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The Secretary
Queensland Law Reform Commission
PO Box 13312
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Queensland, 4003

Re: Review of Termination of Pregnancy Laws in Queensland

The Australian Christian Lobby (ACL) is grateful for the opportunity to comment on the current review of laws relating to the termination of pregnancy in Queensland.

ACL's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 100,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

Please feel free to contact me if I can be of further assistance in the consideration of this matter. I would be pleased to meet to discuss my submission or any other aspect in respect to this review.

Regards,

Wendy Francis
Director for Queensland
Australian Christian Lobby

Who should be permitted to perform or assist in performing terminations

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

The prominence of private commercial interests in Queensland's abortion service industry, where only a minority of abortions are provided through public health facilities, gives rise to concerns for conflict of interest. Clinics with one eye to their commercial best interests are not well-placed to provide impartial counselling to women struggling with an unexpected pregnancy or pregnancy crisis about non-abortion alternatives.

In the United States, former Planned Parenthood Clinic Director Abby Johnson, has been vocal in exposing the business-like nature of abortion clinics which, like all commercial enterprises, operate to projected targets. [1] Directors of Planned Parenthood Clinics are expected to perform a certain number of abortions per month, encouraged to increase that number (and therefore the profit line of the clinic in the business model) and may be dismissed if they fail to achieve these targets.

Ideally, the involvement of private clinics would be phased out and this work instead undertaken by government-funded of not-for-profit organisations. Abortions should not be performed by anyone without medical qualifications.

Recommendation 1: Phase out private commercial interests from the provision of Queensland abortions.

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

The appearance of abortion in Queensland's criminal code is politically charged, despite the fact that it has been invoked in only one case (*R v Leach and Brennan*) in more than a century since it was passed into law. This law was enacted as part of the *Wounding and Maiming Bill*, to protect women from the ministrations of backyard abortionists. The inclusion of the woman herself in the list underscores the fact that no one may perform an abortion without suitable medical qualifications, not even the woman herself. The obvious role of this law in protecting women should be uncontroversial.

The circumstances that led to the case of *R v Leach and Brennan* being brought were not the result of abortion being inaccessible to Ms Leach. Ms Leach admitted that she could have chosen surgical abortion and had visited three separate GPs for examinations but that she did not like the sound of the actual abortion procedure. With the assistance of her boyfriend and his sister, Ms Leach procured abortion drugs not legally available in Queensland to induce a miscarriage at home, without medical supervision. In Ms Leach's case, the drugs appear to have been taken voluntarily. However, the two recent cases of coerced abortion (Miss X and Jaya Taki) by high profile NRL players demonstrates how, even now, women are vulnerable to pressure to 'choose' an abortion. This obvious vulnerability to coercion will only increase if safeguards are reduced.

Accurate data is sadly unavailable, but estimates place the number of abortions each year in Queensland between 10,000 and 14,000. Clearly the current system of exemptions, which are

[1] In her book 'unPLANNED', Abby Johnson, former director of an abortion clinic, describes the result of the annual budget meeting as follows, "I came away from that meeting with the clear and distinct understanding that I … as the clinic director was to find a way to increase the number of abortions at my clinic."

afforded a very generous interpretation, are not preventing women accessing abortion services. It is important that, where they do so, they are provided with proper medical supervision, counselling and support. The decriminalization or deregulation of abortion does not serve the best interests of vulnerable women.

Those who argue for the decriminalisation of abortion do so by prioritising the right of the pregnant woman to self-determination regarding decisions affecting her own body. The right of the unborn child to life, even the humanity of the unborn baby must be considered secondary, or denied entirely, for this point of view to hold. However, this in itself creates an inconsistency with section 313(2) of the Queensland Criminal Code, which recognises that:

> *Any person who unlawfully assaults a female pregnant with a child and destroys the life of, or does grievous bodily harm to, or transmits a serious disease to, the child before its birth, commits a crime.*

If the law is changed to recognise that harm done to aborted babies is not criminal (except given the existing exemptions) how can the law then criminalise harm done to other babies in the womb?

Clearly, when a pregnant woman is assaulted so that her baby is harmed or killed, it seems intuitive to agree that criminal liability subsists for the assailant. However, the perpetrator can only be prosecuted by a law that recognises this behaviour as harmful to a baby who is recognised as human. If the baby is not recognised as human, then the damage suffered through the assault could not be criminal except perhaps to the extent that it causes emotional trauma to the mother. Even recognition of this trauma first requires acknowledgement that the assault has resulted in something traumatic, namely the death or maiming of a child.

This inconsistency exists wherever an unborn child who is wanted is infinitely precious and irreplaceable while a child who might be in all other respects the same is not even recognised as human if the baby's mother decides on abortion.

The only other home for legislation concerning abortion in Queensland might be the Health Code. However, to remove legislation about abortion from the criminal code and insert it to the health code is to equate a procedure to remove an unborn baby with a procedure to remove an appendix. This, again, is to deny the humanity of the baby and again, creates inconsistency with other legislation which clearly recognises, for example, that a miscarried baby (of over 20 weeks gestation) must be reported and registered as a death.

Decriminalisation therefore:

- Removes protections currently afforded to pregnant women from unsafe abortion procedures without proper medical supervision (the very situation this law was enacted to address).
- Increases the exposure of pregnant women to pressure to have an abortion without the opportunity for proper counselling or support.
- Creates an inconsistency with section 313(2) that recognises the humanity of an unborn child as worthy of protection.

Recommendation 2: Retain abortion within the criminal code.

Gestational limits and grounds

Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?

Advocates of abortion and pro-life advocates are unlikely to agree on gestational limits but the absurdity of the pro-abortion position comes most sharply into focus when we consider recent proposals to allow "post-birth abortion" (infanticide):

> *"When circumstances occur* after birth *such that they would have justified abortion, what we call* after-birth abortion *should be permissible. … [W]e propose to call this practice 'after-birth abortion', rather than 'infanticide,' to emphasize that the moral status of the individual killed is comparable with that of a foetus … rather than to that of a child. Therefore, we claim that killing a newborn could be ethically permissible in all the circumstances where abortion would be. Such circumstances include cases where the newborn has the potential to have an (at least) acceptable life, but the well-being of the family is at risk."*[2]

While almost everyone would be rightly outraged by the killing of newborns, the arguments proposed in its favour draw a logical path between infanticide and abortion. "It challenges us, implicitly and explicitly, to explain why, if abortion is permissible, infanticide isn't."[3] It demands that we ask: if infanticide is unacceptable, at what point in the gestation of a baby do we consider abortion acceptable and what is the ethical basis for our reasoning?

The practice of late-term abortion is particularly (and increasingly) difficult to defend ethically, both in terms of increased risks of harm to the mother, and the obvious viability of many aborted babies. With gestational periods to viability decreasing, and more premature babies surviving from what would once have been thought impossibly short gestations,[4] it is apparent that many babies who could survive independently of the mother are being killed or allowed to die. In considering Mr Pyne's two failed abortion bills, the Health Minister stated that 27 late term abortions in Queensland resulted in a live birth in 2015. Those babies were subsequently left to die without being rendered assistance.[5] Arguably, this is post-birth abortion in practice already.

Laws proceed from factual and logical physical realities as well as moral values. The law should convey consistency. Modern technology has brought us to an inconsistent situation that defies any basis in reason: in one room a child may be aborted and left to die at twenty-four weeks of age, in another room in the same Queensland hospital a whole team of specialists will work for countless hours and

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[2] William Saletan, "After-Birth Abortion: The pro-choice case for infanticide" Retrieved 19/09/16 from http://www.slate.com/articles/health_and_science/human_nature/2012/03/after_birth_abortion_the_pro_choice_case_for_infanticide_.html

[3] William Saletan, "After-Birth Abortion: The pro-choice case for infanticide" Retrieved 19/09/16 from http://www.slate.com/articles/health_and_science/human_nature/2012/03/after_birth_abortion_the_pro_choice_case_for_infanticide_.html

[4] Babies have survived and grown to healthy maturity with gestations as short as 21 weeks and 5 days. https://www.verywell.com/worlds-smallest-preemies-2748663

[5] Question on notice asked on 24 May 2016, data provided from Queensland Hospital Admitted Patient Data Collection (QHAPDC) Statistical Services Branch, Department of Health, Queensland.

celebrate the survival of a child of equivalent age. The sole distinguishing factor between these two babies is whether or not another human being desires the child to survive.

Arguments for removing or raising gestational limits to abortion also ignores the very persuasive scientific evidence from the US on the subject of foetal pain capability. New approaches to abortion in the US, which specify a 20-week limit, are informed by over three decades of research by Kanwaljeet Anand, Professor of pediatrics, anesthesiology and neurobiology, which found that preterm babies, as young as 20 weeks, produce stress hormones and pain avoidance behaviours comparable to newborns.

> *"Anand's research was so broadly accepted it produced a new global standard in pediatric medicine. But when the research leapt the boundary of science into the politics of abortion, it was suddenly refuted by everyone from pro-abortion lobbyists to a working party of the British College of Obstetricians and Gynaecologists."*[6]

Polls show that two-thirds of voters in Queensland (66%) believe that an unborn child at 20 weeks of pregnancy is a human person with human rights.[7] In most European countries, even those considered to have liberal abortion laws, access to abortion after 12 weeks gestation is more restricted.[8] ACL would advocate for a similar approach to be taken in Queensland.

Recommendation 3: Recognising an unborn baby as fully human, the ACL does not support abortion at any gestational period. If abortion is available, at least let it be limited to early gestational periods. In Europe, abortions after the 12-week period are rare and this should be a model for Queensland.

Q-4 *If yes to Q-3, what should the gestational limit or limits be? For example:*

(a) an early gestational limit, related to the first trimester of pregnancy;
(b) a later gestational limit, related to viability;
(c) another gestational limit or limits?

Recommendation 3: Recognising an unborn baby as fully human, the ACL does not support abortion at any gestational period. If abortion is available, at least let it be limited to early gestational periods. In Europe, abortions after the 12-week period are rare and this should be a model for Queensland.

Q-5 *Should there be a specific ground or grounds for a lawful termination of pregnancy?*

Abortion is often presented as a consequence-free, 'easy fix' solution to unplanned or unwanted pregnancy. This is profoundly misleading and does a disservice to the very women it purports to help. Robust research demonstrates a causal link between an abortion decision and later negative mental

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[6] Jennifer Oriel, "Abortion laws must recognise scientific changes", *The Australian*, January 11, 2014. Retrieved 19/09/16 from http://www.theaustralian.com.au/opinion/abortion-laws-must-recognise-scientific-changes/story-e6frg6zo-1226799220817.

[7] Galaxy Research, *Abortion Study*, Prepared for the Australian Family Association, May 2016, p.5. Retrieved 16/09/2016 from http://www.family.org.au/reports/May_2016_Abortion_Galaxy_poll.pdf.

[8] Luis Acosta, "Abortion Legislation in Europe", The Law Library of Congress, January 2015. (Available here: https://www.loc.gov/law/help/abortion-legislation/abortion-legislation.pdf)

health outcomes including significantly increased risk of depression, anxiety, suicidal behaviour and drug/substance abuse. Dr Priscilla Coleman's meta-analysis of more than 40 studies from peer-reviewed literature that include controls, demonstrates a strong effect of abortion as a risk factor contributing to the development of these mental health problems.[9] The growing number of testimonies of aborted women continues to add weight to the arguments that the easy availability of abortion, particularly in combination with low support for other alternatives, is not serving women well.[10]

Similarly, peer-reviewed medical research indicates risks to women's physical health post-abortion, including:

- Complications of anesthesia
- Postabortion triad (i.e., pain, bleeding, low-grade fever)
- Hematometra
- Retained products of conception
- Uterine perforation
- Bowel and bladder injury
- Failed abortion
- Septic abortion (i.e. pelvic infection)
- Cervical shock
- Cervical laceration
- Disseminated intravascular coagulation (DIC).[11]

The deVeber Institute for Bioethics and Social Research provides a most informative detailed study of various indices of women's health post-abortion which included the results show below:

Suicide	Increased rate of suicide within twelve months of an abortion. Scandinavian women who aborted experienced a suicide rate of 34.9 per 1000, compared to a suicide rate of 5.9 per 1000 for women who delivered their babies. (This is a suicide rate nearly six times greater).
Mental health problems	They site a rigorously neutral study from New Zealand which notes a strong correlation between induced abortion and subsequent mental health problems. "By every measure, whether it is major depression, anxiety disorder, suicidal ideation, alcohol dependence, illicit drug dependence, or mean number of mental health problems, those who terminated their pregnancy by abortion suffered much higher rates of disorder than those who were never pregnant, and those who were pregnant but did not abort."
Hospitalization for psychiatric problems	Hospitalization for psychiatric problems was also more than four times greater in aborted women (5.2 per 1,000) compared with the control group (1.1 per 1,000).
Problems relating to prematurity in subsequent pregnancies	Induced abortion was associated with an 86% increased risk of very preterm birth (under 33 weeks' gestation) among women with previous first-trimester abortions, and a 267% increased risk among women with previous second-

[9] Priscilla K. Coleman, "Does Abortion Cause Mental Health Problems?", World Expert Consortium for Abortion Research and Education, 2012. (Available here: http://www.wecareexperts.org/sites/default/files/articles/Causal%20evidence_abortion%20and%20mental%20health.pdf)

[10] See, for example, David Reardon, *Aborted Women, Silent No More*, Elliot Institute, 2002; Melinda Tankard Reist, Giving Sorrow Words: Women's Stories of Grief After Abortion, Sydney, 2000.

[11] http://emedicine.medscape.com/article/795001-overview. Retrieved 16/09/16.

	trimester abortions. Prematurity in turn is associated with an enormous increase in the risk of cerebral palsy and other health problems.
Lower fertility after abortion	Women who have abortions experience 6% lower fertility than women who do not have abortions.
Pelvic inflammatory disease	Women with a history of induced abortion were found to be 3.15 times more likely than women without a history of induced abortion to be seropositive for the organism causing Pelvic Inflammatory Disease.
Increased risk of breast cancer	Out of 37 studies up to the year 2003 of the link between induced abortion and subsequent breast cancer, 23 showed a 30% increased risk of breast cancer for women who experienced induced abortion. [12] The fact that actuaries in the United Kingdom use abortion as the primary risk factor for breast cancer in insured clients further supports the view that the link between abortion and increased risk of breast cancer is well-recognised outside the abortion industry.[13]

The physical and psychological consequences of abortion to women are sufficient to argue for this being available only in cases of medical emergency.

Recommendation 4: Abortion should be available where the mother's life is at risk and where the mother's and baby's lives cannot both be saved through medical intervention.

Q-6 If yes to Q-5, what should the specific ground or grounds be? For example:

(a) a single ground to the effect that termination is appropriate in all the circumstances, having regard to:

(i) all relevant medical circumstances;

This is clearly very broad and too poorly defined to provide guidance.

(ii) the woman's current and future physical, psychological and social circumstances; and

Again, this requires a subjective assessment of vague and poorly-defined considerations that are arguably unknowable.

(iii) professional standards and guidelines;

Abortion is not simply a medical procedure to be guided by professional standards and guidelines. Medical best practice, without recourse to the law, is inadequate for the task of deciding when abortions should and should not be performed. Legal instruments are needed to provide guidance regarding the ethical considerations and implications of abortion that are beyond the scope of professional standards and guidelines to contemplate.

[12] http://www.deveber.org/drupal/womens-health-after-abortion Retrieved 16/09/16.

[13] Rise Up Australia site a study which showed the overall increased risk of developing breast cancer after one abortion was 44% and a 76% increased risk after two abortions http://riseupaustraliaparty.com/our-policies/abortion/. Retrieved on 16/09/16.

(b) one or more of the following grounds:

(i) that it is necessary to preserve the life or the physical or mental health of the woman;

Where it is necessary as a matter of emergency to save the mother's life, abortion is uncontroversial. Mental health is a much more subjective standard and would require closer scrutiny.

(ii) that it is necessary or appropriate having regard to the woman's social or economic circumstances;

This opens the door to the idea that, where a woman cannot provide for her child, that abortion becomes an acceptable solution to her 'problem'. This is to confuse a 'quick fix' with genuine compassion. Abortion is not some magical surgery which turns back time to make a woman "un-pregnant." Instead, it is a real-life event which is always very stressful and often traumatic. The provision of abortion to women on the grounds of social or economic circumstances would only serve to entrench inequality and compound its detrimental consequences for disadvantages women and their children. Why should babies conceived by poor or vulnerable women be more expendable than those conceived my women in comfortable circumstances? Poor and vulnerable women need further help and this can be offered in many forms including practical support to continue their pregnancy, access to adoption, increased support for women wanting to complete their education or undertake tertiary studies, increased childcare and parenting support for working and stay-at-home mothers, support for women under pressure from violent partners, or as a result of addiction, poverty, homelessness or mental health issues.

(iii) that the pregnancy is the result of rape or another coerced or unlawful act;

It is commonly assumed that rape victims who become pregnant would naturally want abortions. So strong is this assumption that rape victims are in greater danger than other women of being funneled towards abortion as a matter of course. Women who are already traumatised by sexual assault are at risk of being further traumatised by well-meaning abortion advocates who believe this a way of undoing at least some of the 'problem'. The testimonies of aborted rape victims need to be listened to. Many women report that their abortions only compounded the problems associated with their sexual assault, likening their experiences of abortion to a degrading and brutal form of medical rape.[14]

In one of the only studies of women who conceived as a result of rape, Dr Sandra Mahkorn found that 75 to 85 percent chose against abortion.[15] None of the women who gave birth said they did not want their children or wished they had aborted instead. Of those who aborted, nearly half did so because of the demands of others. 94% of women who gave birth said abortion would not be a good solution to a pregnancy resulting from rape. 93% of those who had abortions said it "had not been a good solution to their problems" and they "would not recommend it to others in their situation."[16] Dr David Reardon, notes that this also applies to cases of incest:

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[14] Francke, The Ambivalence of Abortion (New York: Random House, 1978) 84-95, 167.; Reardon, Aborted Women – Silent No More (Chicago: Loyola University Press, 1987), 51, 126

[15] Mahkorn, "Pregnancy and Sexual Assault," *The Psychological Aspects of Abortion*, eds. Mall & Watts, Washington, 1979, pp. 55–69.

[16] Dr David Reardon, "Rape, Incest, and Abortion: Searching Beyond the Myths", 1994. (Available here: https://www.abortionfacts.com/reardon/rape-incest-and-abortion-searching-beyond-the-myths#1). See also, "Abortion for victims of rape and incest? No: They deserve better", ProLife Action League. (Available here: http://prolifeaction.org/wp-content/uploads/docs/RapeAbortion.pdf)

> *Edith Young, a 12-year-old victim of incest impregnated by her stepfather, writes twenty-five years after the abortion of her child: "Throughout the years I have been depressed, suicidal, furious, outraged, lonely, and have felt a sense of loss… The abortion which was to 'be in my best interest' just has not been. As far as I can tell, it only 'saved their reputations,' 'solved their problems,' and 'allowed their lives to go merrily on.'… My daughter, how I miss her so. I miss her regardless of the reason for her conception."*

Far from being open and shut cases for abortion, cases of rape and incest demand even greater sensitivity and support for the women involved. Assuming the answer to their circumstances may serve to compound their pre-existing trauma in the long-term.

(iv) that there is a risk of serious or fatal fetal abnormality?

How many women have been advised that "there is a risk" that their baby has a serious abnormality only to find that the diagnosis was incorrect? In her book *Defiant Birth: women who resist medical eugenics*, Melinda Tankard Reist has documented the testimonies of women who resisted pressure (sometimes amounting to coercion) to abort. She described how these women were "disparaged and treated as pariahs for departing from accepted medical wisdom they have chosen non-compliance with medical/social prejudice and defiantly said yes to their babies, and no to the cult of perfection."

Again, this is not a simple ethical issue. It is contaminated with discrimination against the disabled and involves agreeing with the arguments of eugenicists, that some lives can legitimately be ended for reasons of genetic purity. This issue also opens the question of what defines 'serious or fatal fetal abnormality'? Do we abort for a cleft palate, of a mal-formed limb? Is it possible to simply discard a foetus and try again, as though abortion were no more than a matter of pressing 'control z' on pregnancy? Does a baby that will live only days or hours not still deserve all the love that can be crammed into that time? Again, the fact that the answer to this question is often assumed as an obvious case for abortion makes pregnant women vulnerable to coercion and means that they are at greater risk of being unsupported in a decision to continue with the pregnancy.

Q-7 *If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?*

Recognising that a gamete is a human being and that abortion carries demonstrable negative outcomes for many women, the ACL opposes abortion at any stage of gestation other than for cases of medical emergency where this is necessary to save the mother's life. This being so, it would be ethically inconsistent to approve abortion within defined gestational limits.

Nevertheless, the logical and ethical arguments that stand in opposition to abortion in principle, only strengthen as the baby grows, becomes pain-capable and develops sufficiently to be (even potentially) viable outside the womb. If abortion is to be available at all, it is appropriate for access to abortion to become increasingly restricted as gestation progresses, and to be performed only on the grounds of medical emergency to save the mother's life.

A relevant overview of some European abortion laws is included here in regards to this question. In making this comparison please note that Australia's abortion rate is relatively very high with 19.7/1,000 women.

<u>Germany</u>

Waiting period of 3 days applicable regardless of when abortion is sought (including first trimester).
Mandatory counselling required for women seeking abortion. Certificate of counselling (not less than 3 days prior) must be presented to her doctor when requesting an abortion.
Abortion permitted up to 12 weeks (first trimester). Between 12 and 22 weeks available on grounds of *medical necessity* ie to prevent danger to mother's life or grave injury to her physical or mental health and if the danger cannot be reasonably averted in another way.
The rate of abortion in Germany is 6.1/1,000 women.

Belgium
Waiting period of 6 days applicable after the first doctor's consultation, regardless of when abortion is sought (including first trimester).
Abortion permitted up to 12 weeks (first trimester). After 12 weeks available on grounds of: *risk to life of the mother; severe, incurable foetal abnormality or illness*. Two doctors must confirm. Doctor is required by law to inform patient of alternatives to abortion, and the risks of abortion.
The rate of abortion in Belgium is 9.2/1,000 women.

France
Waiting period of one week is normally mandatory, but can be shortened if the circumstances require (ie close to 12 weeks).
Abortion permitted up to 12 weeks (first trimester). After 12 weeks only where a multidisciplinary team of two doctors, having consulted with their teams, determine that there is a serious risk to the health of the mother or incurable foetal illness or defect. Doctor is required by law to inform patient of alternatives to abortion, and the risks of abortion.
The rate of abortion in France is 17.4/1,000 women.

Switzerland
Mandatory counselling required for women seeking abortion. Patients are informed of the alternative of adoption, and provided with a list of organisations which can help them.
Abortion permitted up to 12 weeks (first trimester). After 12 weeks available on grounds of "profound distress" to the woman where it can be shown that the distress increases as the pregnancy progresses.
The rate of abortion in Switzerland is 6.4/1,000 women.

Finland
Abortion not permitted after 20 weeks. Up to 20 weeks possible on grounds of: risk to mother's life, considerable burden to mother, minor, rape or incest, severe illness or disability of the child.
The rate of abortion in Finland is 10.4/1,000 women.

Austria
Abortion permitted up to 12 weeks (first trimester). After 12 weeks only permitted on the following grounds: life of the mother; mother is a minor; physical or mental impairment of the foetus, serious danger to health of the mother.
The rate of abortion in Austria is 1.4/1,000 women.

Recommendation 5: ACL advocates for greater restrictions on abortion which should only be available on the grounds of medical emergency to save the mother's life.

Consultation by the medical practitioner

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

Yes.

If yes to Q-8:

Q-9 What should the requirement be? For example:

(a) consultation by the medical practitioner who is to perform the termination with:
(i) another medical practitioner; or
(ii) a specialist obstetrician or gynaecologist; or
(iii) a health practitioner whose specialty is relevant to the circumstances of the case; or
(b) referral to a multi-disciplinary committee?

The majority of women and girls who have abortions do so because of a lack of support from partners, parents and friends. 70% of women say they felt they had no alternative to abortion, a problem that is compounded by lack of informed guidance regarding available support.[17] Consultation with another health practitioner, such as a counsellor or social worker, would provide support for those women who are being pressured into abortion or help to ameliorate the effects of social or economic pressure. This could perhaps be combined with the requirement for independent pregnancy support counselling. (Post-abortion counselling should also be provided as a matter of course for women who decide to proceed along this route).

Recommendation 6: Consultation with a counsellor or social worker, in addition to at least one doctor, should be required.

Q-10 When should the requirement apply? For example:

(a) for all terminations, except in an emergency;
(b) for terminations to be performed after a relevant gestational limit or on specific grounds?

(a) For all terminations, except in an emergency.

Conscientious objection

Q-11 Should there be provision for conscientious objection?

Yes. This does not seem to be a particularly controversial question. Representatives of different groups within the Queensland medical community, even those who supported the two Bills brought by Mr

[17] A story by Tony Moore in the Sydney Morning Herald ("Hidden Abortion Pressure Revealed", September 2, 2009) quoted a senior counsellor from Pregnancy Counselling Link in Brisbane as saying that 70 per cent of women were pressured into abortion by their partners. Surveys by Marie Stopes ("What Women Want When Faced with Abortion", 2006) and Lifeway ("*Study of Women Who Have an Abortion*", 2015) show the significant influence of others in the pregnancy decision. The Guttmacher Institute also has research revealing that many teenagers who have abortions are directly and indirectly influenced by the opinions of others.

Robert Pyne, have expressly stated that this is essential and will not reduce women's access to abortion services. [18]

Recommendation 7: Yes, provision should be made for conscientious objection.

Q-12 If yes to Q-11:

(a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?

(b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?

In a medical emergency where the mother's life is at risk, it is clearly impractical and burdensome to require a doctor to consult with other specialists. However, in cases of elective abortion, the lack of other medics with a "reasonable geographic proximity" is no reason to compel doctors or nurses to violate the convictions of their conscience and their professional assessment of their patient's best interests. Given the significant evidence of deleterious outcomes for aborted women, there are ample reasons for doctors to refuse to perform or refer a patient for an abortion. Many medics serving in remote communities do so from a vocation to serve those in need. To then require these medics to act in a manner that violates their conscience is clearly untenable on ethical grounds.

Recommendation 8: The existing arrangements whereby doctors may choose not to refer women to abortion services should remain.

Counselling

Q-13 Should there be any requirements in relation to offering counselling for the woman?

Particularly where private clinics are involved (but for all women with pregnancy concerns) independent counselling is essential. Lack of pre-abortion information and counselling is specifically mentioned among the list of possible contributing factors to women's need for post-abortion counselling. Pregnancy Counselling Link, funded by the Queensland Government, recognises that the emotional after-effects of an abortion can be acute:

> *"Some of the emotional reactions a woman can have after an abortion include relief, regret, sadness, isolation, denial, guilt and loss. These can occur in any order. You might feel one or some of them soon after the abortion or they may be triggered at a later date by reminders of the experience … Following an abortion there are a number of factors that often influence your reactions and feelings. These factors may include:*

- The level of information you received prior to the abortion regarding your options.

[18] See, for example, Submissions 14 and 86 to the Inquiry into Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland. Available here: https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/AbortionLR-WRC-AB2016

- The extent to which you were able to talk about your feelings to others, both before and following the procedure.
- The degree of pressure you might have felt from your partner or family members.
- Whether or not your decision to terminate was consistent with your personal values and belief systems – including religious and spiritual beliefs.
- Past experiences including childhood memories and relationships, previous losses or trauma.
- Whether you have had a previous pregnancy or loss of pregnancy.
- Your personal coping strategies and whether you have any history of depression.
- You may have decided to keep your pregnancy and the abortion a secret."[19]

All of this acknowledges that an abortion decision is not simple for many women. Very rarely does it represent the exercise of feminist autonomy and the glorious triumph of women's rights to self-determination over their own bodies. Quite the opposite. In practice, many women choose abortion because they cannot see a viable alternative – they are trapped by circumstances or relationships that are impossible for them to navigate successfully on their own while caring for a child. In such circumstances, it is vital that support is available for women to make other choices and that women know about this support.

A 2017 survey from the US of women who presented for post-abortion counselling found that:

- 73.8% admitted that they experienced at least subtle forms of pressure to terminate their pregnancies.
- 30% of survey respondents admitted that they were afraid that they would lose their partner if they failed to terminate their pregnancy.
- 58.3% indicated that they decided to abort in order to make others happy.[20]

Even in a society which prioritises freedom of choice, women can only be said to have this choice where they have at least two good options and where each is well-supported. If women are presenting to abortion clinics because continuation of the pregnancy is inadequately supported, this is indicative of a failure in social services – failure that would only be compounded by then reducing barriers to abortion; effectively presenting women with only one viable solution to their "problem". A compassionate response to women facing the crisis of an unplanned or unwanted pregnancy is to consider her long-term needs holistically and, wherever possible, to support her in carrying her child to term.

Recommendation 9: Ensure all patients at clinics (whether private or public) receive independent counselling and are fully aware of support for alternative choices.

Cooling off period

It is widely recognised that the conditions in which women make their abortion decisions are also deserving of closer scrutiny if we are to address the issue of counselling and consent. In their book *Complications: Abortion's Impact on Women*, the deVeber Institute notes:

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[19] http://www.pcl.org.au/assets/PCL-AbortionBrochure.pdf

[20] Priscilla K. Coleman, Kaitlyn Boswell, Katrina Etzkorn, and Rachel Turnwald, "Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences", *Journal of American Physicians and Surgeons*, vol. 22(4), 2017, pp. 113–118.

"the highly charged atmosphere of an abortion decision may not be conducive to a woman who is emotionally vulnerable, and may be in the midst of a frank clinical depression."[21]

In the case of adoption, there is a mandatory period before which the adoption cannot take place. A parent cannot sign an Adoption Consent Form until at least 30 days after the birth of their child, and at least 14 days after information has been given and pre-consent counselling has been completed.[22] This cooling off period allows the parent(s) of the child time to consider and reflect upon their decision before proceeding. Similar safe-guards are in place for consumers. Anyone changing their energy provider or buying a home has a cooling off period in which to change their minds without penalty.[23]

In glaring contrast, no such 'cooling off' period is stipulated for those considering the very grave and irreversible decision of whether to abort their baby. Given that there is widespread acceptance these decisions are often undertaken in emotionally-charged circumstances and women report deeply conflicting emotions on the subject at the time. The contrast in legal protection for pregnant women and consumers here is unaccountable and illogical.

Recommendation 10: Ensure all patients at clinics (whether private or public) have the benefit of a cooling-off period.

Protection of women and service providers and safe access zones*

Q-14 Should it be unlawful to harass, intimidate or obstruct:

(a) a woman who is considering, or who has undergone, a termination of pregnancy; or

(b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

The existing laws are sufficient to ensure access to abortion facilities remains unobstructed for women and workers who wish to access them.

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

No. This is the approach that has been adopted in Victoria and the first conviction made under this law is is currently being challenged in the High Court[24]. On one side of the equation is the importance of the purpose that the law seeks to achieve (namely, enabling people to access facilities that provide particular services, or protecting their privacy). On the other side is the importance of

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[21] http://www.deveber.org/text/chapters/Chap18.pdf p. 273.

[22] http://www.qld.gov.au/community/caring-child/considering-adoption-for-your-child/

[23] The Queensland government web site states: "The standard contract for buying a home comes with a cooling-off period of 5 business days. This means if you're not totally happy, you can cancel the contract during this time." http://www.qld.gov.au/law/housing-and-neighbours/buying-and-selling-a-property/buying-a-home/making-an-offer-on-a-home/cooling-off-period/

[24] https://www.buzzfeed.com/ginarushton/an-abortion-protester-has-lost-her-case-despite-australian?utm_term=.lwG9O9K95#.yc4mvmRmQ

freedom of political communication and the severity of the restriction of the freedom. The demarcation of exclusion zones serves to promote the prosecution of those whose religious convictions are enlivened on the issue of abortion, even when they do not interfere with the women approaching these facilities. The offers of help these charities convey to women are particularly important in the absence of independent counselling.

If yes to Q-15:

***Q-16** Should the provision:*

> *(a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or*
>
> *(b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?*

Q-17 What behaviours should be prohibited in a safe access zone?

Australians already have the right to safe access. Our Public Order laws prohibit physical obstruction and verbal abuse.

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

Australians have the right to walk safely without harassment at any time. Timeframes for safe passage would seem to indicate that outside of those hours there will be no protection. This is clearly against the law as it currently stands.

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Yes.

Collection of data about terminations of pregnancy

***Q-20 Should** there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?*

Yes. According to best estimates, one in three women in Australia will have an abortion at some point in her life. It is only to marvelled at that the data so vital to informing public policy on a subject that effects such a significant portion of the population is not already being systematically captured. Only Western Australian and South Australia collect data on abortions. Information for the rest of Australia is often extrapolated from this information. Better information is clearly vital to inform good health policy. Specifically, Queensland should record:

- The number of annual abortions

- The methods used
- Gestational age of the foetus
- The age of the mother
- The reasons why the mother chose an abortion, compared with parenting or adoption.

This information is vital to inform good policy and to ensure that government, health and charitable organisations can provide for the needs of women facing pregnancy crisis in Queensland.

Recommendation 11: That Queensland record and publish anonymised abortion statistics.

Recommendation 12: That the data be collected and presented in a manner that facilitates comparison and cross-referencing with South Australian and Western Australian abortion data.