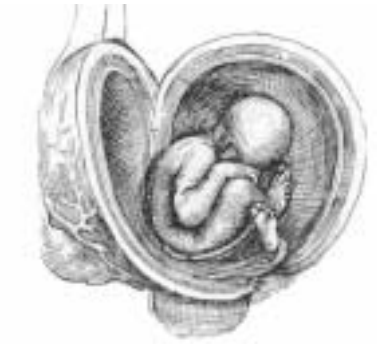

WORLD FEDERATION OF DOCTORS WHO RESPECT HUMAN LIFE

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"

October 2nd 2008

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

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OUTLINE OF SUBMISSION: ON THE CONSEQUENCES OF DISALLOWING ITEM 16525

1. **Summary statement as to why item 16525 is no longer defensible and should be disallowed / revised**
2. **Taxpayers will no longer be subsidising cruel and gratuitous child destruction**
    a. **Facts showing that most second-trimester abortions are done on entirely healthy babies of entirely healthy mothers, some babies older than those in our hospital nurseries**
    b. **Facts about the practice of second-trimester abortion in Australia – including a method denounced by the US Senate as "gruesome, inhumane, and never medically indicated" but subsidised by Medicare item 16525.**
    c. **The pain inflicted on the innocent victims of second-trimester abortion**
3. **Withdrawing the Medicare subsidy will have no consequence for the safety of women**
    a. **Genuine medical cases should be performed in hospitals for the sake of women's safety, not in private clinics: therefore Medicare rebates do not apply**
    b. **Debunking the myth of danger to women where abortion is restricted / defunded**
4. **CONCLUSION**

1. SUMMARY STATEMENT

Senators may once have believed in good faith that abortion in the second trimester was only performed for grave medical conditions, but the Victorian Abortion Law Reform Bill 2008 has put an end to that illusion – stating in law that there is now no requirement for any medical justification for abortion up to 24 weeks.

The Senate is therefore facing a new situation: it can no longer grant Medicare funding in the expectation that such abortions will be justified on medical grounds. The Senate now knows that many such abortions will be performed simply because, for private social and emotional reasons, adults wish the death of their offspring. Item 16525 will now be seen unavoidably as a subsidy for the killing – sometimes involving extreme cruelty and pain – of babies older than those in our hospital nurseries; entirely healthy babies of entirely healthy mothers, who can be lawfully terminated without any need for medical justification.

In this new era of legalised 'abortion on demand', Senators now know that many second-trimester abortions will lack the grave medical grounds that a reasonable person would consider prerequisite. That is a new situation. Therefore the Senate should disallow the current indiscriminate subsidising of second-trimester abortions through item 16525, and redesign this item to fund only genuinely grave medical cases – such as intra-uterine foetal death or unequivocal risk to the mother's life.

We accept that withdrawing the small subsidy from Medicare (only about 5% of a private clinic fee for late second-trimester abortion) will not deter most adults from obtaining the death of their unwanted offspring. However, the principle at stake is that Australian taxpayers should not be compelled to subsidise the cruel and unjustifiable 'on demand' abortion of entirely healthy babies of entirely healthy mothers, some older than the infants in our hospital nurseries.

- We know that even prior to the Victorian Abortion Law Reform Bill 2008 most second-trimester abortions subsidised by Medicare have been done for no valid medical reason, and most have been done on entirely healthy babies of entirely healthy mothers.

- We know that some of these aborted babies are older than the youngest premature babies (23 weeks) in our hospital nurseries.

- We know that such babies aborted after 20 weeks of age require, like any other dead Australian, a Death Certificate reported to the Coroner.

- We know that some of these babies are killed by a method which the Senate and the Supreme Court of the United States, and the American Medical Association, have all condemned as "gruesome, inhumane, and never medically indicated" – but which continues unrestrained in Australia, subsidised by Medicare.

- We know from expert testimony that babies in the late second-trimester are likely to feel more exquisite pain than older infants, due to the immaturity of inhibitory pain pathways; yet we know that in the published lecture notes of a leading Australian abortion doctor no pain relief is given to babies over 20 weeks of age during a procedure that inflicts extreme pain.

We respectfully ask Senators how, in the light of this knowledge and in a new era of State laws granting abortion 'on demand', the Federal Parliament can justify making Australian taxpayers subsidise acts of cruel and gratuitous child destruction, masquerading as a medical procedure.

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An initial 'reality check':

May I direct Senators' attention to the website of a respected Harley St (London) Fertility Clinic.

There you may view Professor Stuart Campbell's pioneering 4D video-ultrasounds of the subjects of the proposed disallowance motion, the baby in the womb around the 14-26 week mark, by clicking on this link: http://www.createhealth.org/latestscans.html Excerpts of his scans shown on British television can be seen at http://www.createhealth.org/watchmegrow.html

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ON THE CONSEQUENCES OF DISALLOWING ITEM 16525

2. Taxpayers will no longer be subsidising cruel and gratuitous child destruction

a. Facts show that most second-trimester abortions are done on entirely healthy babies of entirely healthy mothers, some older than those in our hospital nurseries

The truth - that most late abortions (over 20 weeks of pregnancy) are done to entirely healthy babies of entirely healthy mothers –is confirmed by data collected in Victoria.

In that State, data from the Health Department's 2005 survey of perinatal deaths[i] shows that, contrary to pro-abortion claims, the majority of late abortions were for psychosocial reasons, not foetal abnormality.

The term 'psychosocial' means there is no medical problem with the mother or the baby, but the parents request abortion because of economic or emotional stress.

In many cases these are babies older than those in our hospital nurseries, who might have been born alive and adopted to loving parents, but were instead 'terminated'.

At 23-27 weeks of pregnancy, when other premature babies are being cared for in the hospital nursery, the records for 2005 show 108 healthy babies terminated for psychosocial reasons - five times as many as those terminated for congenital abnormality.

Late abortion for psychosocial reasons is by far the biggest single cause of 'stillbirth' in Victoria. In 2005 the deliberate ending of these healthy babies' lives accounted for one in every three stillbirths.

Late abortion for psychosocial reasons has fifteen times the body count of stillbirth due to infection, and thirty times that due to hypoxia – such as when the cord is tight around the neck. It is the fastest growing cause of perinatal death.

How does that official data square with the pro-abortion spin – that late abortion is merely a tragic necessity in response to grave foetal abnormality or risk to the mother's life? No, late abortion is done for any reason that sufficiently stresses the parents, and its numbers are climbing fast.

Now, with the tabling of the Victorian Law Reform Bill 2008, there is no longer any basis for the comforting belief that second-trimester abortion is only done for grave medical indications. This Bill makes clear that it can be done, no questions asked, no medical justification required, up to 24 weeks – and on the colluding nod of two abortion clinic doctors beyond 24 weeks.

b. Facts about the practice of second-trimester abortion in Australia – including a method denounced by the US Senate as "gruesome, inhumane, and never medically indicated" but subsidised by Medicare item 16525.

This Medicare-subsidised ‘service’ as publicised and practised by a leading Australian abortion doctor, David Grundmann of the Planned Parenthood clinics in Brisbane and Melbourne, was banned by the US Senate in 2003 as “gruesome, inhumane and never medically indicated” yet continues here.

The opening paragraph of the US Partial-Birth Abortion Ban Act 2003 sets the context for the Australian Senate’s decision on funding these abortions: [ii]

> The Congress finds and declares the following:
>
> (1) A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion - an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant -- is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

The ban has been upheld by the United States Supreme Court in 2007.

The procedure of ‘partial-birth abortion’ was performed in Dr Grundmann’s clinic only a few blocks from the Royal Brisbane & Women's Hospital where I recall assisting at the birth of a baby just under 24 weeks.

It seems to me that if I had taken that baby from its mother's arms and pushed a puncturing instrument through its skull, that would be murder. Even if it had some minor abnormality, even if the mother wanted it dead and threatened suicide if I did not kill her baby, it would be indefensible murder. But when another doctor does this to another 24-week baby while it is being delivered at his clinic, that is family planning, subsidised by Medicare item 16525.

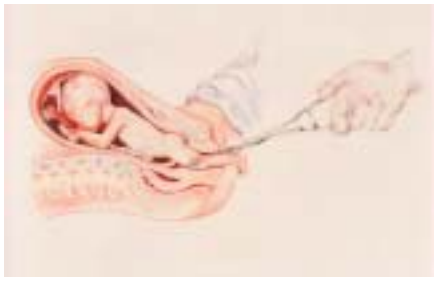
I know the realities of this practice in detail. Our Federation first brought Dr David Grundmann’s practice of second-trimester ‘partial-birth abortion’ to the attention of Queensland Parliament in October 1994, and I have since appeared with Dr Grundmann at an AMA(Qld) enquiry into the practice (1995), and debated Dr Grundmann on an SBS *Insight* forum (2005).

A physician friend surprised me with the strength of his reaction to that televised SBS forum. “Everyone in Australia”, said this liberal-minded doctor, “should have to watch a video of what Grundmann does to these babies. Then the debate on late-term abortion would be over”.

I cannot provide Senators with a link to a video of Grundmann’s published technique, but here below are medical drawings (validated by an eminent specialist in O&G) of Grundmann’s “cranial decompression” partial-birth abortion technique on a foetus in the second trimester. These drawings were provided to the US Senate during their debate on ‘partial-birth abortion’:

Dr Grundmann describes his “method of choice” (on the *ABC 7.30 Report* Oct 26th 1994) as:

"essentially a breech delivery where the foetus is delivered feet first…



"and then when the head of the foetus is brought down into the top of the cervical canal…

"…it is decompressed with a puncturing instrument so that it fits then through the cervical opening".

A decade later, on *60 Minutes* (April 17th 2005) he was asked again about his practice: "Do you pierce the baby's head with a sharp instrument?" and he replied, "I'm not going to discuss details or specifics about procedures because I don't think that you or the public needs to know." (Transcript available).

He was again asked directly, a few months later in November 2005 on the SBS *Insight* forum which I shared with him on abortion, to describe the procedure. He declined: "I'm not sure that the debate would be in anyway enhanced by descriptions of fairly explicit surgical and destructive procedures".

He continued, "It tends to be this issue that has people on both sides of the debate coming more or less to blows with each other." Indeed it does, in a rhetorical sense, and so it should in any decent society. Another participant asked him, referring to Grundmann's published lecture notes, "Do you tell women you'll crush the baby's skull and suction out the brain?" but he gave no reply. (Transcript available).

Respectfully, I think this is information that should not be hidden from Senators considering what level of violence is to be given Federal Medicare funding. I hope the Committee can make fresh enquiries of Dr Grundmann as to his past and current practice, including his stated justifications for performing such late second-trimester abortions.

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Dr Grundmann gave full and frank information about his technique in his Monash University lecture, August 1994: "Abortion over 20 weeks" (copy available).[iii]

First he must make the baby present as a breech delivery – as per the diagrams and statements on the previous page. “Breech” means legs first - and babies almost always lie head first – so the doctor first reaches into the womb with grasping forceps and pulls the baby's struggling legs round and down into position. By being careful to dilate the birth canal to only three-quarters of the skull diameter (as Grundmann specifies in his lecture) the doctor can deliver the legs but be confident of lodging the baby's head in the cervix, so it can be penetrated in the back of the head before birth is complete.

This is important, since if the baby were to slip out another few centimetres before the scissors were applied, that would be murder. While it remains partly in the birth canal, it is Medicare item 16525.

“Cranial decompression” involves removing the skull contents under high-pressure suction so that, as Grundmann’s lecture notes put it, there is "no chance of delivering a live foetus."

Dr Grundmann is reported by the Age (3/2/06) to be “concerned about restricting abortion at any level, regardless of the length of the pregnancy”. This restates his preference, as he put it in the lecture, for unrestricted abortion where “abortion is an integral part of family planning, theoretically at any stage of gestation”.

Contrary to the widespread claim that late-term abortion is only done in extreme cases, Grundmann gave the *7.30 Report* a specific example of an entirely healthy baby of an entirely healthy mother, which I later clarified with him as around 24 weeks. When I asked him at a formal medical forum why he could not have delivered that baby alive and let it be adopted out, he replied that he was 'there to do an abortion, not put some woman's fetus in an incubator'.

His lecture also gives justifications for late-term abortion such as: "Women who do not know they are pregnant” at six months, and "major changes in socio-economic circumstances” such as “desertion of the partner." Then he lists "Minor or doubtful abnormalities", where the baby may or may not have something minor wrong.

When I asked him, at the medical forum, how “minor” an abnormality could be and still justify this assault on a little baby, he gave no answer. One surgeon challenged his as to how he could justify a late-term abortion on a baby with cleft lip and palate, when that could be surgically repaired. Grundmann replied to the effect that it depended on whether the woman wanted to put her fetus through all that surgery (my contemporaneous notes of the 1995 forum available).

This remains his practice on the public record, unaltered over fourteen years, with about a thousand late-second-trimester abortions done since then in Grundmann’s Planned Parenthood clinics in Brisbane and now in Victoria.

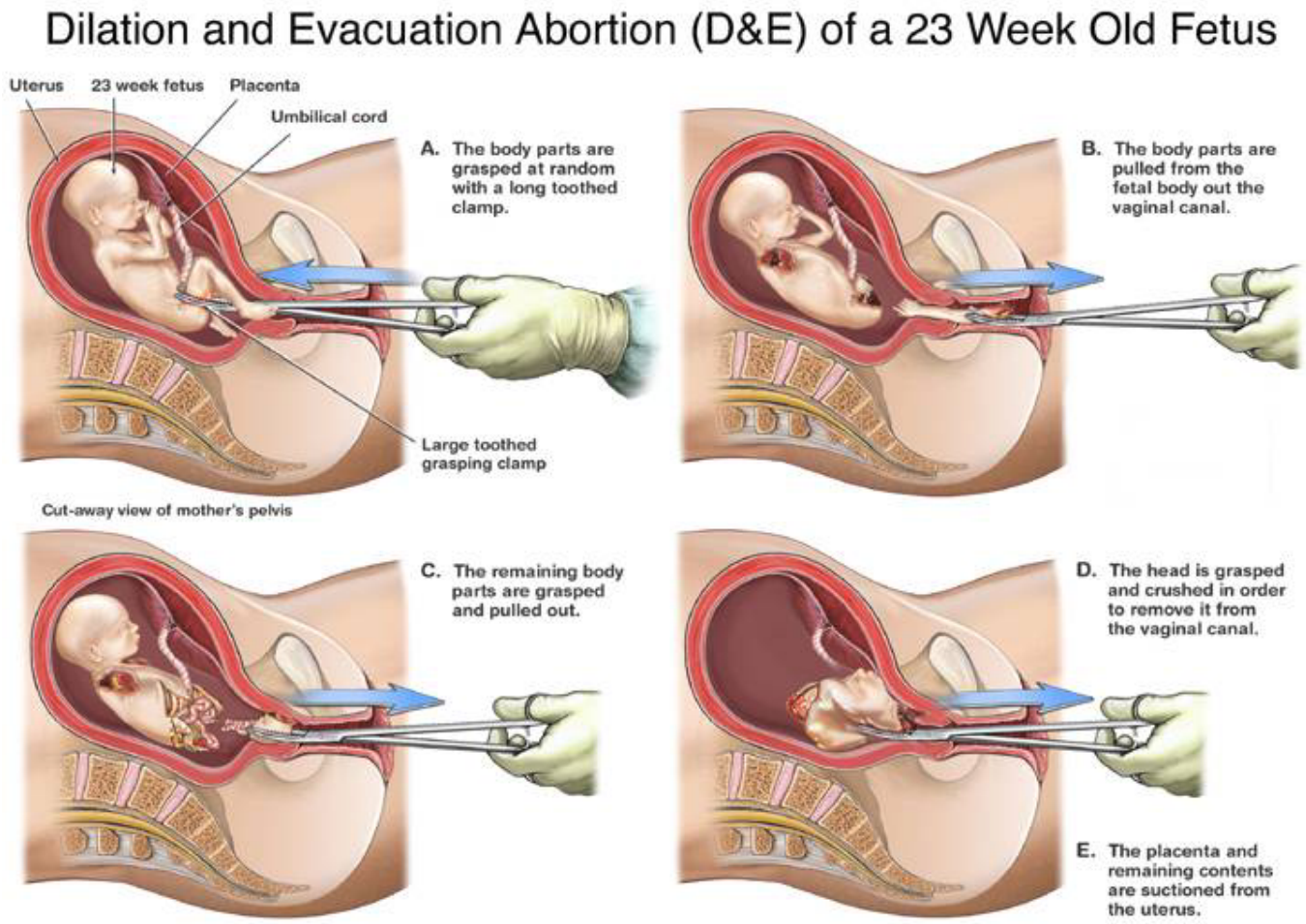
Of such babies aborted in private clinics in Victoria, we know the majority are entirely healthy with entirely healthy but disturbed mothers (who need to be counselled and supported, not aborted) and some babies are older than those in our hospital nurseries. They are killed by a method so cruel that you could not apply it to animals without prosecution.

And yet there is one other technique referred to in standard textbooks of abortion, and in Dr Grundmann’s lecture, which would, if possible, cause more physical pain and suffering than ‘partial birth’ abortion, and that is ‘D&E’ (dilatation and evacuation).

On the ABC television screening a few years ago of the *My Foetus* film, British late-term abortionist John Parsons does not use ‘partial birth abortion’, but ‘D&E’, and describes how he pulls apart the baby in the womb, noting that it is “not nice” to see “dismembered pieces of foetus falling into a bucket between my legs”, but that he will do this if the baby is “seriously unwanted”.

Unwanted? And that is grounds for this torture and killing – subsidised by item 16525?

The steps in this doctor's technique – also practiced in Australia – are shown in the following diagram of a fetus in the second trimester (note: this is more commonly done in the first half of the second trimester – around 13-20 weeks, but technically can be done throughout the second trimester, to 26 weeks):



Any parents who would take their unborn child, visibly kicking and jumping, to such a doctor to have such an unspeakable act of violence performed, require restraint and counselling for their disturbed state. They do not require Medicare subsidies.

c. The pain inflicted on the innocent victims of second-trimester abortion

Grundmann's lecture confirms that the baby has no pain relief ("no need for narcotic analgesia") even though we know from studies in the Lancet and elsewhere that such babies are exquisitely sensitive to pain.

The Lancet (9/7/94) observed the full range of pain responses in unborn babies given needles in utero for blood transfusion at 23 weeks-not only "vigorous body and breathing movements" but "a hormonal stress response to invasive procedures." Grundmann seems to be indifferent to the "sentient" nature of these babies. On ABC Radio A.M. (27/10/94) he was asked: "So at what point do you believe the foetus does become a sentient human being?" and replied: "When it is born."

If Senators are concerned about the infliction of extreme pain during partial-birth abortion, let them study the expert testimony to the US Congress by Professor of paediatrics and anaesthetics, Jean Wright. She concludes (PDF 736kb): [iv] "The pain experienced during 'partial birth abortions' by the human fetus would have a much greater intensity than any similar procedures performed in older age groups."

She also addresses the falsehood put about by the abortion lobby in the US – that the anaesthetic given to the mother would provided adequate pain relief to the baby being aborted. She states:

> Current methods for providing maternal anesthesia during 'partial birth abortions' are unlikely to prevent the experience of pain and stress in the human foetuses before their death occurs after partial delivery.

Another expert on foetal pain gave testimony in 2004 to the Congress, and likewise observed:

> Similar to the physiological response of preterm neonates, foetuses greater than 16-20 weeks respond to painful procedures with hormonal stress responses… All the lines of evidence reviewed above suggest the presence of consciousness from about 20-22 weeks of foetal life. [v]

Such 20-22 week foetuses may now be terminated 'on demand' in Victoria, no questions asked, no pain relief given. There is no justification for giving Medicare subsidies to such gratuitous and unspeakably cruel acts of child destruction.

3. Withdrawing the Medicare subsidy will have no consequence for the safety of women

a. Genuine medical cases should be performed in hospitals for the sake of women's safety, not in private clinics: therefore Medicare rebates do not apply

Arguably there is no place for Medicare benefits to be paid for second-trimester abortions, since on grounds of women's safety alone, such abortions should not be happening in private clinics (where Medicare benefits are payable) but should only occur in hospitals with full emergency facilities (where Medicare benefits do not apply).

In the Weekend Australian (Feb 5/6 2005), the former AMA Queensland president David Molloy was reported as saying that late terminations should be performed only in public hospitals, on medical grounds, for the sake of women's safety. "These procedures do represent a very significant danger for women", he said, and "should be performed with full hospital facilities".

Dr Molloy was responding to the revelations by the present Director of Gynaecology at the Royal Brisbane and Women's Hospital, Dr David Baartz, about the series of major and life-threatening injuries sustained by women having late abortions in the surrounding clinics. "Abortions after 20 weeks are dangerous for women", Dr Molloy said, "and should only ever be undertaken in a public hospital for medical reasons".

His position reflects that of the Queensland branch of the Royal Australian College of Obstetricians and Gynaecologists, of which he is a prominent member, which maintains that "there is absolutely no justification for termination of pregnancy after 20 weeks by anyone other than a recognised specialist".

The Senate and the Federal Government cannot control the registration of clinics, but they can do what little they can – namely, block subsidies for such unjustifiable and dangerous procedures, and

urge the States to follow their lead by limiting any such late-term abortion to public hospitals – not private clinics.
That would be a gain for those dozens of babies who would never be killed at a public hospital, but only at a for-profit clinic. We see that in Victoria between 2001 and 2005, of the 581 abortions over 20 weeks done for dubious 'psychosocial' reasons, only 4 were done in a public hospital. All the rest were rejected by the hospital but done by private operators, subsidised by Medicare. If the Senate disallows these subsidies to private clinics for unjustifiable 'psychosocial' abortion, that may reinforce the need for States to restrict such abortions to public hospitals – in the interests of women's safety.

b. Debunking the myth of danger to women where abortion is restricted / defunded

I understand that the inevitable and absurd argument has been put to Senators, that limiting abortion funding in this way will somehow send women to the 'backyard' again.

One Senator wrote to me stating his opposition "to creating a situation where is abortion is legal but only available to those able to pay for it. *This could force poorer women to resort to illegal abortionists, at grave risk to their health*."

On a moment's reflection, that is an entirely unrealistic concern:

Firstly, because the Medicare rebate of some $226 is only around 5% to 20% of the fee charged by private abortion clinics (around $1250 pre-20 weeks and $4000 post-20 weeks currently) and such a small financial disincentive is not really going to stop a determined adult obtaining late-term abortion. The disallowance will not prevent second-trimester abortions happening – nevertheless it is important that the Senate not support such abortions. The disallowance will remove the social offence of taxpayers having to fund what they consider unjustifiable child destruction.

Secondly – and perhaps introducing historical data that Senators are not aware of – it must be understood that the whole hysterical threat of the 'backyard', which is the emotional trump card of the abortion lobby, is untenable, as I demonstrate below using the only reliable data (that of the Australian Bureau of Statistics maternal mortality data for last century).

The facts show that legal restrictions on abortion never, historically, had the slightest detectable link to women's safety. The only detectable improvements came through medical advances, not legal change, and these improvements were of course dramatic and irreversible.

Senators will be aware of the popular idea that, prior to abortion being made legal, there was a veritable 'holocaust' of victims at the hands of backyard butchers. Once the law changed, women were safe at last. This argument – usually embellished with images of coathangers – is always at the forefront of moves to abolish any legal restriction on abortion, including the current proposal to remove Medicare funding from unjustifiable mid-trimester abortion.

It is a false argument. Historically, the facts do not support any detectable link between legalising abortion and improving women's safety, as the following analysis of the available ABS data will show.

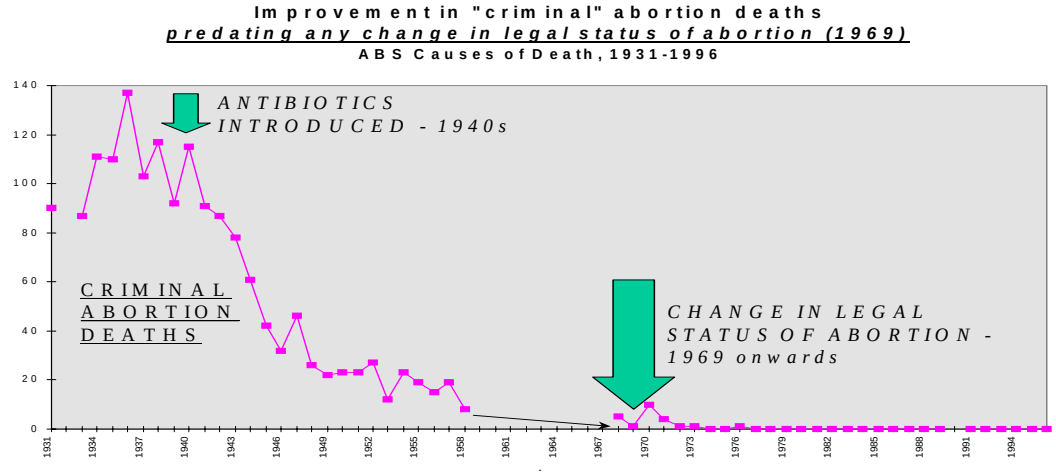
Senators should not be guilty of repeating the same weak-minded falsehood about abortion becoming 'safe' because it became 'legal'. There is no reasonable basis for the argument that we must fully

decriminalise abortion, or desperate women will still seek abortion and die at the hands of backyard butchers. For your information, the national data follows in graph form:

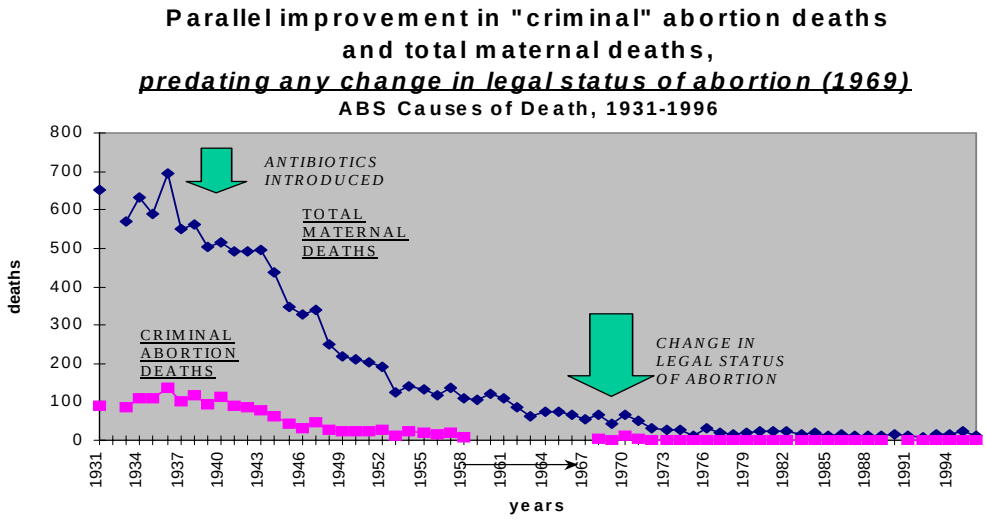
Fact one: Making abortion legal or illegal has never, historically, made the slightest detectable difference to the safety of women. This is because of **fact two**: Medicine alone, not the law, has achieved all the proven gains in maternal safety.

These gains were made by medical breakthroughs such as the introduction of antibiotics in the 1940s, blood transfusion, improved surgical techniques and emergency services, and were achieved before there was a single liberal law or "safe legal clinic". If these legal changes made any additional contribution to safety, it is too small to show up in the historical records.

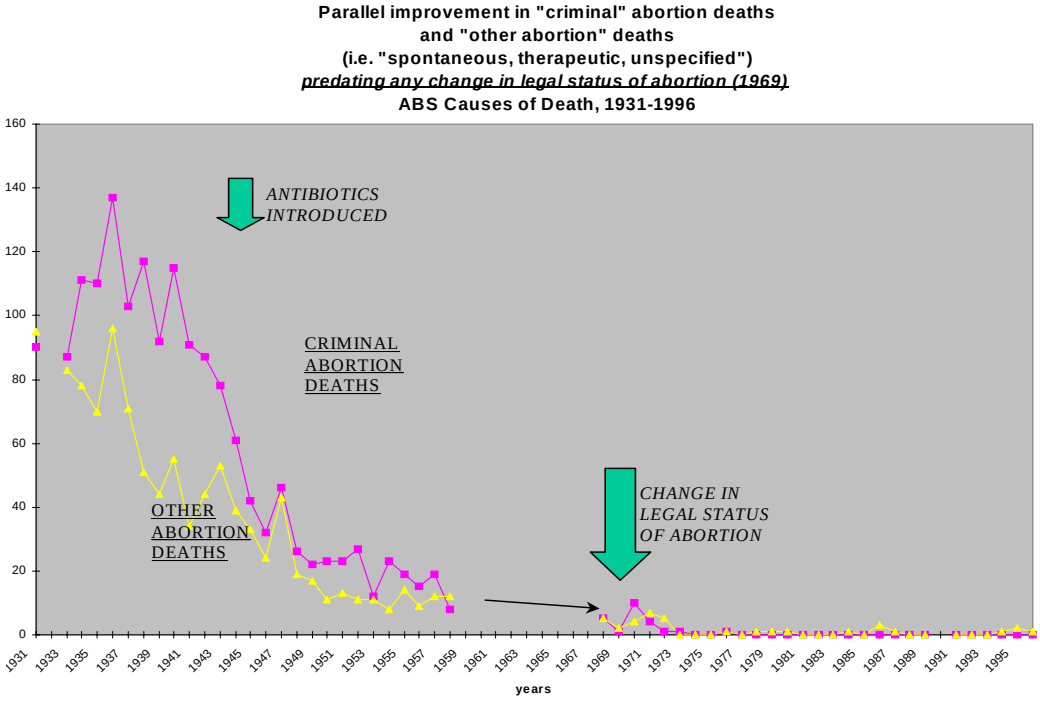
By studying the entire Australian Bureau of Statistics data on Causes of Death last century (1906-1996) it can be observed that the death rate for illegal abortions plummeted from about 100 deaths every year in the 1930s (before antibiotics) to just one death in the whole of Australia in 1969 (the last year of the old "backyard" regime, with the Victorian Menhennit ruling coming late in September of that year) – and this was before there was a single "legal" clinic anywhere in the country.



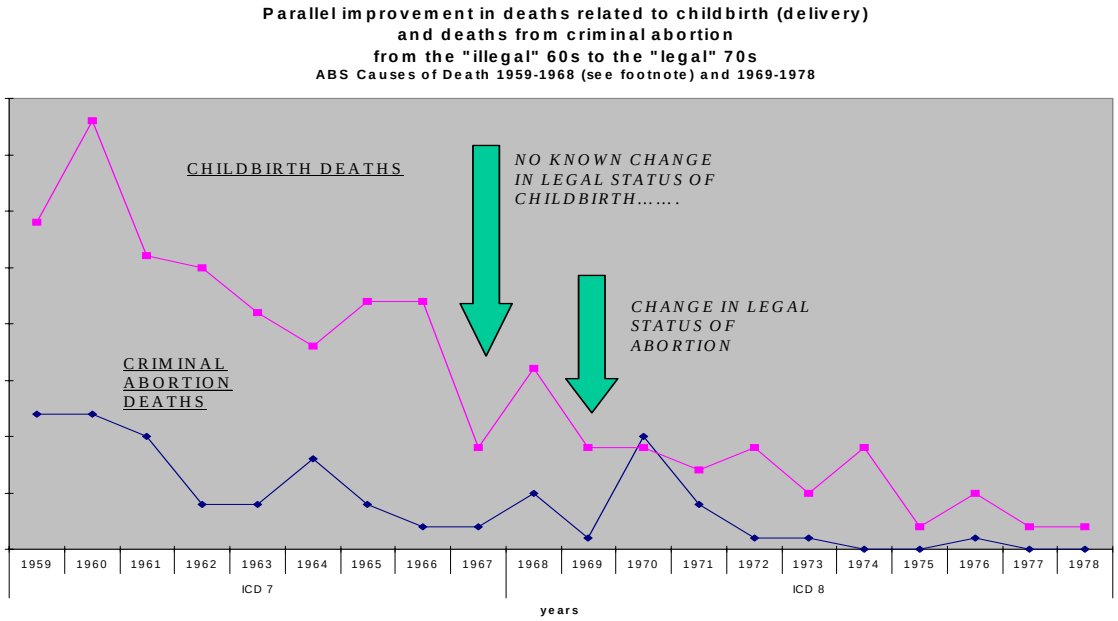
All this magnificent improvement was thanks to medical advances alone, with the legal status of abortion unchanged and irrelevant. It is also noteworthy that maternal deaths from all causes - childbirth, miscarriage and abortion - dropped exactly in parallel (see next graph) for the same medical reasons. Abortion deaths have always been about one fifth of total maternal deaths.



And the graph below shows that deaths from 'miscarriage' paralleled the drop in death from 'criminal abortion' for the exact same medical reasons. Nothing to do with legal changes.



Note in the next graph that in the new "legal abortion" era of the seventies, further small gains in average abortion mortality *exactly matched* further gains in childbirth mortality - but nobody suggests childbirth had been recently legalised! Medical progress, not legal agitation made abortion (whether criminal or medical) and childbirth, irreversibly safer.



(NB: interpretation of the data was clarified with the experts at the ABS. Details can be taken up with me if required.)

Facts one and two dispel the cherished illusion that "illegal" means "unsafe" and that "therefore it must be made legal" - the trump card of the abortion lobby. This is beginning to be acknowledged even by abortion supporters. Writing in the US journal *Women's Quarterly*, Candice Crandall reluctantly accepts that medical advances, not legal changes, were responsible for improved safety, "In fact, it wasn't Roe v Wade (the Supreme Court ruling in 1973 to legalise abortion) that made abortion safe, it was the availability of antibiotics beginning in the 1940s".

She also confirms "The most powerful of the pro-choice arguments was the claim that any infringement of the right to an abortion would return America to the dark ages when thousands of women died because of unsafe, back-alley abortion".

Thousands of women? In fact, she notes, the US death toll had dropped to 41 in the year before Roe v Wade, not the 10,000 figure promoted by the National Association for the Repeal of Abortion Laws (NARAL). Co-founder of NARAL, Dr Bernard Nathanson, writes, "I confess that I knew the figures were totally false - but the overriding concern was to get the laws eliminated, and anything within reason that had to be done was permissible". Whatever it takes.

Even the fearful figure of the ‘backyard butcher’ is largely the stuff of legend. Historically the so-called "backyard" usually was, and would be again, the "backroom" of a qualified doctor's surgery.

So we read in the *Age* September 6th 2008 a review article (supportive of abortion legalisation) by Gideon Haigh called "Abortion: the way we were" which confirms that the backyard butcher is largely a figment of propaganda, certainly from WW2 on: [vi]

> Far from being the stuff of backyards and knitting needles, the illegal abortion industry was revealed as a hugely lucrative racket of apparently respectable doctors perfectly comfortable with paying graft, and even with setting the detectives in their pay on disliked rivals.

And it also also confirms that the real change in safety came with antibiotics and other medical advances, not with legal agitation:

> Antibiotics having made abortion a relatively safe procedure, huge rewards beckoned the doctor prepared to operate in the twilight between legality and illegality.

Past Director of Planned Parenthood, Dr Mary Calderone, admitted in the *American Journal of Public Health* that even in the illegal 60s in America, with its ghettoes of black and Hispanic poverty, 90 per cent of all "backyard" abortions were in fact carried out by trained physicians. More so today, in the covert but clean circumstances of the "backroom" of a colluding doctor's surgery - or alternatively, done by experienced amateurs using the cheap sterile suction pump seen on theABC's *My Foetus* film - and with routine backup at casualty, the immediate physical risk of illegal abortion would be very ordinary.

Therefore laws enforcing genuine, agreed limits on abortion do not – contrary to popular mythology - place women at any dramatic physical risk, because medicine has minimised that risk; it might drive a few women to a safe and secret backroom, but not to the propagandist's "backyard", nor to his anachronistic "coat hanger". Likewise, withdrawing funding from unjustifiable second-trimester abortions will have no consequence upon the risk to women.

For purposes of Senators considering this disallowance motion, let there not be the usual feeble acceptance of the emotional blackmail that says "if you limit any abortions at all by force of law or withdrawal of public funding, you will be condemning women to death in the backyard again". The facts say that there is no detectable link between abortion being legal (or publicly funded) and abortion being safe. Arguments along that line should be dismissed as unsubstantiated rhetoric.

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4. CONCLUSION

We ask Senators to support the disallowance motion for Medicare funding of second-trimester abortion.

It is no longer tenable for the Federal Government to fund such abortions on the naïve assumption that they are being performed for grave medical indications. That comforting illusion has been dispelled. With the tabling of the Victorian Abortion Law Reform Bill 2008, it is clear that second-trimester abortions will be performed, and subsidised by Medicare, 'on demand', with no requirement for medical or moral justification up to 24 weeks, and beyond that age on the mere colluding nod of two abortion clinic doctors.

As a matter of record, and as a mockery of law, the majority of second-trimester abortions in abortion clinics around Australia are performed for 'psychosocial' indications, where we have both a healthy baby and healthy mother - rarely ever for grave medical indications (see data below). But we enter a new era of transparent brutality with the Victorian Bill, which makes clear that these late-term abortions are officially to be a free-for-all, with no questions asked.

The Victorian development gives a new reality-check to Federal lawmakers – and that newly understood reality means the old misguided provision for funding such abortions must be disallowed.

If Senators are prepared to look at the data as to the current reality of second-trimester abortion – the 'on demand' justifications, and the appallingly cruel methods – they will find that the current provision compels taxpayers to subsidies gratuitous child-destruction, not medical care.

If Senators are prepared to look steadily at the nature of what certain doctors in Australia have done to babies older than those in our hospital nurseries – some of them entirely healthy babies of entirely healthy mothers – they will come to the same conclusion as the Senators of the United States: that such practices are "gruesome, inhumane, and never medically indicated".

Why should the public be forced to contribute money through Medicare for deranged adults to go to doctors to have such babies killed 'on demand', killed by a method so cruel that you could not apply it to animals without prosecution, as has been happening covertly around Australia and will now occur overtly in Victoria?

The pretence is over. Item 16525 must now be seen to be subsidising acts that are "gruesome, inhumane, and never medically indicated". It should, in its current form, be disallowed. As one senator wrote to me, "I know of no one who would not support Medicare funding for second trimester abortions for intra uterine death, lethal foetal abnormality or if the procedure is unequivocally necessary to prevent the death of the mother, and this inquiry should identify if it goes beyond this."

I trust that this Senate Committee will indeed identify how current practice indeed goes well beyond this reasonable position, and modify the item 16525 so that it is targeted to justifiable indications only.

Thank you again for the opportunity to contribute to your deliberations on this disallowance motion.

Yours faithfully,

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Endnotes

[i] Consultative Council on Obstetric and Paediatric Mortality and Morbidity
See section "Perinatal Mortality Review 2005" especially pp 1,3,13 and following, at
http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf

[ii] Partial-Birth Abortion Ban Act US Senate 2003 at http://news.findlaw.com/hdocs/docs/abortion/2003s3.html

[iii] Dr David Grundmann, Abortion over 20 Weeks in Clinical Practice, Monash August 1994.

[iv] Prof Jean Wright, paediatric pain specialist, testimony to Congress 1996 at
http://www.nrlc.org/abortion/Fetal_Pain/Wright%20testimony%20on%20fetal%20pain.pdf

[v] Dr KS Anand, paediatric pain specialist, testimony to US Federal Court 2004 at
http://www.nrlc.org/abortion/Fetal_Pain/AnandPainReport.pdf

vi Haigh article *The Age* 6 September at:
http://www.theage.com.au/national/abortion-the-way-we-were-20080905-4aq7.html