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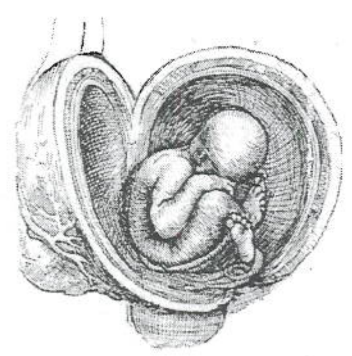

WORLD FEDERATION OF DOCTORS WHO RESPECT HUMAN LIFE

QUEENSLAND BRANCH

PATRONS ***Major General W.B."Digger"James*** *AC MBE MC MBBS FRACS DTP&H DPH DIH*
Past Director General Army Health Services (DGAHS) and
Queen's Honorary Physician (QHP).
The Hon. John Herron *MBBS FRCS(Edin) FRCS(Lond) FRACS.*
Past Pres. AMA(Qld) and Queen's Honorary Surgeon (QHS).

"primum non nocere"

Senate F&PA Committee
Tabled Document
Inquiry: Item 16525 Health Insurance Reg.
Date / Time: 29/10/08 11:
Witness Name: Dr David van Gend
Organisation: World Fed. of Doctors Who Respect Human Life

October 29th 2008

Attachments to Submission

to the Senate Finance and Public Administration Committee

on Item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007

from Dr David van Gend, Queensland Secretary
World Federation of Doctors who Respect Human Life

1. Lecture notes by Dr David Grundmann: "Abortion after 20 weeks in Clinical Practice", Monash University August 1994, describing his technique and reasons for late-abortion.
2. *ABC 7.30 Report* transcript of interview with abortionists Dr Grundmann and Dr Peter Bayliss on late-term abortion, 27 October 1994, where Dr Bayliss considers it 'murder'.
3. *60 Minutes* transcript including comments by Dr Grundmann where he refuses to comment on his method of 'putting scissors through the baby's head', April 17 2005.
4. *SBS Insight* transcript including similar evasive comments from Dr Grundmann, Nov 16 2004.
5. AMA (Qld) position statement on 'late second-trimester termination of pregnancy' April 1996.
6. Hansard (Qld Parliament) including reports on Dr Grundmann's late-term abortion practice, such as for a correctable cleft-lip at 23 weeks, Nov 14 1995.
7. Death Certificate (Qld) showing requirement for death certificate for baby aborted over 20 weeks, in the late second trimester.
8. News conference of specialists associated with our Federation condemning Dr Grundmann's technique for late-term abortion as 'horrendous' and 'more cruel than abattoir slaughters', *Courier Mail* Nov 18 1999.
9. Confession by leading abortion practitioner in the US that late-term partial birth abortion (Dr Grundmann's technique) is "performed far more commonly than his colleagues have acknowledged, and on healthy women bearing healthy fetuses".

Peter SINGER's Conference

Monash University
Centre for Human Bioethics

AUSTRALIA

THE PROCEEDINGS
OF THE CONFERENCE

ETHICAL ISSUES IN PRENATAL DIAGNOSIS AND THE TERMINATION OF PREGNANCY

Tuesday, August 30th, 1994

Centre for
Human Bioethics,
Monash University,
Clayton, Vic. 3168

Abortion After Twenty Weeks in Clinical Practice: Practical, Ethical and Legal Issues

David Grundmann

Medical Director, Planned Parenthood of Australia

1. Of the 80,000 - 110,000 abortions performed in Australia annually, less than 5% are performed over 14 weeks from the LNMP (last normal menstrual period).

2. Of those performed after 14 weeks less than half are performed over 18 weeks and of these most are planned or wanted pregnancies that have to be terminated because of fatal or major fetal abnormalities or catastrophic changes in relationship, social or economic circumstances.

3. In 1973 the US Supreme Court, in its landmark Roe Vs Wade decision mandating abortion as an inalienable constitutional right, made three incisive observations:

   (A) In the first 14 weeks of pregnancy the court has no role to play in abortion as the procedure is intrinsically safe and existing legislation controlling prudent medical practice is already in place.

   (B) In the second 14 weeks of pregnancy the court has an increasing role to play to safeguard the mothers' life. The court recognised the increasing complexities and risks of advanced procedures and felt that some regulations were needed to safeguard the health of the mother.

   (C) As the pregnancy proceeded to viability and beyond, the court recognised that it had an increasing role to play to safeguard the rights of the developing and possibly viable fetus.

4. In the 20 years since Roe Vs Wade, medical science has made such tremendous advances that the boundaries of reproductive technology have been pushed beyond all known limits at both ends of the spectrum.

   Babies born after 26 weeks are now routinely being salvaged and the technology to perform very late abortions safely is readily available and routinely used.

23.

So I pose the question: 20 years ago, would the title of this talk have been abortion beyond 28 weeks and more importantly in 5 to 10 years time, will it be abortion beyond 16 or even 14 weeks?

I have been an abortion provider for 18 years and I have always been an advocate for women's rights to choose abortion on request. So I approach this topic from a particularly biased pro choice point of view.

This exciting topic presents a number of interesting challenges that I will attempt to address in this talk.

1. Can abortions beyond 20 weeks be performed safely?
2. Should abortions be performed beyond 20 weeks?
3. Are abortions beyond 20 weeks being performed? If so ... where?
4. What are the legal implications?
5. What are the ethical implications?
6. Why is this service not more prevalent?
7. What can be done to improve or expand this service?

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1. CAN ABORTION BEYOND 20 WEEKS BE PERFORMED SAFELY?

There are two methods for post 20 week abortion:

A. Medical induction and delivery
B. Surgical evacuation

A. Medical induction and delivery.

There are three principal methods for medical induction and delivery:

1. Amniocentesis and infusion of hypertonic solutions such as urea, saline or glucose. This causes fetal demise and stimulates uterine contraction.
2. Prostaglandin induction and delivery. *i.e.* intra vaginal cervagem pessaries. This promotes cervical softening and uterine contraction.
3. A combination of one and two.

Advantages of medical induction.

(a) Requires minimal skill.
(b) Requires minimal medical intervention.
(c) Acceptable safety level.
(d) Acceptable failure rate.
(e) Has been in use for a long time and is well known.

Disadvantages of medical induction.

(a) Always requires hospitalisation and takes a long time. Women can labour for two to three days.
(b) Always requires analgesia, usually a narcotic.
(c) Always need anti emetics.
(d) May require anti-diarrhoreal agents.
(e) Patient may deliver unattended.... This can be very frightening to the patient and can be quite dangerous *i.e.* heavy uncontrolled bleeding.
(f) The induction may fail and a hysterotomy may be required.
(g) The method may result in the delivery of a live baby.

B. Surgical methods.

1. Hysterotomy.

This is mentioned only to relegate it to history. It is never indicated as a primary method for late abortion. No doctor should ever consider putting a scar in the uterus, to deliver a dead fetus as a primary method of abortion.

2. Dilatation and extraction.

This is my method of choice. It is achieved by serial dilatation using a combination of mechanical dilatation and passive osmotic dilators such as Dilapan, Laminaria and Lamicel over a period of 24 to 72 hours. Osmotic dilators work in three ways. Firstly they absorb water from the cervical cells, thereby flattening them. Secondly they cause the connective tissue of the cervix to alter, softening the cervix considerably. This allows the swelling dilators to slowly atraumatically open the cervix.

The principle of this method is to extract an intact fetus whose soft tissues protect the cervical canal from laceration. To do this it is necessary to achieve an internal cervical os diameter of 75% BPD (Biparietal Diameter), which is roughly equal to the bi-trochanteric distance of the fetus. This measurement is important as the pelvis is the most incompressible part of the fetus. Cranial decompression then allows the delivery of the fetus with ease either by breech or vertex extraction. The BPD at 22 weeks from LNMP or 20 weeks of gestation is 53 mm.

Advantages of dilation and extraction.

(a) Can be performed under local and/or twi-light anaesthetic.
(b) Can be performed as an ambulatory out patient procedure.
(c) No need for narcotic analgesics.
(d) No need for large amounts of anti emetics.
(e) Patient is never delivered unattended.
(f) The attending physician is intrinsically involved in the procedure.
(g) No chance of delivering a live fetus.
(h) Low complication rate. The world wide figures indicate that this technique is much safer than medical induction.
(i) There is never a need to resort to hysterotomy.
(j) The method is easily taught.

Disadvantages of dilation and extraction.

(a) There is a need for greater technical skills.
(b) The aesthetics of the procedure are difficult for some people; and therefore it may be difficult to get staff.
(c) Although rare, complications can be serious and may include; haemorrhage, disseminated intravascular coagulopathy, uterine perforation or cervical trauma. All require hospitalisation and surgery.

2. SHOULD ABORTION BEYOND 20 WEEKS BE PERFORMED?

It is my belief that abortion is an integral part of family planning. Theoretically this means abortion at any stage of gestation. Therefore I favor the availabillity of abortion beyond 20 weeks.

The question then arises, under what circumstances?

Here I have a list of what I believe are appropriate indications for late second trimester abortion.

A. Risk to maternal life. Psychotic/suicidal behavior or life threatening obstetric related illness.

B. Lethal fetal abnormalities.

C. Gross fetal abnormalities.

These first three categories are self explanatory and straight forward. Abortion is available for these indications in many major hospitals, in most capital cities and large provincial centres.

D. Minor or doubtful fetal abnormalities.

E. Rape, incest, sexual abuse, extreme maternal immaturity, *i.e.* girls in the 11 to 14 year age group.

F. Women who do not know they are pregnant. This includes women who are intentionally or unintentionally misled by the doctor of first contact. This is particularly prevalent in remote country areas. Continuing or irregular periods whilst on oral contraception. Alternately ammenorhea in women who are very active such as athletes or those under extreme forms of stress *i.e.* exam stress, relationship breakup, anorexia....

G. Intellectually impaired women, who are unaware of basic biology, may be taken advantage of, become pregnant and not know of the pregnancy until late in the mid trimester. The guardian or carer of such women may similarly be unaware of the pregnancy until after 20 weeks when physical signs in the mother become obvious.

H. Major life crises or major changes in socio-economic circumstances. The most common example of this is a planned or wanted pregnancy followed by the sudden death or desertion of the partner who is in all probability the bread winner.

Abortion beyond 20 weeks is unavailable anywhere in Australia, except at our clinics for the last 5 categories.

3. ARE ABORTIONS BEYOND 20 WEEKS BEING PERFORMED? IF SO ... WHERE?

I have answered much of this in the previous section but to summarize, abortions to preserve maternal life, for fatal fetal abnormalities and for gross fetal abnormalities inconsistent with normal cognitive, independent existence are available at most major obstetric hospitals in all capital cities and many larger provincial hospitals. Some Queensland hospitals that I know of, are performing abortions between 18 and 22 weeks for other fetal indications such as Downs syndrome. To the best of my knowledge post 20 week services are almost non existent in Victoria. For indications other than the ones I have just mentioned, abortion beyond 20 weeks is unavailable anywhere in Australia other than at my clinic in Brisbane.

4. WHAT ARE THE LEGAL IMPLICATIONS?

Only in the Northern Territory is gestational age actually mentioned as a limiting factor, when performing legal abortions. In that jurisdiction the law restricts legal abortion:

A. To registered hospitals
B. To be performed only by specialist Obstetrician / Gynecologists.
C. May be performed only up to 14 weeks.

In the rest of Australia the only other statutory requirements are that abortions performed over 20 weeks gestation or 400G in weight must be registered by completing a death certificate. This added paper work is certainly an inconvenience and can be intimidating to many potential providers. However it should be born in mind that in Atlanta, Georgia, in the United States, it is a statutory requirement to register all abortions on a death certificate. The abortion providers in that state have taken this barrier in their stride and continue to provide an excellent service.

It is clear to me of course, that as gestation progresses, the indications for abortion need to be reassessed. However I strongly oppose any formalization of restrictive criteria either by law or peer pressure as each case is different and should be assesed on its own merits with due consideration given to all of the associated circumstances.

At our clinics all patients undergoing late termination are extensively counseled about all aspects of the procedure, the extent of fetal development and size, and the risks and complications of the procedure. If the indication for termination are for fetal abnormality the patient's paediatrician and genetic counselor and the obstetric attendant will be involved in her management.

5. WHAT ARE THE ETHICAL IMPLICATIONS?

This is obviously the area of greatest contention. For me the balance weighs heavily in favor of allowing women to choose whether they wish to continue a pregnancy or not. As we approach the 21st century in a world beset with overpopulation, famine and ecological disasters, it makes no sense to take the right to make decisions about fertility, contraception or abortion, away from those most directly affected, that is the women, and to place this right in the hands of mostly male dominated, legislative, judicial or religious bodies.

Advances in prenatal diagnosis such as ultra sound, amniocentesis and genetic screening are giving us the ability to detect serious fetal abnormalities. Why invest so much time and money in pre natal diagnosis if we are not prepared to act on the results? Why perform expensive, invasive and potentially dangerous tests, if when the results reveal an abnormal fetus we are not prepared to terminate this pregnancy if that is what the patient wants. How can a just and ethical society condemn a women to a further 20 weeks of pregnancy against her wishes, knowing that the baby she is carrying, is deformed?

6. WHY IS THIS SERVICE NOT MORE PREVALENT?

Due to the controversy and unpopularity of late abortion, doctors with the appropriate skills are rare.

The aesthetics of late abortion make it difficult to recruit competent and committed staff to provide an appropriately supportive environment for patients making this difficult decision.

Doubts about legal issues can dissuade many potential doctors and ancillary staff from entering the field.

Special reporting and certifying requirements are intimidating and dissuasive.

Late abortion requires a large and committed staff and is therefore very costly to provide.

Harassment by anti choice groups such as the Right to Life Association may be a disincentive to enter this field of medicine.

7. WHAT CAN BE DONE TO IMPROVE OR EXPAND THIS SERVICE?

1. Demystify abortion particularly late abortion by appropriate education of the population. Adequate training of medical students and resident doctors needs to be addressed urgently in all areas of abortion service delivery.

2. Decriminalize abortion.

3. Remove the moral and social stigma associated with abortion.

4. The medical profession must stop being judgmental about abortion.

5. We must accept that women can make important decisions.

We allow women to make vital decisions in industry, commerce and government. Female doctors make life and death decisions daily. What strange affliction overcomes a pregnant women, that renders her incapable of deciding whether to continue with the pregnancy or not? And does this rare malady become worse as the pregnancy progresses? Of course it doesn't. We must allow women to make these difficult and important choices themselves and we must be prepared to use all of our skills and abilities, to help them with these choices with humanity, compassion and dignity.

7:30 Report - Cathy Job

27 October 1994

Caitleen Shea interviewing Dr Brundmann & Dr Bayliss

Abortion

Cathy - First the Brisbane Doctor at the centre of a furious row over late abortions. Doctor David Grundmann claims his is the only clinics in Australia where women can get terminations when they're more than 5 months pregnant. Amidst a barrage of outrage today the AMA suggested legal action, the Right to Life group called for police raids and the Opposition demanded an investigation. There was support for Dr Grundmann from the Children by Choice Association, but there was trenchant criticism from a quite unexpected quarter. Dr Peter Bayliss, the man who defied Premier Joh Bjelke-Pertersen to pioneer safe abortion in Qld. Caitlyn Shea takes up the story.

Dr Brundmann - The issue of whether it's barbaric or inhumane is a question of interpretation and up to the individual. What we do here is certainly not inhumane for our patients and it's really often the port of last call for a lot of these women who are very desperate.

Dr Bayliss - I don't think he's doing the long battle that most of us has fought for many years to ensure that women have a right, and men, to freely available methods of family planning and fertility control.

Shea - As a med. student in the 60's Dr David Grundmann first saw the results of backyard abortions. The horrors women experienced he says made him committed to providing a safe, legal abortion service. Now at 48 Grundmann has 4 clinics from Townsville to Newcastle. For him a woman's right to chose is paramount, to the point where he's admitted terminating healthy foetuses more than 20 weeks old.

Dr Grundmann - Now if a woman comes to me with a pregnancy over 20 weeks and has a sudden change in her social circumstances like the death of her husband perhaps or desertion and she's left financial distraught and that distress has caused her to become acutely depressed and suicidal, then that I think is an appropriate indiction for doing an abortion.

Dr Bayliss - There are other solutions to that problem and I doubt whether under the MaGuire ruling that would pass muster.

Shea - Do you feel that Dr Grundmann is breaking the law?

Dr Bayliss - I'm not a lawyer, the lawyers will let him know whether he is or not.

Shea - It's unusual to see Dr Peter Bayliss questioning a fellow abortionist. Police raids

on his clinic during the Bjelke-Petersen era and protests outside it have made his name synonymous with abortion. But even Peter Bayliss has doubts about what Dr Grundmann is doing.

It's a fine line though, you feel comfortable with performing abortions before 20 weeks, he feels comfortable afterwards, who is right?

Dr Bayliss - It's not a matter of right, you at that picture, you at an ultrasound and you know it's an inescapable fact that if you did miniature caesar on that woman at 26 weeks and passed the baby across the neonatologist you've got a living human being.

Dr Grundmann - There are reports in the literature that babies delivered av 24 have lived.

Shea - Why isn't this murdering babies then?

Dr Grundmann - Because we're concerned with the welfare of the patient.

Shea - Do you think it's murder?

Dr Bayliss - Yes.

Shea - Grundmann rejects that, pointing out his Townsville practice has been investigated and cleared. He says 5% of abortions in his clinics are late term an average of 1 or 2 a week, but insists they are only performed in extreme cases and cite the example of a young middle eastern woman from a fundamentalist family.

Dr Grundmann - She presented beyond 20 and said to me plainly that if she went back to her family in the middle east, in this condition, her family would have her killed. Now this clearly is a case of life and death for her. I felt that I had no option but to help this woman regain her life and indeed to safe her life.

Shea - In most States terminations are legal in life threatening situations and where there's a serious threat to the physical and mental health of the woman. In the later stages of pregnancy the law is less clear. Grundmann operates in this grey are and it won't be clarified until there's a prosecution.

Grundmann - The technic that we use ensures that the foetuses are removed intact and soft tissues of the foetus protect the cervical canal and that does involve what we call cranial decompression. But it's essentially a breeched delivery where the foetus is delivered feet first and than when the head of the foetus is brought down to the bottom of the cervical, into the top of the cervical canal, it is decompressed with a puncturing instrument, so that it fit than through the cervical opening.

Shea - Sounds rather barbaric really.

Grundmann - Well it's eh. I don't consider it barbaric, it's a technic which is designed primarily to protect the woman, who is indeed my patient.

Dr Bayliss - Well if you believe the embryologists at that stage, a period gestation they would be capable of feeling pain.

Shea - You've done this one yourself though, haven't you, and how did you feel about performing it?

Dr Bayliss - It's gut-churner, I don't like it, my staff don't like it.

Shea - For Grundmann the opinions that ultimately count are those of the women he treats.

Dr Grundmann - We often get phone calls and letters and cards from patients, saying thank you, you've giving me back my life, and that's really quite satisfying. It's very satisfying to know that we are able to change a persons life to enable them to continue to live their life and to resume normality. Whereas at one stage they may have been faced with such a depressing future that suicide is crossing thought.

Cathy - Caitlyn Shea reporting. And Qld ALP senator Margaret Reynolds points out that it's nearly 3 years since the Premier gave her an inprinciple commitment to hold an inquiry into womens reproductive health, including abortion. We rang Health Minister Ken Hayward earlier this evening; he said he didn't think the inquiry had ever been conducted but he'll look into it.

Transcript - The great debate
April 17, 2005
Reporter: Peter Overton
Producer: Lincoln Howes, Glenda Gaitz

Abortion debate

Introduction
PETER OVERTON: Everyone has an opinion, but not everyone has the facts. Once again we're arguing over a woman's right to choose □ old war, brand-new battle. This time the rallying point is what they call late-term abortions □ pregnancies terminated after 20 weeks. It's emotional, it's heated, it's a dirty fight. Even though only a tiny proportion of abortions are late term and usually they're carried out when something is terribly wrong with the baby. So if you thought it was all over 30 years ago, this story from Peter Overton is sure to make you think again. And I should mention one scene in particular could distress some viewers.

Story: The Great Debate

PETER OVERTON: It is the miracle of emerging life. Graphic images of the developing child. By 20 weeks, or nearly five months, babies' features are clearly recognisable. Tonight we'll meet two women who had to abort their unborn children at this point and discover why late-term abortion has become the new battleground in an old war. So four daughters?

NATALIE WITHERS: Definitely four daughters. And my other three daughters will say the same. If I say three to people, they say, "No, Mum, four." So we all say that she's included, yes.

PETER OVERTON: Natalie Withers already had three daughters when she fell pregnant with another girl.

NATALIE WITHERS: I sort of had two names in mind and I was sort of referring to her by that name when I knew that she was a girl for sure, yep.

PETER OVERTON: Which was?

NATALIE WITHERS: Dellaney.

PETER OVERTON: But a routine ultrasound at 19 weeks brought devastating news.

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NATALIE WITHERS: Massive heart abnormality, two great big gaping holes in her heart and the tubes were in incorrect position and her stomach and liver were reversed, which meant that her spleen couldn't form to functioning size.

PETER OVERTON: At 20 weeks, Natalie had to decide whether to carry her baby full term and deliver it □ probably stillborn □ or to abort the pregnancy. She decided to abort.

NATALIE WITHERS: Most people that I speak to now who haven't dealt with it don't realise that you're presented with a little baby the same as you would be full term, just that they're smaller.

PETER OVERTON: Fiona and Maverick Richards were familiar with tragedy. As an SAS soldier, Mav had seen 18 of his mates die in the Black Hawk helicopter crash of 1996. When Fiona and Mav fell pregnant two years ago, it was a new beginning.

MAVERICK RICHARDS: I've had a lot of loss in my life and this is the first time that I've had something tangible to hang on to □ you know, a child, your first child.

FIONA RICHARDS: Yeah, over the moon. Just wouldn't believe we were pregnant 'til we had every test done. The blood test came back and confirmed we were about five weeks' pregnant. So, yeah □ we were amazed.

PETER OVERTON: But their joy was short-lived. At 19 weeks, a massive tumour was discovered in the heart. Doctors advised there was no hope. The baby would not survive outside the womb and probably not even make full term.

FIONA RICHARDS: And that's when we decided we've got no choice. We're gonna have to just pull our strength together and get through and terminate this pregnancy.

PETER OVERTON: At 24 weeks, Fiona's baby was aborted. Late in the second trimester, her gravely ill child would have looked like this, displaying clear human characteristics. For Australia's anti-abortion lobby, that's sufficient reason to consider banning late terminations.

SENATOR JULIAN McGAURAN: Abortion is too good a word for it. It is child destruction.

PETER OVERTON: National Party Senator Julian McGauran: believes he's in step with changing public opinion. McGauran's view is termination beyond 20 weeks should be banned. Why have you chosen 20 □ why haven't you chosen 19, chosen 21? Why the distinction at 20 weeks?

SENATOR JULIAN McGAURAN: Well of course my position is that abortion itself is wrong. When you believe it's a human being, all abortion is wrong. But there seems to be a particular fault or horror about late-term abortions and it's ever on the increase. 20 weeks is the accepted viability stage of the baby. And we have gone well beyond that. I mean, there are case examples of 32 weeks. Now that should be stopped.

PETER OVERTON: It's at eight to 12 weeks that most abortions in Australia are carried out. At that stage the foetus is just 7cm long and it's a simple procedure. Between 20 and 24 weeks, the growing foetus is already displaying most of the features it will have at birth. If born at 23 weeks, though premature, some babies survive. And this is why late-term abortion is so contentious, because it raises the question whether problems suffered by the foetus are in themselves sufficient to terminate life. Would you perform a late-term abortion if there was a serious heart abnormality?

DR DAVID GRUNDMANN: If that abnormality created a crisis in the family sufficient for them to want the pregnancy terminated that's when I would consider the operation.

PETER OVERTON: Spina bifida?

DR DAVID GRUNDMANN: If it's severe enough, yes.

PETER OVERTON: Down syndrome?

DR DAVID GRUNDMANN: Down syndrome pregnancies are terminated all the time. We just move the head of the ultrasound around 'til we get the image we want.

PETER OVERTON: To the anti-abortion lobby, Dr David Grundmann is a butcher. He's one of the few doctors in Australia willing to carry out late terminations and one of the few willing to speak out on this debate.

DR DAVID GRUNDMANN: It's wedge politics. The abortion debate has been had. It's over and done with. It's been a dead issue for 30 years. The conservative right □ the religious conservative right □ is trying to create an opening to try to take the right of choice away from women in Australia and the only way they can do that is by trying to splinter people who are pro choice into those who find abortion late in gestation distasteful.

PETER OVERTON: Senator, why are we sitting here having this discussion? I thought it was sorted out 30 years ago?

JULIAN McGAURAN: Well, the line has shifted. Thirty years ago, the law just didn't contemplate late-term abortions at all.

PETER OVERTON: Look, is this wedge politics on your part? You are putting your hand up and saying, "Let's bring the emotive issue of late-term abortion into the public forum" and then hopefully that will lead to a ban on all abortions?

JULIAN McGAURAN: Look, this is far from wedge politics. This is a hot-button, moral, ethical issue. It's hardly wedge politics. It has nothing to do with politics, quite frankly. I don't see the political advantage for either side. This has everything to do with social values and the tenets we wish to run our society on.

PETER OVERTON: Abortion has always been controversial. But it's a decision no woman takes lightly. This woman is eight weeks pregnant and she's courageously given us permission to film her procedure. It's the first time a termination has been filmed in an Australian abortion clinic. And a warning □ some viewers may find it distressing to watch. It's a relatively routine procedure, but nonetheless clinical and unpleasant. Abortions have been legal in some states of Australia since 1969, but if Julian McGauran has his way, the clock is about to be rolled back. So do you want a ban on late-term abortion?

JULIAN McGAURAN: I'd be more than happy to support legislation through the parliament to ban late-term abortions and certainly the methods by which they're undertaken.

PETER OVERTON: What techniques do you use to perform late-term abortions?

DAVID GRUNMANN: We use a range of techniques. I'm not going to go into the specifics because I don't believe it advances the debate on either side terribly much.

PETER OVERTON: Do you pierce the baby's head with a sharp instrument?

DAVID GRUNMANN: As I said, I'm not going to discuss details or specifics about procedures because I don't think that you or the public needs to know specifics about a very small number of procedures. If I'm talking to a

medical audience I'll have no problem discussing procedures because they understand it.

PETER OVERTON: Is that because the procedure is so bad and so explicit and destructive?

DAVID GRUNMANN: It's because the anti-choice people like to create hysteria about certain aspects of late abortion which I don't think that the public really needs to debate.

PETER OVERTON: Only two percent of abortions are considered late term. But it's a potent weapon for anti-abortion protesters like Anne Dowling. Okay, you're now under arrest from state police...

ANNE DOWLING: If there is a baby on the road, you would jump on the road, stop the traffic to pick up the baby. I can't pick up the baby, but I can stop the traffic.

PETER OVERTON: Anne has seven children of her own but is prepared to go to jail for the cause. She's been arrested 25 times.

ANNE DOWLING: A baby's going to die. A baby's going to be killed. What do you do? You hand someone a leaflet about it? No, you block the door and that's what we do.

FIONA RICHARDS: We definitely did do the right thing because we weren't able to see that at the time, that it was the right thing, because we were so overwhelmed by feelings of guilt and loss and grief but once we were able to think about it, basically we had no choice.

PETER OVERTON: Isn't it about the woman?

JULIAN McGAURAN: Well, the women of course do not have an unfettered choice in this matter. If society is going to lead itself down that slippery slope where they will start aborting late term on the grounds of disability, then where do you draw the line? Where is the new line?

PETER OVERTON: But, Senator, we're not talking disability, we're talking severe abnormalities, abnormalities that specialists have told the parents will kill their child?

JULIAN McGAURAN: With modern medicine, a great many of these physical disabilities can be fixed up. It's a nonsense argument to say that you've been given evidence or a diagnosis by a doctor of a disability and that is exactly how it will be born. Quite often it does not.

PETER OVERTON: No, hold on, who's the expert □ the senator or the doctor?

JULIAN McGAURAN: Well, I know of many examples and many doctors speak to me about it, that there's a prolifera of misdiagnosis. I mean, how close are we going to get to the point of infanticide?

PETER OVERTON: What if this woman is told by a cardiologist, by her obstetrician, that your child has no chance of surviving. Doesn't the woman have a right to make a decision about what she wants?

JULIAN McGAURAN: Well, it's my view that she doesn't. If she's been given those views, there are many equally case examples of survival. And that child ought to be given a chance to survive.

FIONA RICHARDS: I would have probably killed myself if I could not terminate that pregnancy. If I had to carry that baby for another four months, feeling that kicking and then knowing that this baby, once it's a fully grown baby, was going to die □ I could not live with that. Excuse me, we'd like to speak to you if we can. We're a couple that did have to have a late-term abortion.

PETER OVERTON: When it comes to abortion, emotions run high on both sides.

FIONA RICHARDS: Whether it's a 16-year-old girl who decides to terminate her pregnancy for whatever reason, or a 30-year-old whose baby is dying, that is a very personal thing. No-one should butt in, not a politician and not you.

PETER OVERTON: The argument once seemed black and white □ you were either for or against. But the focus on late-term abortion has brought shades of grey.

FIONA RICHARDS: You've got to decide what you think is right for yourself. No-one else could have decided that for me. I was the one carrying that baby. I was the one suffering. It was my loss, it was my grief, I had to deal with it the only way I knew how to.

PETER OVERTON: At a Melbourne cemetery, Natalie mourns the girl she never held. Four years on, the pain hasn't receded. At times the hurt so great she even thought of ending her own life.

NATALIE WITHERS: I really didn't want to live with the pain anymore. So ... there was ... probably times of thinking that I would've rather go and be with her. She looked pained when she was born. She was born with her mouth open. If I was confronted with it again, I could not do it again. I couldn't play God again.

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ARCHIVES - November 16, 2004

ABORTION
Tonight on Insight - back to the future. Why is the abortion debate flaring now and where is it heading?

JENNY BROCKIE:

Tonight we are coming to you from the National Museum in Canberra. We're in the national capital because it's Government figures who just weeks after the federal election have decided to raise the issue of abortion. Health Minister Tony Abbott claims there's an epidemic of abortions in Australia. Deputy PM John Anderson says the number is out of hand and has backed the Health Minister's call for a debate on the issue. We invited both men to be part of that debate on Insight tonight but they declined. With us though, two Coalition MPs with starkly differing views, as well as women who've had abortions, doctors, counsellors and members of the public. Welcome to all of you to Insight tonight.

De-Anne Kelly, can I start with you and I would just like to get your position on this issue clear. Are you against abortion under any circumstances?

DE-ANNE KELLY, NATIONAL MP: I'm in favour of a public debate now for a whole range of issues - demographic, economic, social. I believe that after 30 years it is time again with an ageing population, and the purported figures for abortion being around 100,000 a year, to look again at this very important issue.

JENNY BROCKIE: Well, we'll get on to the figures in a moment, but I would just like to get your own position on this clear because I'm interested in what is driving you to want this debate. Is it because you're opposed to abortion?

DE-ANNE KELLY: Can I just say I think that personal views push people into ideological corners, and we've had that now for 30 years with arguments about pro-choice, pro-life. I don't think that is helpful in a debate now in the new century. My personal view -

JENNY BROCKIE: But don't people have a right to know? If you're a politician pushing this issue, don't people have a right to know where you stand on it?

DE-ANNE KELLY: My electorate, and obviously we speak for our electorates and broader, don't expect us always to debate our personal views. They expect us to take up issues on behalf of the nation and issues of concern and carry them forward. I think what is driving this is firstly the purported figure, and we do need some expert input on to what that is, of 100,000 abortions a year, an ageing population, where there has now quite rightly been a great deal of money spent on increasing productivity, encouraging older Australians to stay in the work force. I think that there is a new opportunity to talk about demography, economics and social matters, rather than just the narrow ideology and religious views of the past.

JENNY BROCKIE: Judith Troeth. What do you think? You sit alongside De-Anne Kelly in the Coalition. I wonder what your position on this is.

JUDITH TROETH, LIBERAL SENATOR: My position has always been that abortion should be available on demand for those women who need it and who feel that their circumstances - I won't say justify it - but it should be freely available. I have always held that position and my view on the current debate is that any move to constrain that or to change what are

properly State laws is quite deplorable.

JENNY BROCKIE: Do you think people should be declaring their position now?

JUDITH TROETH: Not necessarily, I think if its the view that we have reached a satisfactory status quo in terms of legislation, probably on any issue, I would say there is not a necessity to fix it. Abortion is a particularly personal thing and it's my belief that it is between a woman and her doctor or a woman and her partner and the doctor, and that governments and particularly politicians and, dare I say it, particularly male politicians should not be entering into this.

JENNY BROCKIE: De-Anne Kelly, your response to that?

DE-ANNE KELLY: It certainly is a personal matter. However, having said that, with 100,000, and as I said that is a purported figure - we really need -

JENNY BROCKIE: The 100,000 figure is not an accurate figure at all.

DE-ANNE KELLY: That's quite right. I say purported figure.

JENNY BROCKIE: Everyone is saying we don't know how many abortions there are, including the AMA.

DEANNE KELLY: That is why many of us are calling for an expert forum to be able to establish what the facts are rather than deal with conjecture.

JENNY BROCKIE: The initial focus on this debate is very much on late-term abortions. Dr David Grundmann, you are one of the few doctors in Australia who perform late-term abortions. How do you define late term? Let's get a definition. What does that mean?

DR DAVID GRUNDMANN, ABORTION PROVIDER: I don't think the issue is how I define late-term - it is really how other people define it for me. Abortion can be divided into three trimesters, if you would - the first trimester I would consider ends at the beginning of the 14th week, the second trimester ends at the beginning of the 28th week, and then you have the third trimester. I think common convention suggests that early abortion is up to the 14th week or around the 12th or 14th week. After that you get into late, later and latest.

JENNY BROCKIE: What is the latest? Do you draw a line on how late you are prepared to perform this procedure?

DR DAVID GRUNDMANN: If I was faced with the need to do an abortion on a patient in the middle or late second trimester or even the third trimester, if the situation and circumstances were appropriate, I wouldn't hesitate to do it.

JENNY BROCKIE: Can you describe the procedure for us?

DR DAVID GRUNDMANN: The procedure has changed considerably since I first introduced it into Australia back in the early 1990s. I'm not sure that the debate would be in anyway enhanced by descriptions of fairly explicit surgical and destructive procedures. It tends to be this issue that has people on both sides of the debate coming more or less to blows with each other.

JENNY BROCKIE: Can you understand why it is such a sensitive issue for some people?

DR DAVID GRUNDMANN: I can understand that if graphic descriptions of late abortion are promulgated through the community and the emphasis is placed on this as being the significant issue in abortion, I can understand that being a concern. But the reality is that 95% of all abortions done in Australia are done from 14 weeks down.

JENNY BROCKIE: So this is a very small number, you're saying?

DR DAVID GRUNDMANN: It is a very small number and the reasons for doing these abortions are very personal and very tragic in most cases.

JENNY BROCKIE: David van Gend, you're campaigning against abortions. Do you accept that it's a relatively rare procedure?

DR DAVID VAN GEND, GENERAL PRACTITIONER: Dr Grundmann has described that he will do 100 per year, which is not insignificant for each individual baby. You have come across the reason why the debate is being driven. The debate is being driven in Australia because, as Mr Christopher Pyne said, we have reached the situation with technology for looking after premmie babies where we blur the line between abortion and infanticide, in that late-term abortions are occurring on babies, even entirely healthy babies of entirely healthy mothers, older than those we look after in our premmie nursery.

JENNY BROCKIE: Why do you think women are having these late-term abortions? Why do you think they're having them?

DR DAVID VAN GEND: Dr Grundmann has put on the public record why he will do them.

JENNY BROCKIE: No, that wasn't my question.

DR DAVID VAN GEND: That's how we learn. We learn from the people who do them. In his published lecture, he has written that he will do them for women who do not know they are pregnant, which he repeated last week in the 'Australian' helpfully, and also women who have major change in socioeconomic circumstances, such as desertion of a partner and also minor or doubtful abnormalities.

LESLEY CANNOLD,ETHICIST, MELBOURNE UNIVERSITY: That is not up for debate. That is simply a fact.

DR DAVID VAN GEND: This is from Dr Grummond's lectures.

DR DAVID GRUNDMANN: The important thing here and the question I am asked most often is: what is the single most common reason for doing late abortions? The only common denominator is that the women are pregnant and that they are women. That is the only common denominator. Each individual case represents a significant individual crisis for the patient, whether it be at six weeks, at 16 weeks or at 26 weeks, and if you don't analyse the circumstances of each individual case, you'll completely miss the point.

JENNY BROCKIE: Let's look at one particular case. Fanou Filali, who is one of Insight's reporters, has been speaking to one woman who has confronted the dilemma of a late-term abortion. Here's her story.

LATE TERM ABORTION STORY:

REPORTER: Fanou Filali

Saturday afternoon in a quiet suburb of Newcastle. Annette Faulkner is off to meet her friends. Friends she would have preferred not to have.

ANNETTE FAULKNER: After Joshua was born, as sad as it was to imagine that anyone else had been through what we'd been through, in another way it was comforting to know that someone else had been through similar and they could survive.

REPORTER: What Annette shares with her friends is the experience of late-term abortion, which in their case was due to foetal abnormality. Annette's baby Joshua was born dead at 24 weeks, following his parents' decision to terminate the pregnancy. This happened 13 years ago. Annette had previously had problems falling pregnant so this baby was very much wanted. 23 weeks into the pregnancy she was told her baby had been diagnosed with Dandy Walker Cyst, a major neural tube

defect.

ANNETTE FAULKNER: It was explained to us that our baby would possibly die in utero and if he didn't, that he may die soon after birth or if he didn't die that he would be severely disabled and not have a good quality of life. In the week between his initial diagnosis and his birth, it was just running through our heads all the time, and we talked about how if he lived we would cope with a disabled baby and then a disabled child, a disabled adult. And I think my father summed it up well when I said, "What right do I have to make a decision like this for our baby?" And my dad said to me, "What right do you have to accept such a dreadful life for him if he lives?" We feel we made a very loving and informed decision. My husband and I made a joint decision with that, and we just felt it was mainly the best option for him. I can be honest and say that our main fear was that he may live and that if he did live it wasn't a life that we wanted for him.

REPORTER: Do you have any regret about your decision to terminate the pregnancy?

ANNETTE FAULKNER: No, I have never - I have carried guilt with me because to make a decision like that just goes against your morals, your mothering instincts, all those, but, no, I have never regretted making the decision. I know it was the right decision for him. I've just always regretted the need to make that decision.

In Annette's mind, there was never any doubt that it was a life she had decided to end.

ANNETTE FAULKNER: Because of the stage of pregnancy I was at, I was induced and went through a labour and gave birth. I was actually, for want of a better word, happy to do that, because Joshua is our son and is part of our family and we got to spend time with him. It was very difficult to give birth knowing what the outcome would be, but he is part of our family and we got to spend time with him and show him that we loved him.

Since then, Annette has had two children but she will always remember Joshua.

ANNETTE FAULKNER: I don't often look at Joshua's photos because I just feel so sad when I see them, but they're one of my most precious things I have, and to me this photo, it is still, I really feel the raw grief that I felt back then. It just to me shows a mother's love and grief, and we so desperately tried to get some family photos because we knew that it was our only chance. And another thing that is precious to me are his foot and handprints that we have here, his actual foot and handprints.

As a Catholic, Annette wanted a priest to bless the baby. She turned to her church for support.

ANNETTE FAULKNER: If you believe in God, God knows everything you do, so I explained to the priest. I didn't try and hide what we were doing, and I said to him, "I guess in the eyes of the Church what were doing is wrong but we feel it is the best decision." And he said to me, "There's no doubt about it, you're excommunicated, but we'll do all we can for the baby." And it was pretty shocking but at the time I guess he said to me what I felt I deserved and I just let him say that to me and concentrated on the fact that he would bless the baby. And it was only after Joshua's birth and I'd moved through the grief processes a bit that I started to deal with that and didn't think that was the way I should have been treated.

Despite the initial support from close friends and relatives, Annette felt she couldn't truly confide in anyone.

ANNETTE FAULKNER: I think overall it is a very silent loss. Whatever the reason for ending the pregnancy is, I think it is quite often a very silent loss. It took a lot for me to actually tell people that we had made that decision, and I still don't tell everyone because people are very judgmental and some just can't understand and some people don't make an effort to understand.

REPORTER: How do you feel about the current debate?

ANNETTE FAULKNER: I feel it's very dangerous because you're playing with peoples' lives. It's not just statistics. It's very personal stories, and unless you have been there, you just don't know. In an ideal world, there wouldn't be any unwanted pregnancies and there wouldn't be any unhealthy babies, but that's never going to happen. So please, leave people with these choices so they can be cared for in the best physical and emotional way, rather than create dangerous situations.

JENNY BROCKIE: Well, David van Gend, I wonder what you'd say to Annette. If she had come to you with that situation, what would you say to her?

DR DAVID VAN GEND: I have faced similar situations and I have accepted that when you have a baby who is so injured and ill that they are going to die, of course one would only support the person through that, but to get a true perspective on this debate that is not what upsets people. The fact is that the majority of babies suffering late-term abortions are entirely healthy.

JENNY BROCKIE: But let's talk about this situation. This situation is very real. This woman's story is very real. Are you saying that you're better equipped to make that decision for her than she is and her husband is, about what they want to do in relation to that?

DR DAVID VAN GEND: Not at all, I wouldn't question - I wouldn't, one would of course if you knew the person as a patient you'd offer them all support around it. Because if it is my child, I would simply let the child be born and see how things go.

JENNY BROCKIE: But that is your choice.

DR DAVID VAN GEND: Exactly.

JENNY BROCKIE: What you are arguing is to have that choice taken away from a woman like Annette.

DR DAVID VAN GEND: No. No-one is suggesting that the States block that sort of induction of pregnancy.

JENNY BROCKIE: What are you saying you're opposed to? Are you trying to stop late-term abortions altogether?

DR DAVID VAN GEND: No, because in cases of lethal malformation like that, that is not the same issue. What I'm trying to stop is Dr Grundmann's late-term abortions both because of the technique he uses, which was banned last year in America as the Partial Birth Abortion Ban Act, because that is a form of terrible pain to the baby where it is, as he has described on the '7:30 Report', partly delivering a live baby before, as he puts it, puncturing its head with scissors.

JENNY BROCKIE: But I am still trying to get it clear what -

DR DAVID VAN GEND: This is so important. We've got to hear it.

MELINDA TANKARD REIST, AUTHOR, 'GIVING SORROW WORDS': And you keep cutting him off. I think the public has a right to know.

JENNY BROCKIE: I am just trying to get clear exactly what your position is, what you're prepared to accept and what you're not prepared to accept in terms of late-term abortions by law.

DR DAVID VAN GEND: My position would be the same as the AMA Queensland's position, because that is where we last met, Dr Grundmann and I, when we were formulating that position, and it was debated.

DR DAVID GRUNDMANN: That was 10 years ago.

DR DAVID VAN GEND: Yes, and it hasn't changed. It is that we oppose late-term abortion except - and I don't speak for the AMA, but they oppose it except in lethal malformations or where there was no other way to prevent the woman dying or in such severe malformations that the baby would have no independent life. But the majority of babies who are the age of our premmies are healthy babies and they are killed by a method which was banned by the Congress as, quote, "inhumane and gruesome" and never medically indicated. These are facts.

JENNY BROCKIE: Sarah Maddison, you're a pro-choice advocate. Is there not a broader issue here now, where we are in a situation where technology can keep babies alive at earlier and earlier stages, premature babies, and at the same time we are prepared to abort foetuses at that same stage?

SARAH MADDISON, WOMEN'S ELECTRAL LOBBY: I guess my response to the so-called late-term abortion issue, or the mid-trimester abortion issue, is that I think very clearly it is being used by the anti-choice lobbyists to upset people I think, to create the sort of constituency that Tony Abbott and his conservative Christian colleagues are looking for in order to advance their views in the Parliament. I think that we have to, as Dr Grundmann says, take each case as an individual case.

JENNY BROCKIE: Do you draw the line anywhere on abortion, on how late you think is too late?

SARAH MADDISON: Look, I'm not a medical practitioner. I think that the experts here have both presented a range of views and a range of circumstances in which they as practitioners would make those choices, and I would certainly defer to their judgment in those cases.

JENNY BROCKIE: Lesley, what about you as an ethicist? I just wonder because we have seen this change in technology, we do know a lot more about the foetus and we can keep a foetus alive at a much earlier stage, at 25, 26 weeks. Does it alter the debate at all?

LESLEY CANNOLD: Well, it's altered what's happened on the ground. But I don't necessarily think - in other words, what the argument constantly is, is that there is some kind of inconsistency going on because in one room of the hospital we're trying to save a child and in another room we're terminating. But of course what that is really saying is that the reasons, which David has been trying to get across, as to why those things are happening, are irrelevant. All we need to know is that it is this age in one room, this age in another room. These are the same. But what we say in ethics is there are morally relevant distinctions. I think the woman, her life, her circumstances and what she and her partner have decided is extremely morally relevant. So if they have decided, as this woman did, that they can't raise, they can't be good parents, the kind of parents they want to be or feel it's a good life for their child to have, to have a baby with a congenital malformation, then that is a decision they ought to make, and the weeks don't change whether or not she's made the right decision.
The claim is constantly that women act immorally. I ask anybody to listen to that story, which is the sort of story I hear over and over, which counsellors in abortion clinics hear over and over, women take these decisions extremely seriously. There is no evidence that it's either open slather. As we see the doctors are regulating it. Women don't just go in there and get abortions because they feel like it. Doctors are telling them when and how and they take their responsibilities extremely seriously, and it is insulting to continue to suggest that somehow they're irresponsible to get pregnant when they ought not to and irresponsible to terminate if that is what they choose to do.

JENNY BROCKIE: Melinda?

MELINDA TANKARD REIST: It's not regulated. It's an uncontrolled, unregulated experiment on women. I would like to ask Dr Grundmann if he believes women have the right to know the particular method that he uses to terminate their babies and why you are wanting to censor that on this program tonight?

DR DAVID GRUNDMANN: I'm not.

MELINDA TANKARD REIST: What do you tell the woman? No, I want to know what he tells women.

DR DAVID GRUNDMANN: I explain to all my patients exactly how developed their pregnancy is, whether it is at six weeks, whether it is at 16 weeks, whether it is at 24 weeks. I discuss the method of terminating the pregnancy, how that is going to –

MELINDA TANKARD REIST: Do you tell them you'll crash the skull and suction out the brain and collapse the skull. Do you tell them that?

LESLEY CANNOLD: Melinda, you're against all abortions, so why are you so concerned?

MELINDA TANKARD REIST: I'm trying to talk to Dr Grundmann and you continue to try to censor this debate. I'm not talking to you at the moment, Lesley. I'm talking to Dr Grundmann because I've spoken to women who've been to your clinic and I believe there are a number of women who have ended up at the Royal Brisbane Hospital with severe injuries as a result of terminations in your clinic.

JENNY BROCKIE: Do you have proof of that?

MELINDA TANKARD REIST: Yes, my piece was published in the 'Canberra Times' yesterday, it will be published elsewhere.

WOMAN: That doesn't constitute proof.

MELINDA TANKARD REIST: I've interviewed the doctor who repaired this particular 16-year-old girl, and he described, and she described, a fist-sized hole through her uterus needing 200 stitches, a perforated bowel and bladder. There were three feet - You continue to interrupt, you continue to - No, what we are seeing here is very typical of the pro-choice police who don't let us speak.

JENNY BROCKIE: It is difficult dealing with stories when we don't have the people here to actually tell them first-hand. That is the trouble.

MELINDA TANKARD REIST: They'd love to come. Let's get them on.

JENNY BROCKIE: David, I will let you quickly respond to that, and then we'll move on.

DR DAVID GRUNDMANN: I think that any area of medicine where surgery is contemplated there will be complications. If the complications that arise out of the practice that I have or indeed any abortion clinic in Queensland are as common and consistent as what is being suggested here, we would have malpractice litigation, we would have the police at our door, we would have patients, we would have the hospitals demanding that we close down. We have the finest surgical, medical clinical record in Australia for pregnancy termination at all stages, and to suggest that we are willy-nilly and as cowboys marching into these pregnancies and damaging women all around the place is not only an insult to me but an insult to women that they haven't got the sense to make up their mind about where to go to seek help.

JENNY BROCKIE: OK, I'd like to move on. Margaret.

MARGARET KIRKBY, BESSSIE SMYTH FOUNDATION: I have a different perspective on the methodology issue. For the woman in the film, I can understand why she went through induced labour. It was part of the grieving process. But for some women who find they're pregnant and not only pregnant but 19 or 20 weeks and they didn't even realise they are pregnant, and that is another large cohort of women who require access to late-term procedures, they're just going to find it too upsetting to go through induced labour, so the method that David uses and that other late-term doctors use are far more humane for both the woman and the foetus. It has implications in terms of how people deal with it afterwards.

The New York Times

VOL. CXLVI . . . No. 50,715 WEDNESDAY, FEBRUARY 26, 1997 A11

An Abortion Rights Advocate Says He Lied About Procedure

By DAVID STOUT

WASHINGTON, Feb. 25 — A prominent member of the abortion rights movement said today that he lied in earlier statements when he said a controversial form of late-term abortion is rare and performed primarily to save the lives or fertility of women bearing severely malformed babies.

He now says the procedure is performed far more often than his colleagues have acknowledged, and on healthy women bearing healthy fetuses.

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said he intentionally misled in previous remarks about the procedure, called intact dilation and evacuation by those who believe it should remain legal and "partial-birth abortion" by those who believe it should be outlawed, because he feared that the truth would damage the cause of abortion rights.

But he is now convinced, he said, that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

In an article in American Medical News, to be published March 3, and an interview today, Mr. Fitzsimmons recalled the night in November 1995, when he appeared on "Nightline" on ABC and "lied through my teeth" when he said the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged.

"It made me physically ill," Mr. Fitzsimmons said in an interview. "I told my wife the next day, 'I can't do this again.' "

Mr. Fitzsmmons said that after that interview he stayed on the sidelines of the debate for a while, but with growing unease. As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common.

In the procedure, a fetus is partly extracted from the birth canal, feet first, and the brain is then suctioned out.

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist borders on infanticide and some abortion rights advocates also believe should be outlawed as particularly gruesome. Polls have shown that such a ban has popular support.

Senator Tom Daschle of South Dakota, the Democratic leader, has suggested a compromise that would prohibit all third-trimester abortions, except in cases involving the "life of the mother and severe impairment of her health."

The Right to Life Committee and its allies have complained repeatedly that abortion-rights supporters have misled politicians, journalists and the general public about the frequency and the usual circumstances of the procedure.

"The abortion lobby manufactures disinformation," Douglas Johnson, the committee's legislative director, said today. He said Mr. Fitzsimmon's account would clarify the debate on this procedure, which is expected to be renewed in Congress.

Mr. Fitzsimmons predicted today that the controversial procedure would be considered by the courts no matter what lawmakers decide.

Last April, President Clinton vetoed a bill that would have outlawed the controversial procedure. There were enough opponents in the House to override his veto but not in the Senate. In explaining the veto, Mr. Clinton echoed the argument of Mr. Fitzsimmons and his colleagues.

"There are a few hundred women every year who have personally agonizing situations where their children are born or are about to be born with terrible deformities, which will cause them to die either just before, during or just after childbirth," the President said. "And these women, among other things, cannot preserve the ability to have further children unless the enormity — the enormous size of the baby's head — is reduced before being extracted from their bodies." A spokeswoman for Mr. Clinton said tonight that the White House knew nothing of Mr. Fitzsimmons's announcement and would not comment further.

In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said. "The abortion-rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," he said in the article in the Medical News, an American Medical Association publication.

Mr. Fitzsimmons, whose Alexandria, Va., coalition represents about 200 independently owned clinics, said coalition members were being notified of his announcement.

One of the facts of abortion, he said, is that women enter abortion clinics to kill their fetuses. "It is a form of killing," he said. "You're ending a life."

And while he said that troubled him Mr. Fitzsimmons said he continued to support this procedure and abortion rights in general.

Queensland Government

Department of Justice and Attorney-General

Form 9

Births, Deaths and Marriages Registration Act 2003 *(Section 30)*

CAUSE OF DEATH CERTIFICATE

Please print clearly, using BLOCK letters

To the Registrar-General, Brisbane

Office Use Only	
TB:	☐
Date Rec:	
District Code:	
Registration No:	

(Note: This certificate shall not be given without authorisation of the Coroner in relation to a reportable death. This certificate must also be completed for a stillborn child (see Note below). If particulars are unknown, write "UNKNOWN". All items marked with an asterisk (*) are for statistical or administrative purposes only and will not appear in the Register of Deaths. Form distribution: Original (white) to the Registrar-General or the person arranging for the disposal of the body; Duplicate (blue) to the person arranging for the disposal of the body; Triplicate (yellow) to be retained by Doctor. Form should be completed within 2 working days of the death.)

I, ______________________________, **a registered Doctor:**

(a) For a stillborn child:*	or	*(b) For any other deceased person (including a neonatal death †)*:*
☐ was present at the stillbirth; or		☐ attended the deceased person when alive; or
☐ examined the stillborn child's body.		☐ examined the deceased's body; or
		☐ considered the deceased's medical history and the circumstances of the death.

and certify that: ______________________________ was aged: ____ / ____ / ____

(full name of deceased) Y M D

and born on: ____ / ____ / ____ *(if known)** sex: M F *(circle one)* and I believe that he/she died on: ____ / ____ / ____

at: ______________________ For stillborn or neonate: time of birth* __________ time of death* __________

In my opinion, the probable cause of death is as stated below in section 'A' or 'B':

'A' – *(for a stillborn child or neonate†):*	STILLBORN:
1(a) Main disease or condition in foetus or neonate	See below: " at least 20 weeks
1(b) Other diseases or conditions in foetus or neonate	gestation".
1(c) Main maternal disease or condition affecting foetus or neonate	
1(d) Other maternal diseases or conditions affecting foetus or neonate	
2 Other relevant circumstances	
Underlying Cause of Death*:	

'B' – *(for any other deceased person):*			**Duration of last illness** *(approximate interval between onset and death)*
Disease or condition directly leading to death: *(This means the final disease or condition which caused death – NOT the mode of dying such as heart failure, respiratory failure, etc, UNLESS explained by Antecedent Causes below.)*	1(a)		
		due to, or as a consequence of	
Antecedent Causes – *morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.*	1(b)		
		due to, or as a consequence of	
	1(c)		
		due to, or as a consequence of	
	1(d)		
		due to, or as a consequence of	
	1(e)		
Other Significant Conditions – *contributing to the death, but not related to the underlying cause given in Part 1.*	2		

Date and type of **operation** in the last 4 weeks* ____ / ____ / ____ ______________

Pregnancy: Was the deceased **pregnant** within 6 weeks of death?* ☐ No ☐ Yes

Was the deceased **pregnant** between 6 weeks and 12 months of death?* ☐ No ☐ Yes

Does the body of the deceased pose a **cremation risk** under the Cremations Act 2003*? ☐ No ☐ Yes __________ *(please specify eg, pacemaker)*

Is the death a **reportable death** under the Coroners Act 2003 (CA)*?

☐ No

☐ No, Coroner has advised death not reportable under s.26(5)(a) of CA.

☐ Yes, issue of this certificate was authorised under s.12(2)(b) of the CA.

Note: *Please complete a Perinatal Supplement (to Cause of Death Certificate) (Form 9A) if the above information relates to a child who was stillborn (of at least 20 weeks gestation or 400 grams weight at birth) or who died within 28 days after birth (neonate) †.* ✱

______________________ ____ / ____ / ____

(Insert name of Coroner who advised or who authorised this Certificate and Date)

Doctor's Signature ______________

Date ______________

Initials and Surname ______________

Professional Qualification(s)* ______________

Address ______________

Telephone ______________

Non-Coronial Autopsy Consented by Next of Kin*

☐ Carried out ☐ To be carried out ☐ Not to be carried out

Was the deceased of Aboriginal or Torres Strait Islander origin?

(If of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes)*

☐ No ☐ Yes, Aboriginal origin ☐ Yes, Torres Strait Islander origin

Note: This Certificate must be issued without charge

Late second trimester termination of pregnancy

A policy regarding the procedure of late second trimester termination of pregnancy was recently endorsed by the Queensland Branch of AMA.

The policy incorporates the duty of care to a foetus in the late second trimester, and the medical indications for the termination of pregnancy in this stage.

A working party on late second trimester termination of pregnancy was established by AMAQ Branch Council and Chaired by Dr Thomas McEniery.

The working party sought the opinions from the appropriate Specialist Colleges on this issue prior to the formation of the policy.

Through the development of this policy the Branch has sought to clarify its position on late second trimester termination of pregnancy.

Regarding the procedure of late second trimester termination of pregnancy the policy of the Queensland Branch of the Australian Medical Association is that:

- In circumstances where there is a serious threat to the physical or mental health of the mother, the preservation of the life of the mother is paramount.
- A neonate of equivalent gestational age to a foetus in the late second trimester is usually viable with the use of technology and medical care.
- There is a duty of care to the foetus in the late second trimester of pregnancy.

Given this duty of care, the medical practitioner performing a late second trimester termination of pregnancy must be able to demonstrate:

1. in the case of a viable foetus, that the foetus could not reasonably have been delivered alive, but necessitated a destructive procedure such as cranial decompression.
2. in the case of risk to the life of the mother, that specialist obstetric and psychiatric opinion could not reasonably propose an alternative to foetal destruction.

The Queensland Branch of the Australian Medical Association opposes late second trimester termination of pregnancy except in the gravest of circumstances such as:

1. lethal foetal chromosomal abnormality.
2. severe foetal malformation where there appears little possibility of independent life.
3. unequivocal risk to the life of the mother where no other medical procedure would suffice to save the life of the mother.

AMAQ Council

President Dr Stephen Phillips Tel: (074) 443 011	**President-Elect** Dr Eileen Burkett Tel: (07) 3217 2211
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A full list of Councillors is published in the AMAQ NEWS quarterly editions.

AMAQ NEWS is published by: AMA Queensland Branch, 88 L'Estrange Terrace, Kelvin Grove Qld 4059
Tel: (07) 3872 2222 a/hrs: (019) 470 431
Fax: (07) 3856 4727

Print Post Approved: PP490927/00049
ISSN 1325-4626

Obituaries

The AMA extends sympathy to the family and friends of the following deceased members:

Farrelly, MCE formerly of Hermit Park
Green, KJ formerly of Albany Creek
Manser, RWE formerly of Burleigh Heads

QUEENSLAND PARLIAMENT HANSARD 31/10/95

It was a year ago, on 27 October 1994, that I called for an urgent inquiry into the illegal and brutal practice of late abortions performed by Dr David Grundmann at his clinics in Brisbane, Rockhampton and Townsville. I have tried to make it clear to honourable members that what we are confronted with is no typical abortion dispute but is most blatantly a case of child killing. As we pass the anniversary of Government inaction on this matter of life and death, angry objections to the practice continue in the public media, and an inquiry into the practice by the Queensland Branch of the Australian Medical Association has affirmed that there is a duty of care to babies in the late second trimester of pregnancy.

But the only people in the community with power to enforce that duty of care are sitting opposite, and they have done nothing. The AMA inquiry in September heard from Dr Grundmann that he has killed 21 babies, around the age of the youngest premature babies in our hospitals, since the Government was first asked—in October 1994—to act in their defence. Regarding his duty of care to these babies, Dr Grundmann stated to the inquiry—

> "There is no stage of pregnancy at which I regard the foetus as my patient".

He described a recent abortion of a 23-week baby with severe cleft lip and palate, which can be corrected by surgery. His response was that it depends on whether the woman wants to put her foetus through all that surgery.

The inquiry heard that Dr Grundmann has been routinely understating the age of the babies by two weeks, and, therefore, not fulfilling the requirements of the law to issue birth and death certificates for the birth and death of all babies over 20 weeks. He rejected the idea of a panel of specialists reviewing his decisions on late abortions on the grounds that it would take too long and the panel might not agree on whether the abortion was appropriate.

The Government has neglected this matter for a year, and 21 premature babies have been cruelly killed. Dr Grundmann does not intend to change his lucrative practice, and it rests finally with this House as to whether any effective action is taken to restrain this commercial slaughter of the innocents.

A year ago I appealed for an immediate inquiry, by the Attorney-General or the Minister for Health, into this violent practice but, when no action was forthcoming, I submitted a formal complaint to the Commissioner of Police. In December I received a letter from the Police Minister outlining why there would be no criminal prosecution. He referred to the 1985 ruling by Judge McGuire in which he stated—

> "This ruling serves to illustrate the uncertainty of the present abortion laws of Queensland. It will require more imperative authority (either the Court of Appeal or Parliament) to effect changes if changes are thought to be desirable or necessary with a view to amending and clarifying the law."

That ruling stands as a challenge to this House. It is both desirable and necessary to prevent the unrestricted killing of unwanted premature babies in this brutal manner and if that requires a thorough inquiry into the practice and careful legislation to clarify the law, then that must be addressed.

The Government says that it has arranged for an inquiry by the Health Rights Commission and that there is no need for further action. However, one year and 21 babies later, there is still no final report from that inquiry. More importantly, the Health Rights Commission does not have the imperative authority referred to by Judge McGuire; only Parliament has that authority and any report that may be forthcoming will inevitably place the responsibility for effecting changes back in the hands of Parliament, where it belongs. The Government has evaded this responsibility, cynically delegating it to a commission that exists to deal with consumer complaints, not with child killing.

On 25 May, when the Premier was asked in Parliament to act on significant Supreme Court findings against Grundmann, he dismissed the request as a "cheap point" and gave the impression that there was no illegality to be found; whereas it is clear that the judge was merely reluctant to discuss criminal matters in a civil hearing.

The Government should have arranged for a review of the evidence in a context where criminal matters could be considered. It has failed again in its responsibility to uphold the reasonable law of this State.

I said a year ago that Dr Grundmann—

> ". . . grossly misjudges the sentiment of the people of Queensland if he expects to be allowed to continue to commit these repugnant acts on defenceless premature babies without public outcry."

The outcry has been intense and sustained. The people of Queensland have heard even abortionist Dr Peter Bayliss say on national television that Grundmann's acts of late abortions amount to murder. Last year, they heard the head of the Queensland branch of the AMA, Dr Robert Hodge, say that Grundmann stands alone in justifying his practices and that the law should be enforced. The people of Queensland have heard the Supreme Court say that his abortions are often not justified under our law. They have heard the statement from the AMA that doctors have a duty of care to these babies. They have heard Grundmann himself describing his gruesome practice, and they want to know why there has been no action.

If this practice of Dr Grundmann's late-term abortions is to be stopped, it is clear that the ultimate responsibility rests with this Parliament. Can petitions, public outrage and medical and judicial opinions be ignored any longer? Those of us who represent the people of Queensland in our respective electorates are the ones charged with the final responsibility of heeding the outcry and the clamour for action to stop this inhumane practice. This week in Parliament, honourable members will be given the opportunity to let the Parliament take responsibility for this sensitive and tragic matter. The Opposition will place before the Parliament a notice of motion seeking a judicial inquiry into the late-term abortions of Dr Grundmann. That means that the decision to conduct a proper and full inquiry can be taken by 89 representatives of the people in this Parliament.

This matter can no longer be left to the Premier, the Attorney-General, the Minister for Health, the Police Minister, or the Goss Cabinet to brush aside and sidestep. I ask all honourable members to consider carefully the facts that I have placed before this Parliament in October 1994, February 1995 and today. Their individual support of a move to institute a judicial inquiry will be proof that the Queensland Parliament is an effective institution that can listen to the people and can make the correct decisions in difficult and sensitive areas. Members of the Queensland Parliament who support the call for an inquiry will know that they have made the right decision in the interests of humanity in this State.

Qld HANSARD (31/10/95: (Excerpts))
↖ Speech by Mike Horan, Shadow Minister for Health
↙ Motion by Shadow Attorney-General, 14/11/95.

MR BEANLAND to move – That this Parliament initiates a judicial inquiry into the late term abortion practices of Dr David Grundman and that this inquiry include—

(a) compliance with the Criminal Code, the *Births, Deaths and Marriages Act* and the *Health Act*;

(b) the method of calculation of age of the foetus used by Dr Grundman; and

(c) the method of killing of the late-term foetus used by Dr Grundman.

Form 9

Births, Deaths and Marriages Registration Act 2003 *(Section 30)*

CAUSE OF DEATH CERTIFICATE

Please print clearly, using BLOCK letters

To the Registrar-General, Brisbane

Office Use Only	
TB:	☐
Date Rec:	
District Code:	
Registration No:	

(Note: This certificate shall not be given without authorisation of the Coroner in relation to a reportable death. This certificate must also be completed for a stillborn child (see Note below). If particulars are unknown, write "UNKNOWN". All items marked with an asterisk (*) are for statistical or administrative purposes only and will not appear in the Register of Deaths. Form distribution: Original (white) to the Registrar-General or the person arranging for the disposal of the body; Duplicate (blue) to the person arranging for the disposal of the body; Triplicate (yellow) to be retained by Doctor. Form should be completed within 2 working days of the death.)

I, ______________________________ **, a registered Doctor:**

(a) For a stillborn child:*	or	*(b) For any other deceased person (including a neonatal death †)*:*
☐ was present at the stillbirth; or		☐ attended the deceased person when alive; or
☐ examined the stillborn child's body.		☐ examined the deceased's body; or
		☐ considered the deceased's medical history and the circumstances of the death.

and certify that: ______________________________ *(full name of deceased)* was aged: ___ / ___ / ___ (Y M D)

and born on: ___ / ___ / ___ *(if known)** sex: M F *(circle one)* and I believe that he/she died on: ___ / ___ / ___

at: ______________________ For stillborn or neonate: time of birth* __________ time of death* __________

In my opinion, the probable cause of death is as stated below in section 'A' or 'B':

'A' – *(for a stillborn child or neonate†):*	STILLBORN:
1(a) Main disease or condition in foetus or neonate	See below: " at least 20 weeks gestation".
1(b) Other diseases or conditions in foetus or neonate	
1(c) Main maternal disease or condition affecting foetus or neonate	
1(d) Other maternal diseases or conditions affecting foetus or neonate	
2 Other relevant circumstances	
Underlying Cause of Death*:	

'B' – *(for any other deceased person):*			**Duration of last illness** *(approximate interval between onset and death)*
Disease or condition directly leading to death: *(This means the final disease or condition which caused death – NOT the mode of dying such as heart failure, respiratory failure, etc, UNLESS explained by Antecedent Causes below.)*	1(a)		
		due to, or as a consequence of	
Antecedent Causes – *morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.*	1(b)		
		due to, or as a consequence of	
	1(c)		
		due to, or as a consequence of	
	1(d)		
		due to, or as a consequence of	
	1(e)		
Other Significant Conditions – *contributing to the death, but not related to the underlying cause given in Part 1.*	2		

Date and type of **operation** in the last 4 weeks* ___ / ___ / ___ ______________

Pregnancy: Was the deceased **pregnant** within 6 weeks of death?* ☐ No ☐ Yes

Was the deceased **pregnant** between 6 weeks and 12 months of death?* ☐ No ☐ Yes

Does the body of the deceased pose a **cremation risk** under the Cremations Act 2003*? ☐ No ☐ Yes __________ *(please specify eg, pacemaker)*

Is the death a **reportable death** under the Coroners Act 2003 (CA)*?

☐ No

☐ No, Coroner has advised death not reportable under s.26(5)(a) of CA.

☐ Yes, issue of this certificate was authorised under s.12(2)(b) of the CA.

Note: *Please complete a Perinatal Supplement (to Cause of Death Certificate) (Form 9A) if the above information relates to a child who was stillborn (of at least 20 weeks gestation or 400 grams weight at birth) or who died within 28 days after birth (neonate)†.*

______________________ ___ / ___ / ___

(Insert name of Coroner who advised or who authorised this Certificate and Date)

Non-Coronial Autopsy Consented by Next of Kin*

☐ Carried out ☐ To be carried out ☐ Not to be carried out

Was the deceased of Aboriginal or Torres Strait Islander origin?

(If of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes)*

☐ No ☐ Yes, Aboriginal origin ☐ Yes, Torres Strait Islander origin

Doctor's Signature ______________

Date ______________

Initials and Surname ______________

Professional Qualification(s)* ______________

Address ______________

Telephone ______________

Note: This Certificate must be issued without charge

November 18 1999

Experts call for end to cranial abortions

Gil Breitkreutz and Sean Parnell

A PANEL of Queensland medical experts wants late-term abortion by cranial depression outlawed.

The panel described the practice as "horrendously cruel and painful".

They singled out Queensland doctor David Grundmann, Australia's only private late-term abortion practitioner, who they believed carried out as many as 12 cranial depression deliveries of dead foetuses a year.

Leading specialist obstetrician and gynaecologist Clem Marrinan said Dr Grundmann used cranial depression to ensure the baby had no chance of survival.

Dr Marrinan said late-term abortions involved unborn babies at the 20-week stage, with the foetus development enough to require a birth or death certificate.

"Of course, in Dr Grundmann's case it's always a death certificate ... and it's a pretty horrendous way of doing it," Dr Marrinan said.

At a news conference yesterday, specialist anaesthetist Gavin Carroll said the practice was very painful for the unborn baby and more cruel than abattoir slaughters.

AMA Queensland president Beres Wenck yesterday said the association was against later termination of pregnancies, except in the gravest medical circumstances. Even then, the doctor performing the termination needed to demonstrate the baby could not be born alive.

Another consideration was that specialist obstetric opinion could not reasonably propose an alternative to foetal destruction if the mother's life was at risk.

Dr Grundmann said he used cranial depression as it brought about certainty in the result.

He said he performed late-term abortions on women referred from the public hospital system.

"A woman does not choose to have an abortion because it is fun. It is a very traumatic decision that must be taken into account," he said.

Royal Women's Hospital medical superintendent Ifor Thomas said the hospital had strict protocols for abortions, which required two consultants to certify that the procedure was necessary, and the final approval of the medical superintendent.

Dr Thomas said he believed the hospital followed the law and abortions would only be done if the woman's life was in danger or, for example, the baby was diagnosed with a serious congenital deformity which lessened its survival chances and increased the risk of a serious handicap.

Dr Thomas said the criteria for terminations became stricter after 20 weeks, and he was "loathe" to accept any terminations after 24 weeks.

"Strictly speaking, the legislation doesn't state any (maximum) period of gestation at present," he said.

Dr Thomas said the words "life" and "preservation" had not been judicially defined in Queensland, apart from clarifications made by Judge Fred McGuire in a 1986 case involving abortion doctor Peter Bayliss.

The New York Times

VOL. CXLVI . . . No. 50,715 WEDNESDAY, FEBRUARY 26, 1997 A11

An Abortion Rights Advocate Says He Lied About Procedure

By DAVID STOUT

WASHINGTON, Feb. 25 — A prominent member of the abortion rights movement said today that he lied in earlier statements when he said a controversial form of late-term abortion is rare and performed primarily to save the lives or fertility of women bearing severely malformed babies.

He now says the procedure is performed far more often than his colleagues have acknowledged, and on healthy women bearing healthy fetuses.

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said he intentionally misled in previous remarks about the procedure, called intact dilation and evacuation by those who believe it should remain legal and "partial-birth abortion" by those who believe it should be outlawed, because he feared that the truth would damage the cause of abortion rights.

But he is now convinced, he said, that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

In an article in American Medical News, to be published March 3, and an interview today, Mr. Fitzsimmons recalled the night in November 1995, when he appeared on "Nightline" on ABC and "lied through my teeth" when he said the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged.

"It made me physically ill," Mr. Fitzsimmons said in an interview. "I told my wife the next day, 'I can't do this again.' "

Mr. Fitzsmmons said that after that interview he stayed on the sidelines of the debate for a while, but with growing unease. As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common.

In the procedure, a fetus is partly extracted from the birth canal, feet first, and the brain is then suctioned out.

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist borders on infanticide and some abortion rights advocates also believe should be outlawed as particularly gruesome. Polls have shown that such a ban has popular support.

Senator Tom Daschle of South Dakota, the Democratic leader, has suggested a compromise that would prohibit all third-trimester abortions, except in cases involving the "life of the mother and severe impairment of her health."

The Right to Life Committee and its allies have complained repeatedly that abortion-rights supporters have misled politicians, journalists and the general public about the frequency and the usual circumstances of the procedure.

"The abortion lobby manufactures disinformation," Douglas Johnson, the committee's legislative director, said today. He said Mr. Fitzsimmon's account would clarify the debate on this procedure, which is expected to be renewed in Congress.

Mr. Fitzsimmons predicted today that the controversial procedure would be considered by the courts no matter what lawmakers decide.

Last April, President Clinton vetoed a bill that would have outlawed the controversial procedure. There were enough opponents in the House to override his veto but not in the Senate. In explaining the veto, Mr. Clinton echoed the argument of Mr. Fitzsimmons and his colleagues.

"There are a few hundred women every year who have personally agonizing situations where their children are born or are about to be born with terrible deformities, which will cause them to die either just before, during or just after childbirth," the President said. "And these women, among other things, cannot preserve the ability to have further children unless the enormity — the enormous size of the baby's head — is reduced before being extracted from their bodies." A spokeswoman for Mr. Clinton said tonight that the White House knew nothing of Mr. Fitzsimmons's announcement and would not comment further.

In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said. "The abortion-rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," he said in the article in the Medical News, an American Medical Association publication.

Mr. Fitzsimmons, whose Alexandria, Va., coalition represents about 200 independently owned clinics, said coalition members were being notified of his announcement.

One of the facts of abortion, he said, is that women enter abortion clinics to kill their fetuses. "It is a form of killing," he said. "You're ending a life."

And while he said that troubled him Mr. Fitzsimmons said he continued to support this procedure and abortion rights in general.