Bishop's House
183 Abbott Street
Cairns Qld 4870

12th October 2018

Pastoral Letter to the people of the Diocese of Cairns

My dear people,

I began drafting this letter on Tuesday 9th October, when the reading at Mass was from St Paul to the Galatians:

God who especially chose me while I was still in my mother's womb. (Gal. 1/15)

That day's Psalm re-iterated this:

For it was you who created my being
knit me together in my mother's womb
I thank you for the wonder of my being. (Ps. 138/13-15)

These are founding thoughts for any times in our lives: Our own unique self, named, known and loved by God.

However they have a particular relevance now and here in Queensland.

In the coming week our Parliament will debate and vote upon: Termination of Pregnancy Bill 2018

Abortion is always an emotive and contentious issue with positions strongly polarised: either it is claimed to be essentially and exclusively a women's health issue, or it is presented as a fundamental question of human rights and life.

A Catholic position comes from the later perspective – as the earlier Scripture passages assert.

From conception each one of us is a unique life form. We are within our mother, but we are more than just a part of her. About half of us are of a different gender, we may have a different blood type, and our unique genetic structure has a substantial contribution from the one who fathered us.

The centuries' old debate about when does a human life actually begin is rather irrelevant. If uninterrupted, unterminated, what has been conceived will become, will grow into a separate and autonomous human person.

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This is the unique wonder of each one of us – there will never be another person like me, who is at the same time so alike and yet so unlike or different from our parents and our sisters and brothers.

This should be the starting point and indeed the ending point of any discussion about the continuation or the termination of any and every life in the womb.

This is not to deny that there are relatively rare medical exceptions, such as *ectopic gestation*: conception outside the uterus, which would cause the death of both mother and child.

Yet the respect of life is the governing principle even in these circumstances.

It is rather curious that in the draft of this broad Bill itself the personalized phrase *the unborn child* is used rather than the usual clinical term *the fetus*.

I have previously (CP 10/9) recalled that in 1922 the Queensland Parliament was the first jurisdiction in the then British Empire to abolish the death penalty.

That placed us among the then very few countries worldwide to make such a humane and enlightened reform.

It would indeed now be a sad irony if the current Queensland Parliament should pass such a broad termination of life, which also has many ethical inconsistencies.

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I offer more specific comments of the proposed Bill drawing from my background in philosophical ethics and pastoral care.

(This further document will be on the Diocesan Website (www.cairns.catholic.org.au) early next week and covers this in more detail.)

Your own response could be a brief phone call or email to your local state member. (See accompanying list of Local Members' contacts.)

Yours truly in Christ,

+ James Foley
BISHOP OF CAIRNS

PLEASE NOTE: The preceding Pastoral Letter (circulated to parishes in the Cairns diocese on the weekend) comes from a religious/theological perspective, which lays the basis for our deeply held concerns about terminating a pregnancy.

What follows is more of an ethical/philosophical critique of the proposed Bill, which is drawn from my training and teaching of philosophy and from my pastoral experience, particularly as a confessor.

Though this second section is founded on the considerations in the Pastoral Letter, which explains the basis of people's conscientious concerns, what follows can also stand quite on its own as a contribution to consistency in legislation, which is fundamental to good government.

Nothing in my comments and critiques of the draft Bill implies any acceptance of the termination of the life of *an unborn child*. My comments and critique are intended only to stress the serious inconsistencies in this draft Bill.

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1. It is understood that the Parliamentary Committee declined to view any depictions of termination procedures – particularly the dismembering necessary in late term abortions.

   While such a reluctance is humanly appreciated, it should be noted that when the panel examining Bundaberg surgeon, Dr Patel, a similar issue arose. A panel member, with extensive nursing experience, urged that other panel members, without that medical experience, did need to view depictions of seriously botched surgery, so that they could appreciate the gravity of what was at the heart of all their considerations.

   Surely this is all the more pressing and painful when it comes to terminating a pregnancy.

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2. Might I also make the general observation that this whole Bill is not a particularly fine piece of parliamentary draft: it has an incomplete and therefore inadequate Dictionary (p.22, l.1-31, p.23, l.1-4) which for example leaves completely unclear the important phrase *another unborn child.* (p.7, 28-29). Nor does it give a detailed definition of *social circumstances* (p.7, 20)

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Please Note: rather than using the bills's own section numbering system, with which I am unfamiliar, I shall simply make reference to page (p.) numbers and line (l.) numbers.

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3. A pregnancy terminated is arguably the most serious ethical decision a woman may ever make. From my pastoral and confessional experience some carry the burden of this decision throughout their lives and on to their very death beds.

   To decriminalise the mother's part in an abortion would be a law reform which many would welcome. (p.10, l.5-6)

   The fact is that, for obvious reasons, this has rarely been prosecuted. This also raised the question of the degree of *coercion* placed upon the mother by partner, parents or peers.

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4. The draft bill makes no reference to nor does it take into any account, the ethical concepts of **co-operation** or **degrees of moral responsibility** which have been a long complex philosophical study: to what degree is a person's action either praise or blame-worthy. This is an essential element in any criminal justice system, but also in the daily decisions in each of our lives.

   The degrees of co-operation may be *immediate*, *intermediate*, *proximate* or *remote*.

   In a surgical procedure – the surgeon is *immediately* responsible.

   The theatre staff – from anesthetist to wardsman - are in varying degrees *intermediately* responsible.

   The nurse in the recovery unit may be *proximately* responsible, while the hospital cook and cleaners are (very) *remotely* involved.

Some historical examples may help:

- What degree of responsibility (and this raised those ugly but very relevant related terms: *collaborator* and *collaboration*) did German or Polish railway workers and train drivers have in directing traffic and driving known deportation trains to Auschwitz?

  The prime organizer, Adolf Eichmann, of the *Holocaust* at his trial, blandly and blithely referred to himself as merely *a coordinator of railway timetables*!

- A U.S. pharmaceutical/chemical company has declined to make or deliver the chemical components required for execution by lethal injection? To do otherwise would be somewhere between *intermediate or proximate cooperation*

  However a company making and supplying *cannulas* (those needles and tube pieces through which blood is extracted or medications inserted) may provide these very commonly used instruments to prison hospitals – a few of which may be inserted into the condemned. This would be at most *remote* co-operation in an execution.

The draft bill seems blind to all these question of moral co-operation and is silent on the rights of conscience. (p.8, l.3-31) (p.9, l.15-16)

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5. The proposed bill requires that only qualified medical practitioners may perform surgical abortions. This probably does no more than to recognize that *the backyard abortionist* is now only a ghost from the relatively recent past.

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The proposed bill makes no reference to self-administered pharmaceutical terminations up to 9 weeks except possibly for (p8. L.13-16)

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Surgical abortions up to 22 weeks involving only one doctor. (p.7, l.3)

After 22 weeks of pregnancy late-term abortions may be performed considering *the woman's current and future medical, psychological and social circumstances*, (p.7, l.19-20) with a doctor only required to consult with one other medical practitioner. This would not require a second patient consultation nor clinical assessment (p.7, l.13-15).

This could lead to some comfortable collusion among like-minded colleagues.

To avoid this, would it not be better to require the doctor to advise a (presumably more independent) regional Government Medical Office, or another nominated medical professional, that this termination will occur and that the reasons for it would need to be stated in detail.

This would carry with it a higher degree of professionalism and would also provide some useful official monitoring of late-term abortions, region by region. This would usefully track trends in regions – particularly in that very broad, yet undefined, category *social circumstances.*

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6. That any medical practitioner *who has a conscientious objection to the performance of the termination* (p.8, l.28) *must disclose the practitioner's conscientious objection to the person.* (p.8, l.30-31). Where is the doctor's right to personal privacy, a *privacy and dignity* so specifically provided to the patient and interestingly this also extends to others working in or accessing premises providing termination services (p.10 l.14-17)

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7. Such a *practitioner must refer the woman, or transfer her care, to* a *health practitioner* or to a *health service provider*, where the termination could take place and where there would be no conscientious objections. (p.9, l.1-14)

   Where here is there any recognition of or respect for the ethical categories of **co-operation**? In this case the doctor with conscientious objections *must refer the woman*. This would be at least *intermediately cooperating* in an act to which one had strong and deep conscience reservations.

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8. Section 4 (p9. l.15-16) goes much further and cutely puts in the passive: *does not limit any duty owed by a registered health practitioner to provide a service* (a termination) *in an emergency*.

   In more active direct language any doctor must perform a termination in *an emergency* (also left undefined) in spite of their conscientious objections, and their obvious inexperience and what, inevitably must be limited to non-existent, surgical competence arising from the very fact that their conscience reservations have meant that they have never participated in nor witnessed a termination of a pregnancy.

   Doctors in such circumstances would find themselves not only conflicted in their own consciences, but would find themselves being required to act beyond their level of medical professional competence.

   This raises further vexed ethical questions: should a medical student, who has their own reservations, be required, in the course of their training, to witness or participate in or to actually perform an abortion?

   This then leads on to an almost unending chain of moral **co-operation** issues: the theater staff, the nursing staff, the receptionist etc etc.

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9. An obvious solution to any obligation to refer would be for medical practices to clearly display that:

This Practice does, (or does not) provide pregnancy termination services.

Where there are a number of doctors with differing views in one medical center, then a notice at reception could read:

If you require a pregnancy termination please to see Dr so-and-so.

In the past I have seen such a notice in a Brisbane suburban medical centre, where those needing a vasectomy are advised to request to see Dr.

While this may have some small impact on patient privacy, that surely does not outweigh considerations of a doctor's personal convictions or their actual procedural (in)experience.

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10. In this context I would also offer some regional consideration. Far North Queensland has some of the most remote and isolated communities in the country. This raises particular issues for a sole medical practitioner in such places, or for the Royal Flying Doctor who makes routine visits.

Late-term terminations require hospitalization, so a medical evacuation would be necessary and this would be important where the reasons are of a serious surgical or psychological nature. It would be much more problematic to ascertain that broad category of *social circumstances*.

This isolation issue becomes more problematic when it is an early-term termination requiring either pharmaceutical or surgical intervention. Where does that place both the patient and the medical practitioner, if the doctor has personal or ethical reservations and/or, for that very same reason, has no professional expertise in such surgical procedures?

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11. There may also arise a constitutional issue which is not without precedent. A State Governor, for personal conscience reasons, or recognizing legal inconsistencies or inadequacies, could find themselves unable to sign into law such a piece of legislation.

This did happen with King Baudouin of the Belgians (1930-95), who, when required to ascent to a similar piece of legislation, offered rather to abdicate. Because he was so highly regarded a compromise was struck, whereby he would abdicate for a day (4 April 1990) and in his *constitutional* absence all of the Government would sign the act into law.

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12. I could comment at great length, but I will not, on the sections Safe Access Zones (p.10-13) except to observe that this part curiously is rather more detailed and more restrictive and prescriptive than the first (p.7-9) section dealing with termination itself.

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I trust these considerations are helpful in your difficult parliamentary deliberations.

Yours truly,

+ James Foley
BISHOP OF CAIRNS