:** Who does decide?

**Dr Thomas:** The woman and the family decide, but it is the medical practitioner who diagnoses the condition. Until 13 weeks the woman can make a choice based on her social factors or whatever factors without the involvement of the medical fraternity. Between 13 weeks and 22 weeks and six days the medical fraternity is involved. You need a diagnosis.

**Mr McARDLE:** But they are only involved to the extent of the diagnosis.

**Dr Thomas:** Yes, that is right.

**Mr McARDLE:** Not the ultimate determination to have or not have one.

**Dr Thomas:** Yes, that's right.

**Mr McARDLE:** What does the doctor have by way of leverage in that second term we are talking about, because it is the woman who still decides.

**Dr Thomas:** Yes.

**Mr McARDLE:** With all due respect, does it really matter what the doctor says?

**Dr Thomas:** In a sense the doctor's responsibility is to give counsel, to give all the information about what is possible for that foetus in utero—before birth—or ex utero—after birth—and what is the likely kind of life that the baby may have after birth and, if necessary, garnering other paediatric specialists or developmental physicians to come in and counsel the woman. The decision is not medical, it is a family decision or a woman's decision.

**Mr McARDLE:** There is input by the doctor or doctors as the case may be.

**Dr Thomas:** Yes.

**Mr McARDLE:** The woman and her family still determines what is going to happen.

**Dr Thomas:** Yes.

**Mr McARDLE:** Up until 22 weeks and six days the final call is still made by the woman.

**Dr Thomas:** That's right, based on a medical indication.

**Mr McARDLE:** But it still is abortion on demand, is it not, given that the woman can simply ignore the medical advice and say I still want the termination.

**Dr Thomas:** You are right in that sense, but Down syndrome for me, and for maybe Anthony, is a condition that is compatible with life.

**Mr McARDLE:** I take what you are saying, but from a woman's perspective they will consider do I want the baby or do I not want the baby—

**Dr Thomas:** With this abnormality.

**Mr McARDLE:** And the doctor can make all the comments that he likes but he cannot have a ruling.

**Dr Thomas:** No, because there are only very few conditions which are either lethal or not compatible with life—very few conditions. But those are not the only conditions that we see on prenatal scans. There are many other conditions which have serious implications for life and the quality of life for the child and for the family. Those decisions the family has to make. We cannot be making that decision.

**Mr McARDLE:** The way you have worded that second dot point on the second page, does that mean that if there is not an abnormality or genetic issue that is of a serious nature but is one of, for example, a sixth finger as you pointed out you cannot have a termination? I am just very cautious here about the language you are using implies that in that timeline there needs to be a serious issue to be discussed and you point out to us that a sixth finger is not serious in relation to other matters. Does that leave that out or what?

**Dr Thomas:** In my mind it does.

**Mr McARDLE:** They cannot have a termination for that reason?

**Dr Thomas:** You know, in a sense, yes, it will be wrong to have a termination for a sixth digit if it is not associated with a syndrome. In a sense I like to avoid the words 'wrong' and 'right'. It is not fair or it doesn't seem right that a woman should demand a termination at 22 weeks, for instance, because we found a nubbin hanging off its little finger or a cleft lip which can be easily repaired.

**Mr McARDLE:** Thank you very much indeed.

**Mr HARPER:** Thank you, doctors, for your submission, a very sensible practical submission it was. I liked your opening comment that there is a need for abortion and abortion law. In summary, from what I have observed of your submission today, a woman has a right to choose after being provided with unbiased information, being well informed beforehand; I do not know if there needs to be a cooling off period, I will park that as part of a question; the second was conscientious objection should be included; perinatal palliative care as an alternative—I thought that was quite good; the length of gestational periods has been discussed; and the ethics committee. Have I missed anything else?

**Dr Thomas:** Foetal abnormality should be the reason for terminations.

**Mr HARPER:** Yes, fatal foetal abnormalities. On that, are you aware of the current clinical Queensland Health therapeutic guidelines for termination? You were talking about that foetal abnormality being discovered. Generally it is, from what I take from both of you today, in the second trimester, the period where these would be diagnosed. Do you think that the current clinical guidelines that are held go far enough?

**Dr Thomas:** Regardless of the guidelines it is the law that matters and the current law has no provision for termination on foetal grounds at all. It is a criminal act other than for maternal mental or physical reasons. Guidelines are not defensible in a court of law that is arrived at by different—the Mater has a separate set of guidelines. I don't speak on behalf of the Mater though I am working there and no terminations are allowed at all but we see this in part of our daily clinical practice and the struggle that families go through. The Royal has its own guidelines, but we don't have a current law in Queensland that allows termination on foetal abnormalities and I think it is time for us to have that.

**Mr CRAMP:** Thank you, doctors, for coming in today. Dr Thomas, I just want to clarify something. You used the words the family make the decision. Were they just your words? There have been some questions about the man in the relationship when there is a question of termination of a pregnancy. I just wondered was it just a word you were using or do you believe that the woman should, in cases where there is no, as my colleague puts it, rape or incest, where it is a normal relationship, should the woman be seeking the family's input or is that just some terminology you were using?

**Dr Thomas:** It is not a terminology. It is my preference. Ideally, and of course the ideal is not achieved all the time, children are born into families and decisions about children are made jointly in a family. But we don't live in an ideal world. We have so many single mums who come to us. I did use that word as a generic term and where there is a disruption of a relationship between a man and a woman, do we insist that the man should be involved in decision making, no.

**Mr CRAMP:** That is where my question was leading. You are not saying we should legislate that?

**Dr Thomas:** No, not at all.

**Mr CRAMP:** I am very interested in your first point about making your following suggestions on abortion reforms: up to 13 weeks social terminations and in this case it would be the woman's choice. I am just wondering, financial circumstances, would you want to see that stipulated, what sort of social choices? I guess it is a two-part question and they lead into each other. What constitutes social termination? Things as little as perhaps I can't afford this? That leads to the second part of your comment here about appropriate counselling services which could, in fact, educate the woman if she is in that situation that she is uneducated. Dr Herbert, you are welcome to have input into this as well. I am just interested in your comments around that. Do they go hand in hand, where the woman might feel that there is a social issue why she can't have that baby, but appropriate counselling services could alleviate that?

**Dr Thomas:** Yes, of course, and that is the reason why that should be in place so that the woman gets all the information that she can have about all the alternative options that are there to termination.

**Mr CRAMP:** You say appropriate but it is almost compulsory. Is it compulsory or is it just them signing a document saying, 'I have thought about it. I've got the counselling I need, thank you.'

**Dr Thomas:** South Australia has it mandated as part of the process. They come and ask for their termination, they have to meet a social worker or a trained counsellor who gives them all the information and the termination is booked for a later date. The cooling-off period as well is part of the law in some states.

**Mr CRAMP:** What are your thoughts on cooling-off periods? We have them on land contracts. Some of our witnesses have said it is appropriate, others do not prefer it.

**Dr Thomas:** Based on the current way we function in our public system, no woman can walk in and have a procedure straight away, they are booked for a procedure later on. If that is 48 hours later or 72 hours later that could be looked at as the cooling-off period.

**Mr CRAMP:** I have one last question on the hospital ethics committee. My question is not so much who goes on it; are you talking about for each hospital or a statewide body or a hospital and health service body of which there are 16 or 17 in the state or how does that work?

**Dr Thomas:** This is a specialised procedure, as you can imagine. A late-term abortion is done only in a tertiary centre. As of now I think in Queensland there are only two hospitals that do it. One is in Townsville.

**Mr CRAMP:** It would be more about the specialist hospital?

**Dr Thomas:** That's right. Should it be an ethics committee, should it be a regulatory body, should it be just a registry I have not really thought through that. The ethics committee can become a bit onerous and at this moment in time it is a two-week wait sometimes for the woman who is already in distress to wait.

**Mr KELLY:** Thank you, Dr Thomas and Dr Herbert. Dr Thomas, in relation to the current law in Queensland, as you rightly pointed out it is not lawful for a woman to seek a termination solely on the basis of a foetal abnormality regardless of whether that abnormality is fatal or non-fatal. The first bill, are you familiar with that?

**Dr Thomas:** I had glanced through it.

**Mr KELLY:** By removing three sections of the Criminal Code effectively that issue was remedied: it would be lawful to perform a termination based on a foetal abnormality. The second bill now inserts a gestational period of 24 weeks and puts in place considerations. Once again those considerations relate to the mother and not the state of the foetus. Are we, in effect, in the second bill reinserting the same problem that you are trying to address here by putting these provisions, particularly in section 21, back into this bill?

**Dr Thomas:** The autonomy of the mother has to be respected at all times. If the sections that relate to foetal abnormalities are sufficient enough, I would think that the bill—I have not looked through the amendments. Would you be able to tell me—

**Mr KELLY:** Clause 21 effectively repeats the current common law interpretations. The two doctors having to agree is a new thing, but the basis of the decision has to be on the state of the mother, not on the state of the foetus.

**Dr Thomas:** I would not agree with that. A foetal abnormality indication should be the basis for the termination.

**Mr KELLY:** In your view, in relation to foetal abnormalities, do you think about them in the terms that I have been using, that is, fatal and non-fatal, and some people talk about viable and non-viable? For example, I think about conditions such as spina bifida and Down syndrome. I have met many adults whom I consider to have a quality of life equal to my own. Is there additional information or counselling provided to parents when they are in a situation where a diagnosis is made of a foetal abnormality that would not necessarily be fatal?

**Dr Thomas:** Yes. When we talk to parents, we usually use 'mild' or 'minimal' consequences of the baby; 'easily correctable' or 'has no impact' on quality of life; or 'serious' effect on quality of life, 'severe', 'lethal' or 'not compatible with life'. It would be with the last serious or severe conditions, in my mind, that a parent would seek a termination.

**Mr KELLY:** You are a highly qualified and experienced specialist in this particular area of medicine. Would you believe that, generally speaking, the advice that you might give to a mother or a couple would be reflective of the advice that has been given broadly in the medical fraternity when a diagnosis is made of Down syndrome or spina bifida, or some either easily correctable condition?

**Dr Thomas:** I must admit that there might be differences in outlook to life and value of life that we all give as individual practitioners. Most of us would be agreed on serious and severe disability.

**Mr KELLY:** Dr Herbert, we have heard evidence in this committee, both during this inquiry and the previous inquiry, relating to late term abortions primarily being for the reason of fatal foetal abnormalities, where a foetus may not have a brain or a heart and be incapable of sustaining life outside of the mother's uterus. In that instance, the clinical question has been: do you offer a termination, say, at 21 weeks or do you provide a woman with the option of carrying that pregnancy to term knowing that the ultimate outcome will be the same? From your perspective as a perinatal palliative care specialist, are there clinical benefits to carrying a non-viable foetus to term and approaching this from a palliative care perspective?

**Dr Herbert:** Maybe I could go back to the previous discussion as well?

**Mr KELLY:** You can.

**Dr Herbert:** There is a move away from using the words 'lethal' or 'not compatible with life' because some of those babies, when they are born, do actually live for days or weeks. I would probably frame it in terms of the mother is carrying a foetus with a life limiting condition, life limiting being the child will not live to 18. For example, with spina bifida or trisomy 21 they are likely to live beyond 18, hence they do not have a life limiting condition. We are talking about conditions such as trisomy 18 and trisomy 13. I guess the most severe condition is in the example that you give, anencephaly, where the child does not have a formed brain.

My experience is really that it is about giving the family options. The most important thing is that the family do not have regrets about the decisions that they have made. I have met families where they have carried a baby with anencephaly to term. Various complex factors, such as their family of origin and their values, have influenced that decision and they have not had regrets about that. It is about giving options to the family. For me, it would be a real shame if families were not being offered the option of a palliative care approach, in addition to the option of a termination in this context.

**Mr JANETZKI:** The member for Greenslopes has started down a path that I want to take us a little further. I acknowledge the proposal in your submission, but I want to focus a little on the bill before us. You are the first doctors we have had before the committee today. I want to hear of your

personal experience with a couple of issues, for instance, late term abortions. You have spoken a little in the abstract. I want to get your insight as practitioners day to day: how often do you see it and what are some of your personal insights?

**Dr Thomas:** I would see at least one to two women every month with late diagnosis of a serious foetal abnormality. In fact, right now one of my colleagues is seeing a mother where the foetus has a bleed in its brain. She is 29 weeks. We had an MRI done. The report by, again, a specialist MRI radiologist says that there are porencephalic cysts in the brain, which means that this baby is going to be severely disabled and will have serious disabilities through life. Will it progress? Will there be more bleeds in the next 10 weeks? I do not know.

I have had the hard task of being with this family over the last two to three weeks, working with them and trying to find out what is causing the bleed in the baby's brain. She will be meeting with one of my colleagues this afternoon, because I had to come here. It is likely that these parents may either want to go to term, because she is already 30 weeks, or they might choose to seek a termination now. The mother will have to go to the Royal. She will have to go through the ethics committee. She has to be coached, say that she cannot cope or is mentally unstable as a way to the termination. I do not know which pathway she will choose.

The other example that I want to give is a woman who is having her first baby after an IVF pregnancy. I am scanning her at 16 weeks. There are multiple bones in this baby already broken. There are fractures. It has a serious skeletal problem. I do not know what this woman will want to do. She has spent a whole lot of money to get the pregnancy this far. I know of others who have lived with osteogenesis imperfecta and there are different grades, but this is a very severe grade. This baby may not live. I do not know what pathway she may take.

We do see these late and severe late term abortion requests, maybe one to two a month. It is horrendously difficult, both for the parents and for those of us who have to journey with the parents until all of this is solved. It is not an easy task for them. They carry this trauma. Sometimes it is easier for them to take the palliative approach and have the baby born. I have a mother who is now pregnant a second time. The first pregnancy was a serious heart condition that could not be repaired. She is an Islamic woman and would not consider termination, so we were more than happy to offer her the palliative care services. She went through it. The baby lived for five months. The baby died. She was prepared and carried and helped along to farewell this baby. None of that is an easy job or an easy task. Therefore, I hope that our lawmakers will make it easy for the mothers who are found in these difficult situations.

**Mr JANETZKI:** Thank you, Dr Thomas. Dr Herbert, do you have any personal insights that you would share?

**Dr Herbert:** As a paediatrician who does palliative care, I am mainly seeing the families who are deciding to go down the palliative care pathway. Certainly many of those families do not have regrets about that. In terms of research about the outcomes in the context of a life threatening diagnosis antenatally and termination versus palliative care, it is probably too early. We do not have that evidence in terms of outcomes, as to whether one is better than the other. It is important that families do not have regrets. As Joseph said, it does require very thorough assessment, good clinical care, communication and counselling with the family. I guess it is accompanying the family in that difficult process and supporting them in their decision making.

A number of years ago, I looked after a family where the older boy had died of a genetic syndrome. The mother was pregnant with another child who was diagnosed with the same syndrome, which was life limiting. She elected to have a termination. In her particular context, she had particular insight into that condition because she had cared for her other son who had had the same condition. It is just trying to be compassionate and acknowledging the mother's knowledge of what is best for the children.

**Mr JANETZKI:** Finally, without seeking to mischaracterise your position, and please correct me if I am wrong, leaving aside the proposal in your submission, your position in respect of the bill under consideration is that it is unsatisfactory in its current form or does not appropriately reflect the complexity of practice?

**Dr Thomas:** Yes.

**CHAIR:** Dr Thomas and Dr Herbert, thank you very much for your time today. We appreciate you taking time out from your patients.

**Dr Thomas:** Thank you for hearing us.

**CHAIR:** I invite our final witness for the day, Mr Duncan Stuart, to come to the table.

## **STUART, Mr Duncan, Private capacity**

**CHAIR:** Welcome, Mr Stuart. Would you like to make an opening statement of up to five minutes and then we will open for questions.

**Mr Stuart:** I come here today without any medical knowledge whatsoever. I rather felt in awe of the two people who proceeded me. I became involved in this matter when I sent a copy of the opinion from Rachael Wong on the ABC's *Religion and Ethics* to my local member, Mr Kelly. Mr Kelly then sent me a link to the report, which I printed off and read, but obviously have not studied as much as you people on the committee have.

My concern about abortion is that of someone who is concerned about the wellbeing of society as a whole. Most of the material that I read in your report I was reading for the first time, so I am an amateur in this sort of area. My impression of the overall tone of the report was that the committee was seeking to remove all obstacles from abortion on request. That was the impression that I got from reading it. Whether that is your true objective, I do not know. The current law that we have appears to be based on the Mosaic law, that is, thou shalt not kill. It is archaic, as some people have noted, but it was still enforced in the courts yesterday by Justice Ann Lyons.

In section 2.2 of your report you show how lawyers used words to change what I believe—and I think most people at the time believed—to be the intent of the law in that period of history, and that was thou shalt not kill the unborn child. Except for the approach of Professor Elwood, outlined in section 2.3, it seems that most of the medical profession consider the health and wishes of the pregnant woman to be of prime importance while the health of the unborn child is a very secondary consideration.

Section 12.1 of your report, 'Impacts of the current law on medical practice and women', suggests that most abortions are carried out for reasons which do not satisfy the Menhennitt ruling. Therefore, the signature of the two doctors does not provide any source of guarantee or safety for an unborn child.

My particular concern is that the practice of abortion targets all unborn children with a disability. Society seems to want to eliminate them. I ask: is the elimination of people with a disability going to make us a better society? If a person with a disability achieves what he or she is capable of, are they not performing better than others in society with no disability who do not perform to their potential?

In my opinion, the most appalling feature of this report is that each year in Queensland 14,000 pregnant women seek an abortion. Why are we not more concerned about why so many women find themselves in this situation? And what are we as a society going to do to help such women so they do not need an abortion? I also put in my submission that I cannot see that the killing of an unborn child, which is an act of violence in itself, is going to improve our society. Finally, who is going to provide justice for unborn children?

**CHAIR:** Thank you very much, Mr Stuart. I will hand over to the member for Greenslopes for questioning.

**Mr KELLY:** Thank you, Mr Stuart. I declare that I have known Mr Stuart for approximately five years. I myself have witnessed your contribution in terms of local sporting communities, road safety and your deep care of your son. The reason your submission, of the many submissions I read, particularly was of interest to me was your personal experience with a child—now an adult—with Down syndrome. You said in your submission that you had quite a bit of contact with other parents of children with Down syndrome. You described an experience when your wife was pregnant that you felt as though the doctor was encouraging a termination on the basis of Down syndrome. Is that correct? Is that an experience anecdotally that other parents of children with Down syndrome have relayed to you?

**Mr Stuart:** The particular doctor I was referring to we had for two pregnancies. The first pregnancy resulted in a child who died in the womb and the doctor, quite rightly, allowed my wife to carry that through to allow the child to be born naturally but dead. When my wife fell pregnant again we went back to the same doctor who saw the pregnancy through but during the course of the pregnancy advised my wife and wanted my wife to have amniocentesis to determine whether there was something abnormal with the child. As we would not have considered an abortion anyway, we did not see the necessity for that so we declined. When the child was born some weeks early during an emergency, he turned out to have Down syndrome.



What I was quoting was an article in the *Courier-Mail* that same day where one woman who had had a diagnosis of Down syndrome while she was still pregnant said that she had been pressured by her doctor to have an abortion. It does seem reading through the lines and reading the literature that pregnant women are easily diagnosed with Down syndrome and very often are advised and encouraged to have an abortion.

**Mr KELLY:** Mr Stuart, do you have other children?

**Mr Stuart:** Yes, we do.

**Mr KELLY:** Do they have disabilities?

**Mr Stuart:** No.

**Mr KELLY:** Would you say that your son with a disability has had a good quality of life and has been able to attempt to achieve his life goals and satisfy his desires in life?

**Mr Stuart:** I think he has.

**Mr KELLY:** He is a good bowler.

**Mr Stuart:** Yes, very good.

**Mr KELLY:** There have been some challenging times for you, I would imagine, in terms of your son over the years both as a child and then as an adult, but have there been occasions where your children without disabilities have also presented times of worry for you and times where you have had to provide greater degrees of assistance, care and support for those other adult children?

**Mr Stuart:** Only with our third child who was found to have a divided aorta when he was five months old and had to have a heart operation in Melbourne to fix that. Luckily, it was picked up and the operation was successful, but all the others were quite healthy.

**Mr KELLY:** Thank you very much.

**Mr McARDLE:** Mr Stuart, thank you for coming in today. You termed yourself an amateur. I think you are wrong in that. I think you gave a brilliant opening statement. Well done to you. Your wife, I suspect, is in the audience today. There are some people who would define what you have done in regard to your son as heroic. You would not use that term, would you? You provided for your son what you had to because you love your son, he was healthy and was able. It doesn't really matter, does it?

**Mr Stuart:** That is right, but it certainly is hard work. I would not suggest that anyone try to go out and have a disabled child, but having had the child we have done the best we could.

**Mr McARDLE:** You would say that you were given medical advice at the time and you determined to proceed with the pregnancy knowing that your child will be disabled. You made an informed choice.

**Mr Stuart:** No, we did not get advice that the child would be disabled before he was born. The first inkling that the child had Down syndrome was when the paediatrician examined him after he was born.

**Mr McARDLE:** Okay. If a mother and a father have the option based upon medical advice to terminate a child who is disabled, would you say that right rests with the parents or would you say the right rests with a higher authority—that is, the rights of the child?

**Mr Stuart:** I do not believe that even parents have the right to have the life of their child terminated. If our children turn out to be murderers or worse, do we have the right to terminate them? Even our justice system does not allow capital punishment anymore, so why should anyone have the right to say that an unborn child cannot live?

**Mr McARDLE:** So you would argue that the rights of the child supersede the rights of the parents?

**Mr Stuart:** I do.

**Mr CRAMP:** I would echo my colleague's comments. Whilst, as you noted, we often hear from experts, sometimes hearing practical experience from someone who is not an expert, such as yourself about bringing up your son or people from our general populace speaking about an area they are passionate about, can be as, if not more, informative so thank you for being here today. Like other earlier questions, mine are initially centred around your experiences with your son.

I had the great pleasure recently of opening a martial arts tournament and met a young guy named Jai who was a black-belt instructor with Down syndrome. It did not seem to worry him at all. He was just a part of the team. My experience in meeting people with Down syndrome has always been a positive one. I am concerned at commentary not just by you but also by others that removal of any safeguards around abortion and making it, as termed previously, on demand abortion may lead to higher rates of abortion for people who have been diagnosed with a Down syndrome child. Do you think—and I have asked this question previously of other witnesses—that we should legislate to protect against people aborting for reasons like non-life-threatening abnormalities such as Down syndrome?

**Mr Stuart:** I think the law should protect all unborn children whether they have abnormalities or not. One of the most inspirational people I have met in recent years has been a person with spina bifida who is totally dependent on a carer, but his intelligence and scholarship is quite spectacular. From what I heard previously, it would appear that people in that category do not have a great deal of hope if they come before this current proposed law.

**Mr CRAMP:** You obviously associate and network with other parents who have Down syndrome children; is that correct?

**Mr Stuart:** We used to a lot when our son was younger. As our son has grown older, he has become more independent and has gone through school and finished school. The only time that he associates with other Down syndrome people is on particular occasions where the Down Syndrome Association has a function for them such as a camp—

**Mr CRAMP:** Like the camp you mentioned.

**Mr Stuart:**—and the other time is once a month at Carina PCYC where lots of people with disability of all sorts come together for a disco.

**Mr CRAMP:** I was interested to know whether this legislation has come up in the concerns of parents that you may have networked recently in regards to—

**Mr Stuart:** I have not discussed it with them.

**Mr CRAMP:** You mentioned generally the effects on society. I understand that you are coming from the perspective of a lay citizen, but I am interested that you have put in the time to think about the fact that protection for women also tends to look at the emotional and mental wellbeing of women. What are your thoughts on counselling? You said that your doctor gave you an opinion. Do you think at the time it would have been helpful to have a counsellor there to discuss matters with you? Perhaps if we take another scenario and you had prenatal diagnosis that your son had Down syndrome. What are your thoughts around counselling for the mother?

**Mr Stuart:** I think if we had had pre diagnosis we certainly would have benefited from counselling. When our son John was born with Down syndrome, probably the best thing that happened to us was that the paediatrician at the time just hit me straightaway with, 'He's got Down syndrome.' In some cases, this has not happened and parents seem to have regretted that they did not know straightaway because they had expectations that their child was going to be something different and it did not turn out that way. When my son was born, I went to see an aunty who had a daughter with Down syndrome to get advice from her.

**CHAIR:** Thank you. I believe our time is almost expired but the member for Greenslopes has one final supplementary question.

**Mr KELLY:** Yes, I have one supplementary question and it is a sensitive topic. You mentioned that in your first pregnancy you had a child who died in utero and you opted to carry that to term. That is related to a subject that has absorbed a lot of discussion in this inquiry today and previously. We have heard evidence that for foetuses where there is a life-limiting condition—to use the term that we heard from the last speaker—women should have options around whether or not they carry a foetus to term or be given the option of a termination, even if that is diagnosed at 21, 22 or beyond. As somebody who has been through not the exact situation but a similar situation, what are your views in terms of the options that people should have? Is that an option people should have? What information should they be given to support that decision?

**Mr Stuart:** I think my wife could answer that better. In our case, the doctor recommended that she carry the child until it was born naturally, which occurred very early anyway. I do not know whether it was beneficial, but it certainly did not have the trauma of having an abortion.

**Mr KELLY:** Thank you very much.

**CHAIR:** Mr Stuart, thank you for making a submission to the inquiry and thank you for coming before us today. As my colleagues have mentioned, we have heard from a broad range of people today and everyone's testimony has been very helpful for us. The time allocated for this public hearing has expired. If members require further information from any witnesses, we will contact you. If any questions on notice have been taken, the secretariat will contact witnesses to confirm the question taken and in regard to when the response is due. I believe there was only one matter that applies to. The committee thanks everyone who has come before us today. I declare the hearing closed.

**Committee adjourned at 4.32 pm**