BRIEFING NOTE

Reproductive Health Care Reform Bill 2019

Presented by: Right to Life NSW

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The most striking characteristic of this radical Bill is the complete invisibility of the woman as the mother of the unborn child.

Firstly, the Bill introduces the novel notion, rooted in a controversial view of gender contrary to common sense, basic biological facts and anathema to many feminists, of "*a person who is pregnant*" thus denying from the outset **the centrality of the woman who finds herself pregnant** and is faced with a decision.

More significantly there is absolutely no mention of the woman as having ANY role in the decision to end the pregnancy by abortion. She is invisible in this Bill.

Clause 5 – A doctor's unfettered right to abort any pregnancy to 22 weeks: No request or informed consent is required

Clause 5, which is the key clause of the Bill, simply provides that:

> *A person who is a medical practitioner may perform a termination on a person who is not more than 22 weeks pregnant.*

Note that this provision is **not subject to any restrictions whatsoever**, not even the requirement in Clause 6 (2) (c) which applies only to late term abortions, to consider "*the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination*".

By removing the current provisions in Clause 83 of the Crimes Act 1900 [Schedule 2, item 2] , and abolishing any common law offence of procuring the miscarriage of a woman [Schedule 2, item 4], the Bill would result in a complete immunity for any medical practitioner who performs an abortion on any woman or girl who is less than 22 weeks pregnant **regardless of whether or not he has the informed consent of the woman or girl** to perform the abortion.

The Bill therefore could serve to protect a medical practitioner who performs an abortion on a woman at the request of a third party such as an abusive, controlling male partner; the pimp of a trafficked woman or a parent of a pregnant girl. It could also serve to protect a medical practitioner who aborts his own child after coercing the mother of his child to do so.

Evidence[1] shows that up to 64% of pregnant women feel pressured by others to have an abortion. Providing an unfettered right for any doctor to perform an abortion on any woman or girl to 22 weeks, with no requirement for the request to be initiated by the woman or girl herself let alone for her fully informed consent to be obtained, leaves pregnant women and girls vulnerable to coerced abortions.

[1] Rue. V.M. et al., "Induced abortion and traumatic stress", *Medical Science Monitor*, 2004, Volume 10, Number 10, Special Report, p. 5-16 at: http://www.medscimonit.com/pub/vol_10/no_10/4923.pdf

Evidence also shows that 18% of women who have experienced violence by a current partner (34,500 women) experienced violence during their pregnancy, and 48% of women who experienced violence by a previous partner experienced violence during their pregnancy (325,900 women)[2].

Anyone who is genuinely in favour of a woman's **choice** should therefore reject this Bill as it stands.

Clause 5 – A doctor's unfettered right to abort any pregnancy to 22 weeks: Abortions for sex selection

There is recent evidence[3] that under Victoria's "reformed" abortion law, in the five year period from 2011 to 2015, there were on average 37 girls each year missing from Indian-born mothers and 24 girls each year missing from Chinese-born mothers due to sex selection abortions.

Is this want we want in New South Wales?

(Clause 6 would permit abortions for sex selection right up to full term.)

Clause 5 - A doctor's unfettered right to abort any pregnancy to 22 weeks: Abortions for eugenic reasons

The United Nations Committee on the Rights of Persons with Disabilities has stated that:

> *Laws which allow for abortion on grounds of impairment violate the Convention on the Rights of Persons with Disabilities (Art,. 4,5,8). Even if the condition is considered fatal, there is still a decision made on the basis of impairment. Often it cannot be said if an impairment is fatal. Experience shows that assessments on impairment conditions are often false. Even if it is not false, the assessment perpetuates notions of stereotyping disability as incompatible with a good life*.[4]

Attempts to deny the eugenic nature of laws permitting abortion for disability are without any plausible foundation. We will never treat people with disability with the equal respect which is their due if we were to endorse this law which allows for them to be excluded from a chance at life after birth – even if that may be a very short life.

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[2] Australian Bureau of Statistics. 2016 Personal Safety Survey. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4906.0~2016~Main%20Features~Impacts%20of%20partner%20violence%20-%20children%20witnessing%20or%20during%20pregnancy~24

[3] Kristina Edvardsson et al, "Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015" *International Journal of Epidemiology*, https://academic.oup.com/ije/advance-article/doi/10.1093/ije/dyy148/5057663

[4] http://www.ohchr.org/Documents/HRBodies/CCPR/GCArticle6/CRPD.docx

Clause 5 (and 6) would permit abortion for eugenic reasons in contravention of the rights of persons with disabilities to be treated with equal respect both before and after birth.

Clause 6 – Abortion of the viable unborn child at any time up to birth: meaningless additional requirements

Clause 6 authorises any medical practitioner, who after considering certain matters and obtaining the agreement of any other medical practitioner, decides that an abortion "*should be performed*" to perform an abortion on a pregnant woman or girl at any time from 22 weeks of pregnancy right up until full term.

These additional requirements for an abortion from 22 weeks to full term are effectively meaningless.

The range of circumstances to be considered is so broad that it is hard to imagine a scenario where a doctor who personally believed in abortion for any reason or none up to full term could be faulted if he or she claims to have considered "that, in all the circumstances, the termination should" have been performed. Even though the doctor is required to consider the woman's current and future physical, psychological and social circumstances in making the decision, there is no minimum requirement of investigation that the doctor must do in order to understand these circumstances, nor is there a requirement to keep records.

Finding a second doctor to agree would not be difficult.

Note that as in Clause 5 there is NO requirement for a request from the pregnant woman or girl let alone her fully informed consent.

Clause 6 – Abortion of the viable unborn child at any time up to birth: the Victorian experience

Under Victoria's "reformed" abortion law, from 2009 to 2017 there have been 3104 abortions performed at 20 weeks or later. Of these nearly half (1418) were performed for "maternal psychosocial indications" - code for abortion on request. The remaining 1686 abortions were performed on children with a confirmed *or suspected* "congenital abnormality", that is eugenic abortions based on a fear of raising child with a disability, a fear often based on inaccurate and discriminatory information about disability. Given a known false-positive rate in the second and third trimester diagnosis of disability of around 8.8% **this means perhaps 150 perfectly healthy babies were aborted in this period out of a mistaken fear that they had a disability**.

In **more than 10% of cases late term abortion resulted in the delivery of a live born baby**. In Victoria from 2009 to 2017 some 332 babies were born alive after a late term abortion and simply left to die.

Is this what we want for New South Wales?

Clause 6 – Abortion of the viable unborn child at any time up to birth: New developments in viability

In November 2017 the journal *Pediatrics* published a case report on "*a female infant resuscitated after delivery at 21 weeks' 4 days' gestation and 410 g birth weight*" possibly the most premature known survivor to date.[5]

According to the case report this little baby girl "*had multiple risk factors for adverse outcome, including prolonged mechanical ventilation, bronchopulmonary dysplasia, and threshold retinopathy of prematurity*." However, she "*achieved discharge from the hospital on low-flow oxygen at 39 weeks' 4 days' gestation and 2519 g*." By "*24 months' and 8 days' chronological age, she achieved cognitive, motor, and language Bayley III scores of 90, 89, and 88, equivalent to 105, 100, and 103 at 20 months 2 days corrected age*."

The authors conclude "*It is known that active intervention policies at 22 weeks' gestation improves the outcome for those infants and it may be reasonable to infer that these benefits would extend, if to a lesser degree, into the 21st week. Ultimately, such limited data exist at this gestational age that* ***the time may have arrived for obstetrical centers to begin systematically reporting fetal outcomes in the 21st week***."

The decreasing age of viability is relevant insofar as Clause 6 would permit the abortion of an unborn child who could be delivered alive and still survive.

It is difficult to see any rational basis for a doctor to perform a deadly assault on **a viable unborn child** while continuing to treat as murder any deadly assault on a child of the same gestational age who has already been delivered alive.

Clause 6 would permit the abortion of any child from 22 weeks through to full term –ending the life of a child who could potentially be safely delivered, and if given appropriate medical care, survive and flourish.

[5] KA Ahmad, "Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation', *Pediatrics*, Nov 2017, http://pediatrics.aappublications.org/content/early/2017/10/31/peds.2017-0103

Clause 6 – Abortion of the viable unborn child at any time up to birth: Abortion of a child capable of feeling pain

Recent scientific findings have established the developing capacity of the unborn child to feel pain well before birth and certainly by 22 weeks of pregnancy.

(1) Pain receptors (nociceptors) are present throughout the unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks after fertilization.

(2) By 8 weeks after fertilization, the unborn child reacts to touch. ***After 20 weeks, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling.***

(3) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.

(4) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioural, and learning disabilities later in life.

(5) For the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli are applied without such anesthesia.

(6) The position, asserted by some physicians, that the unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and analysis provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

(7) The position, asserted by some commentators, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from engaging in vigorous movement in reaction to invasive surgery.[6]

[6] *Pain-Capable Unborn Child Protection Act 2017 (US),* https://www.congress.gov/115/bills/hr36/BILLS-115hr36rfs.pdf

Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain at least by 22 weeks of pregnancy.

Therefore Clause 6, which would authorise the abortion of unborn children capable of feeling pain, should be opposed.

Clause 8 – Conscripting all health practitioners for unlimited abortion

Clause 8 would require a health practitioner with a conscientious objection to abortion **refer** a woman (or "person") requesting an abortion or advice on an abortion to, or transfer her care to, another health practitioner who "*can provide the requested service*" and has no such objection or to a health service provider where the requested service can be provided by another registered health practitioner "*who does not have a conscientious objection to the performance of the*" abortion is **neither necessary or reasonable**.

It is not necessary because no referral is needed under this Bill for an abortion.

"Refer" in normal medical practice is used in relation to referrals to a specialist, either by a GP or by a specialist in another field of medicine. In Australian law there are very specific requirements for referrals under the *Health Insurance Act 1973* and the *Health Insurance Regulations 1975.* It is potentially confusing to be introducing some different meaning of "refer" for the purposes of this Bill. "Refer" is not defined in the Dictionary of this Bill.

A woman who is told by a health practitioner that he or she has a conscientious objection to performing an abortion can very readily seek another practitioner. [Simply googling "abortion clinics New South Wales" will readily display options].

It is unreasonable to expect a health practitioner who has a conscientious objection to abortion **to choose which abortionist or abortion facility to "refer" a woman to** for the purpose of obtaining an abortion. Normally a health practitioner refers a patient in order for the patient to obtain specialist professional care to improve the patient's health.

In the case of abortion, a health practitioner with a conscientious objection to abortion is likely to genuinely believe that he or she has two patients to which a duty of care is owed - the pregnant woman or girl and her unborn child. The only outcome of abortion for the second patient – the unborn child – is death. And, assuming the health practitioner is familiar with the medical literature on abortion and its adverse impacts on women's mental health and on maternal mortality, the outcome for the woman may also be poor, or even deadly. Why should the law impose a duty on a health practitioner to refer his two patients to a health practitioner who would bring about an outcome detrimental to the life and health of those patients?

Additionally, clause 8(1) allows any person to make inquiries to a medical professional about performing an abortion on another person, and require them to disclose conscientious objection. This is clear when the language of clause 8(1) is compared to that in clause 8(3).

Doctors should not be required to disclose their conscientious objection to those who are not seeking any medical treatment. Indeed, a doctor should not be permitted to discuss abortion with anyone other than the person seeking the abortion or their legal guardian.

Clause 8 should be opposed.

Clause 9 – Penalties

Clause 9 suggests that those medical professionals who fail to comply with the requirements of sections 5, 6 and 7 when performing or assisting with an abortion, and those who fail to refer, are all subject to the complaints process under the National Law and the Health Care Complaints Act.

A failure to refer is not equivalent to performing an abortion outside of the permissions in the bill. Any performance of an abortion that does not comply with the bill should remain a crime, not a matter for medical complaints.

Conclusion

Right to Life NSW unashamedly opposes abortion because:

- In every case it is intended to case the death of *one of us* – an unborn human child[7];
- Strong evidence points to the real harms to women and girls from abortion[8].

However, even those who describe themselves as pro-choice should reject this ill-conceived Bill which makes the *pregnant woman invisible* and fails to provide with her any role.

Instead the Bill creates a complete immunity for any doctor to perform any abortion regardless of how viable the unborn child is, whether the pregnant woman has given informed consent or is being coerced by others, of if the abortion is for sex selection to eliminate the girl child.

[7] See *Appendix One: Who is the Unborn Child?* below
[8] See *Appendix Two: Abortion Harms Women* below

Appendix One: Who is the unborn child?

The science of fetology has dramatically improved our understanding of unborn human life. It is no longer possible in the age of 4-D ultrasound and in utero fetal surgery to hold that the fetus is just a bunch of cells or anything other than "one of us", that is a human being.

These are just some facts about the unborn child revealed by recent scientific developments:

- "*Cardiac motion can be visualized using ultrasonography from as early as 26–32 days after conception, and certain aspects of embryonic heart function have been studied using Doppler ultrasonography from 6 weeks of gestation*."[9] At 6 weeks the mean heart rate is 117 beats per minute. At 10 weeks the mean heart rate is 171 beats per minute.[10]

- A motor response can first be seen as a whole body movement away from a stimulus and observed on ultrasound from as early as 7.5 weeks' gestational age. The area around the mouth is the first part of the body to respond to touch at approximately 8 weeks, but by 14 weeks most of the body is responsive to touch.[11]

- By 15 weeks gestation the human fetus has fully developed and functioning taste buds.[12]

- "*Starting from the 14th week of gestation twin foetuses plan and execute movements specifically aimed at the co-twin. These findings force us to predate the emergence of social behaviour: when the context enables it, as in the case of twin foetuses, other-directed actions are not only possible but predominant over self-directed*".[13]

[9] A. Wloch et al. "Atrial dominance in the human embryonic heart: a study of cardiac function at 6–10 weeks of gestation", Ultrasound in obstetrics & gynecology, 2015; 46: 553–557, http://onlinelibrary.wiley.com/doi/10.1002/uog.14749/pdf

[10] A. Wloch et al., "Doppler study of the embryonic heart in normal pregnant women", *Journal of maternal-fetal and neonatal medicine*, 2007, 20:533-9, http://www.tandfonline.com/doi/abs/10.1080/14767050701434747?journalCode=ijmf20

[11] LB Myers et al. "Fetal endoscopic surgery: indications and anaesthetic management", *Best Practice & Research Clinical Anaesthesiology*, 2004, 18:231-258, https://www.sciencedirect.com/science/article/pii/S1521689604000023?via%3Dihub

[12] M. Witt and K. Reutter, "Embryonic and early fetal development of human taste buds: a transmission electron microscopical study", *The Anatomical Record*, 1996, 246:507-23, http://onlinelibrary.wiley.com/doi/10.1002/(SICI)1097-0185(199612)246:4%3C507::AID-AR10%3E3.0.CO;2-S/epdf

[13] U. Castiello et al., "Wired to Be Social: The Ontogeny of Human Interaction", *PLoS One*, 2010; 5, Published online, http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013199

Appendix Two: Abortion harms Women

Abortion is associated with adverse outcomes for women's mental health

There is a substantial body of research indicating an increased risk of mental health problems following an abortion. Not all the specific risk factors have been identified but some of the research has controlled for factors including pre-existing mental health problems and the unwantedness of the pregnancy and found that abortion is an independent risk factor for increased mental health problems.

Longitudinal studies in New Zealand have found a general association of abortion with subsequent mental health problems. In 2006 David Fergusson and colleagues using data from the longitudinal Christchurch Health and Development Study reported that women who had an abortion before age 25 had 1.49-1.72 times the risk of experiencing mental health problems than women who had not got pregnant or who had become pregnant and not had an abortion. Those having an abortion had elevated rates of depression, anxiety, suicidal behaviours and substance use disorders[14]

In 2008 Fergusson and colleagues reported that exposure to abortion was associated by age 30 with a 1.3 relative risk of mental health problems while carrying an unwanted pregnancy to term was not a risk factor for mental health problems. This study effectively ruled out earlier suggestions that the adverse mental health risks seen in women who had abortion were associated with unwanted pregnancy itself rather than with the abortion.[15]

In 2009 Fergusson and colleagues reported that over 85% of women who had an abortion reported at least one negative reaction to the abortion (sorrow, sadness, guilt, grief/loss, regret, disappointment) with 34.6% of women who had an abortion reporting five or six of these negative reactions. For those women with moderate negative reactions (1-3) to abortion this was associated with a 1.43 relative risk of subsequent mental health problems compared to women who did not have an abortion. For those with stronger negative reactions (4-6) the relative risk of subsequent mental health problems was 1.64-1.81.

[14] D Fergusson, L Horwood and E Ridder, "Abortion in young women and subsequent mental health", *Journal of Child Psychology & Psychiatry*, 2006; 47(1): 16-24, http://dx.doi.org/10.1111/j.1469-7610.2005.01538.x

[15] D Fergusson. L Horwood and J Boden, "Abortion and mental health disorders: evidence from a 30-year longitudinal study", *British Journal of Psychiatry* 2008; 193: 444–51, http://bjp.rcpsych.org/content/bjprcpsych/193/6/444.full.pdf

Fergusson concludes that for this population (women under 30) abortion is responsible for approximately 5% of all mental health problems.[16]

A 2016 US study using data from the National Longitudinal Study of Adolescent to Adult Health confirmed previous findings from Norway and New Zealand that, unlike other pregnancy outcomes, abortion is consistently associated with a moderate increase in risk (45%) of mental health disorders during late adolescence and early adulthood.[17]

This study was particularly significant in providing "*some of the strongest evidence to date that the association of abortion with subsequent mental distress is not merely contingent but is indeed causal*".

Abortion increases maternal mortality

Abortion has been found in population wide studies in Finland, California and Denmark to be associated with an increased risk of mortality, in particular a dramatically increased risk of suicide - up to 6.6 times six times higher than that of women who had given birth in the prior year.[18]

[16] D Fergusson. L Horwood and J Boden, "Reactions to abortion and subsequent mental health", *British Journal of Psychiatry* 2009; 195: 420–26, http://bjp.rcpsych.org/content/bjprcpsych/195/5/420.full.pdf

[17] DP Sullins, "Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States*", SAGE Open Medicine* 2016: 4:1–11, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5066584/pdf/10.1177_2050312116665997.pdf

[18] See:
M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000", *European Journal of Public Health*, 2005, 15:459-63, https://academic.oup.com/eurpub/article/15/5/459/526248
M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000", *European Journal of Public Health*, 2005, 15:459-63, https://academic.oup.com/eurpub/article/15/5/459/526248
E Karalis et al., "Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012", http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.14484/abstract
DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women", *Southern Medical Journal*, 2002, 95:834-41, https://sma.org/southern-medical-journal/article/deaths-associated-with-pregnancy-outcome-a-record-linkage-study-of-low-income-women/
DC Reardon & PK Coleman, "Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980–2004", *Medical Science Monitor,* 2012, 18: PH71-76, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3560645/
PK Coleman, DC Reardon and BC Calhoun, "Reproductive history patterns and long-term mortality rates: a Danish, population-based record linkage study", *European Journal of Public Health*, Volume 23, Issue 4, 1 August 2013, Pages 569–574, https://academic.oup.com/eurpub/article/23/4/569/427991

Registry based studies such as the two Danish studies and the early studies from Finland and California are important in gaining **an accurate picture of comparative maternal mortality** following induced abortion and childbirth.

The claim that abortion is safer for women than childbirth is usually based on limited data with many deaths following abortions not identified as such. This claim cannot be sustained in the light of the registry studies which consistently demonstrate that induced abortion, and even more so late induced abortions or repeat abortions, significantly increase the risk of maternal death.

Abortion, properly understood, is never required for the preservation of the mother's life

Cancer treatment to preserve a mother's life even if that treatment may pose a risk to the health, or even the life, of her unborn child is not abortion.

Nor is the early induction of labour for conditions such as severe eclampsia provided (i) there is no direct assault on the unborn child intended to kill it and (ii) on delivery the child be given the same treatment, including resuscitation, as would be given to any child delivered at the same gestational age.

Neither of these scenarios is accurately defined as abortion, which always includes an intention to end the life of the unborn child, or at least recklessness about causing its death.

The Dublin Declaration on Maternal Healthcare signed by over 100 medical professionals, including 245 obstetricians and gynaecologists expresses this approach succinctly:

> *As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman.*
>
> *We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child.*
>
> *We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.*[19]

[19] https://www.dublindeclaration.com/