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INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

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SUBMISSION TO THE NSW STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE *REPRODUCTIVE HEALTH CARE REFORM BILL 2019*

by

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Sydney **13th August 2019**

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Dear Committee Members,

Thank you for your invitation to make this submission, which is undertaken with a caveat: Because of the very short timeline allowed, this is, of necessity, an overview flagging only the most important issues you need to consider in deciding how to vote on the *Reproductive Health Care Reform Bill 2019* and any proposed amendments to it.

The following selected ethical issues raised by the Bill are addressed below. The list is not intended to be and is not comprehensive.

1. Distinguishing ethics and law in relation to abortion
2. Abortion-on-demand up to 22 weeks gestation and after 22 weeks gestation with approval
3. Informed consent to abortion
4. Abortion counselling and conflict of interest
5. Sex-selection abortion
6. Medicalization of abortion
7. The argument that respect for women requires abortion-on-demand
8. Abandoning the Criminal law on abortion
9. Complicity in abortion
10. The impact of legalized abortion on people with disabilities
11. The *Reproductive Health Care Reform Bill 2019* and "Zoe's law"

1. **Distinguishing ethics and law in relation to abortion**

   Abortion is always a moral and ethical issue. It is a separate question, when it should be a legal issue.

   Most Australians are not adamantly pro-Choice, that is, they do not accept the strongest pro-Choice stance that abortion at any stage of pregnancy is a decision solely for the pregnant woman and that the law should never be involved. Nor are most adamantly pro-Life, that is, they do not accept the strongest pro-Life stance that abortion should never be legally allowed. As a 2017 NSW Galaxy Poll evidenced, most Australians are on a spectrum between these two poles.[1]

   For the record, my personal position is that abortion is *always a very serious moral and ethical issue*, but it should not be a legal issue until 12 weeks of gestation because, with the availability of chemical abortion, the law is unable to implement prohibitions on abortion before that time and ineffectiveness brings all law on abortion into disrepute and makes it less likely to be enforced when it could be.

   After 12 weeks gestation, as a society we have an obligation to protect the lives of unborn children and should legally implement this protection. Some exceptions to a general prohibition of abortion after 12 weeks gestation must be allowed. The pregnant woman should be permitted to decide about abortion when, in the extremely rare situation, an abortion is needed to protect her life or avoid a serious threat to her health and in cases of rape or incest.

[1] *What NSW Really Thinks about Abortion* .file:///C:/Users/216112/AppData/Local/Temp/attitudes%20to%20abortion%20NSW%20Galaxy_Research_NSW%20(2).pdf

2. **Abortion-on-demand up to 22 weeks gestation and after 22 weeks gestation with approval.**

   The Bill allows for abortion on demand up to 22 weeks gestation (sec.5) and after 22 weeks with the approval of two "specialist medical practitioners" (sec.6). This 22 week cut-off for abortion on demand is almost double the twelve week time limit many European countries (for instance, France, Germany, the Scandinavian countries, with which Australia can compare itself) would allow[2]

   Some of these jurisdictions allow "late term" abortions – those after 20 weeks gestation - in exceptional circumstances, but with additional requirements, for instance that the fetus be given pain management prior to carrying out the abortion (there is general agreement that, at the latest, the fetus is pain sensitive at 20 weeks, although a few researchers place this date as early as nine weeks and many more at 13 weeks).

3. **Informed consent to abortion**

   Some jurisdictions require in relation to all abortions that the woman be shown an up-to-date ultrasound of the fetus before proceeding with an abortion, others require a "cooling off" period. *Apart from other reasons for these requirements, they are necessary, but not sufficient, to obtain the woman's fully informed consent to an abortion, which the Bill demands (sec. 5(2)). Yet the Bill contains no such safeguard provisions, rather leaving the decision to provide access to abortion, even after 22 weeks, that is, post-viability of the fetus, to the wide-open discretion of two "specialist medical practitioners".*

   For the same reason of obtaining informed consent, the woman should, as the Bill recognizes for at least some, but not all, women (sec.7), have access to professional counselling. But yet again whether to offer this is left entirely to the doctor's discretion. This counselling should be available independently of an abortion clinic and should be government funded.[3]

[2] https://www.france24.com/en/20180525-abortion-laws-vary-eu-ireland-malta-poland-termination

[3] For a detailed description of a case showing a serious failure of such counselling see Appendix A.

Research, including some by researchers who are pro-Choice, has shown that there are serious mental and physical short term and long term risks associated with abortion of which many women are not aware. It is imperative that women have these material risks explained to them before they decide whether to undergo a termination.

Moreover, informed consent requires more than the pregnant woman being given all the necessary information; it is about the pregnant woman 'appreciating' what that information means – the sort of knowing that has affective impact and which also can have a bearing on the 'freedom' of her consent.

The NSW Bill expressly requires that informed consent to abortion must be free and voluntary (Bill, Schedule 1 Definitions) that is free of coercion, duress or undue influence. Anecdotally, in my experience many women feel very pressured to have an abortion, often by a male partner or husband who does not want to father a child.[4]

4. Abortion counselling and conflict of interest

Providing abortion can also involve a conflict of interest for doctors who work in abortion clinics. A conflict of interest exists when a person has conflicting objectives, no matter what the decision they make proves to be. Doctors have "a primary ethical obligation of personal care to each patient", which requires putting the patient's "best interests" first. An abortion clinic's commercial goals can be in conflict with this obligation, which places the doctor in a conflict of interest, even if the doctor does put the patient's "best interests" first. In short, the presence of potentially

[4] See Margaret Somerville, "The profound complexities of informed consent to abortion", *Ottawa Citizen* March 23, 2012, p. A12 http://www.ottawacitizen.com/news/profound+complexities+informed+consent+abortion/6343930/story.html#ixzz1pwd6uzIC Also published as: "Abortion Regulation. Putting the information into "informed consent"", *MercatorNet,* Tuesday, March 27, 2012 http://www.mercatornet.com/articles/view/putting_the_information_into_informed_consent) This article is attached as Appendix A for your convenience.

conflicting interests in itself constitutes a conflict of interest, not just a decision which breaches a primary obligation. This is yet another reason why counselling of a woman contemplating an abortion is required to be independent of abortion providers.

5. Sex-selection abortion

The Bill "Notes that this House opposes terminations for the sole purpose of gender selection" (sec. 15(1)) and provides for a "Review in relation to gender selection" within 12 months of commencement of the Act (sec. 14).

The Bill uses the term "gender selection" which is incorrect. Its warning is about sex-selection – sex is an immutable biological characteristic, gender is a culturally assigned identity. But it is difficult to know how sex-selection could be avoided as the Bill is currently drafted: if a woman can have an abortion for any reason "no questions asked", why not because she – or her husband or her mother-in-law[5] - wants a child of the opposite sex, usually a boy, to the one with which she is pregnant, usually a girl?

Pro-Choice feminists originally opposed sex-selection abortion labelling it "female feticide" or even genocide, but more recently some have dropped their opposition not wanting to approve of any restrictions on the woman's right to choose abortion.[6] This phenomenon is true in Canada, where I lived for 41 years before recently returning to Australia. As a result of a Supreme Court of Canada ruling in 1988 that the then-current abortion law in the Canadian *Criminal Code*[7] was unconstitutional[8] and since that time the Canadian Parliament failing to enact any new legislation, abortion is legal up until the woman gives birth. The same possibility exists under the NSW Bill, as currently drafted, as two "medical specialists" can approve post 22 week abortions.

[5] I have been consulted by a pregnant woman from an ethnic community with a strong preference for male children, whose mother-in-law was demanding that she abort a female fetus.

[6] Margaret Somerville*, Bird on an Ethics Wire: Battles about Values in the Culture Wars*, Montreal: McGill-Queen's University Press, 2015, 179-82

[7] *Criminal Code* R.S.C., 1985, c. C-46

[8] *R* v *Morgentaler*, [1988] 1 SCR 30

There has been an increasing number of proposals in the academic literature for allowing so-called "after-birth abortion". The argument is that if a baby is born with disabilities which, had the parents known of them before birth they would have opted for abortion, they should have the right to have the baby euthanized, that is, infanticide should be legalized.[9] In a Canadian case of the death of a newborn baby whom the mother had abandoned the judge reasoned that abortion was not a crime and this situation was similar to abortion and hence a very light penalty was appropriate.[10]

In short, with the normalization of abortion, "logical slippery slopes" – that is, expansion of the conditions in which abortion is legal - and "practical slippery slopes" – that is, the law is not strictly interpreted or applied or is clearly breached - are unavoidable.

As well, the normalization of abortion, especially the attitude "it's no big deal" or "it's just a bunch of cells" some pro-Choice advocates espouse, can have a harmful impact on women who want a child, but suffer involuntary miscarriage. They are not given the support and empathy that they need and deserve for the reproductive loss they have suffered.

6. Medicalization of abortion

Aiding in the normalization of abortion is that the procedure is based in medicine. In the vast majority of cases, however, it's not a medically required treatment. The Bill makes abortion an entirely medical intervention and enacts a very wide area of discretionary decision making by doctors with regard to access to and provision of abortion. Consequently, because most people assume that doctors do not engage in unethical conduct, abortion is simply assumed to be ethical.

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[9] Alberto Giubilini and Francesca Minerva, "After-birth abortion: why should the baby live?" *Journal of Medical Ethics* http://dx.doi.org/10.1136/medethics-2011-100411

[10] Margaret Somerville, *Bird on an Ethics Wire: Battles about Values in the Culture Wars*, Montreal: McGill-Queen's University Press, 2015, 216-217.

7. Argument that respect for women requires abortion-on-demand

Pro-Choice advocates, among whom are many feminists, have designated the legalization of abortion-on-demand as the litmus test of whether women are respected by a society. But one can be a feminist and pro-Life, as, indeed, increasing numbers of young people are showing. Surveys in Canada reveal that they are more conservative than their parents with respect to the ethical acceptability of abortion. These pro-Life supporters have often faced threatening opposition on university campuses, sometimes ending up in court to defend their rights of freedom of speech, expression and association.

8. Abandoning the Criminal law on abortion

The Bill will decriminalize abortion. We protect our most important shared values, the ones on which we found our society, in the Criminal Law. One of those values is respect for human life, which operates at two levels: respect for every individual human life and respect for human life in general, at the societal level. Just the fact of taking abortion out of the *Crimes Act 1900* will affect and harm these values and their protections.

An alternative approach would be to amend the *Crimes Act* by way of allowing exceptions to the prohibition of abortion and articulating more precisely, for greater certainty, the conditions in which abortion would not be an offence.

9. Complicity in abortion

With respect, I find sec. 9 of the Bill, “Registered health practitioner with conscientious objection”, incomprehensible. But having seen such provisions before, I’m assuming that the Bill requires that doctors who have conscientious or other objections to abortion must refer a women wanting an abortion to a doctor who does not have such objections. Such provisions are often called a requirement of “effective referral”. They are a breach of

the doctor's right to freedom of conscience and for religious doctors, in many cases, their freedom of religion. This is, as human rights lawyer and Jesuit priest, Frank Brennan has stated, "ideological totalitarianism" and very likely to be treated as a call to civil disobedience by doctors affected by it. And what if the doctor thought that an abortion would be a risk to the woman's health, would she still be required to refer the woman to a doctor wiling to carry out an abortion, that is, to practice what she and other competent doctors would regard as medical malpractice?

The problem for a conscientiously objecting doctor is that providing an "effective referral" constitutes complicity in the act of abortion to which the doctor conscientiously objects and which for that doctor is morally and ethically wrong. The companion legal doctrine is "being a party to an offence", when the accused is liable for an offence carried out by another person, but in which they were only indirectly involved. Stark examples can be found: For instance, in a relatively recent Nazi war crime trial in Germany, the now nearly one hundred year old accountant, who kept the register of the valuable items taken from Jewish victims brought to the Concentration camps was held to be guilty of a war crime for his complicity in the Nazi horrors.

10. Impact of legalized abortion on people with disabilities

The most likely situation in which after 22 weeks gestation abortions would take place are when the fetus is diagnosed with a disability or what is perceived as an aberration from what we regard as "normal". For instance, in North America over 85 percent of unborn children diagnosed in utero with Trisomy 21 (Down syndrome) are aborted.

What message does this send to people with Down syndrome and their families and to all people with disabilities or who are vulnerable, such as fragile elderly people? Do we not want them to be members of our society? For example, a headline in a Danish newspaper declared "Plans to Make Denmark a Down Syndrome Free Perfect Society", which explained that the society "will be perfect by 2030 because they will have no people with

Down syndrome."[11] Is this telling people with Down syndrome they have lives not worth living, that they are "better off dead", or perhaps that they are too heavy a burden on the rest of us?

As this example shows, as a society how we decide to deal with abortion is not an isolated issue or one affecting just individuals, it will have far reaching consequences well beyond its immediate impact on women wanting an abortion and their unborn children.

Other wider spectrum issues raised, especially by late term abortion, include how fetal remains are dealt with: Are they used in research? Are they ever employed in transplantation medicine? Is there any commercial activity, such as manufacturing cosmetic products, involving them?

I would urge you to keep these wider issues in mind in deciding about your vote in regard to the *Reproductive Health Care Reform Bill 2019.*

11. The *Reproductive Health Care Reform Bill 2019* and "Zoe's law".

Finally, a debate has been sparked by the Bill on so-called "Zoe's law": Zoe was a 32 weeks gestation fetus killed by the criminal negligence of a driver on drugs. *The News Daily* reports that "NSW Premier Gladys Berejiklian will warn MPs the decriminalisation of abortion must be "settled" before she can act on tough new penalties for the deaths of unborn babies from criminal acts including domestic violence. ...*The New Daily* understands that the Premier believes the laws can only be advanced when the abortion question is settled".[12] Pro-Choice advocates have long opposed laws establishing criminal liability for harming an unborn child, fearing that recognition of an unborn child as the victim of a crime could make people more opposed to abortion.

[11] Scancomark.se Team, 17 July, 2011)

[12] *The New Daily*, 13th August 2019, https://thenewdaily.com.au/news/national/2019/08/12/abortion-nsw-brodie-donegan/?utm_source=Adestra&utm_medium=email&utm_campaign=Morning%20News%20-%2020190813

> So now we are being asked to accept that abortion-on-demand should be legalized, but that killing unborn babies in association with a criminal offence is a serious crime. At first blush this seems grossly inconsistent. The informing principle connecting the two possibilities is that if the pregnant woman wants the unborn baby and it's wrongfully killed, it will be a crime, but if she doesn't want that unborn baby, it will be legal. Are there any other situations involving the taking of human life, where the verdict of whether or not a criminal offence has been committed depends solely on the wishes of one other person?

Personal experience from a jurisdiction with no law on abortion

As mentioned already, I lived in Canada for 41 years. I was appointed as Samuel Gale Professor of Law and Professor in the Faculty of Medicine at McGill University in Montreal[13]. I was frequently consulted on ethical issues, including those raised by abortion. I would like to briefly describe three of those cases without identifying the people involved for reasons of respect for privacy.

In Canada, it was nearly impossible to obtain statistics on late-term abortions, but there are probably at least a hundred each year. Many pro-Choice advocates claim, however, that late-term abortions do not occur or, if so, only for exceptionally serious reasons, But two cases on which I was consulted contradict that claim.

The first case involved a married woman who wanted a baby and intentionally became pregnant. A scan at 34 weeks gestation showed that the baby had a "cleft palate" – a congenital split in the roof of the mouth which is not uncommon and can be repaired with routine surgery. The woman and her husband declared that they "did not want a 'defective baby'" and the child was aborted.

The second case concerned a 27 year old PhD student from the Middle East, who was 32 weeks pregnant. The student's boyfriend was the father. The student came from a very conservative religious Muslim family where even having a

[13] A "one page bio" is attached as Appendix B, by way of introducing myself.

boyfriend would not have been allowed, let alone engaging in sex. The student and the baby were both healthy. The baby was aborted.

Both these cases raise the issue of whether legal abortion should be limited to allowing the woman to evacuate her uterus or whether it also should allow death to be intentionally inflicted on a viable child.[14] The decision in this regard will determine the nature of the abortion procedure that is used. On the one hand, early labour would be induced and the baby delivered and cared for. On the other hand, the baby would be killed in utero and delivered whether intact or dismembered. This can be a traumatic experience for the healthcare professionals involved, including medical students. Likewise, as sometimes happens, delivering a living baby that was meant to be dead can cause anguish. Horrible stories of such babies being left to die unattended in sluice rooms are reported.

Another case on which I was also consulted shows the unique and difficult ethical issues that can arise in the context of in utero human life and abortion. The married parents had a 5 year old daughter with medically difficult to manage Type 1 diabetes. They wanted to use IVF to create a genetically compatible "saviour sibling", which would be aborted at five months gestation and the fetus's pancreas transplanted to the 5 year old daughter. Their request for this procedure was denied on ethical grounds.

Conclusion

I hope that you will vote against this Bill or at the very least require major amendments. In deciding, remember that we are all ex-fetuses and our lives were protected by the ethics and law governing abortion up to the present time. In deciding how to change those ethics and that law, you, as our lawmakers, need to consider deeply what we, as a society, owe to present and future unborn children with respect to protection of their lives.

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[14] Margaret A Somerville, "Reflections on Canadian Abortion Law: Evacuation and Destruction, Two Separate Issues" (1981) 31:1 *University of Toronto Law Journal* 1-26 (Selected for referencing in *Sociological Abstracts*, May 1981.)

Finally, what would be the impact of legalizing abortion as proposed in The *Reproductive Health Care Reform Bill 2019* on the shared values that bond us as a society and set its "ethical tone"? It's wisely said that *"We can't judge the ethical tone of a society by how it treats its strongest, most privileged, most powerful members, but by how it treats its weakest, most vulnerable and most in need".* Unborn children belong to the latter group.

I would be happy to follow up in more depth with respect to any matters on which you would like more information.

Respectfully submitted,

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Sydney

13th August 2019

APPENDIX A

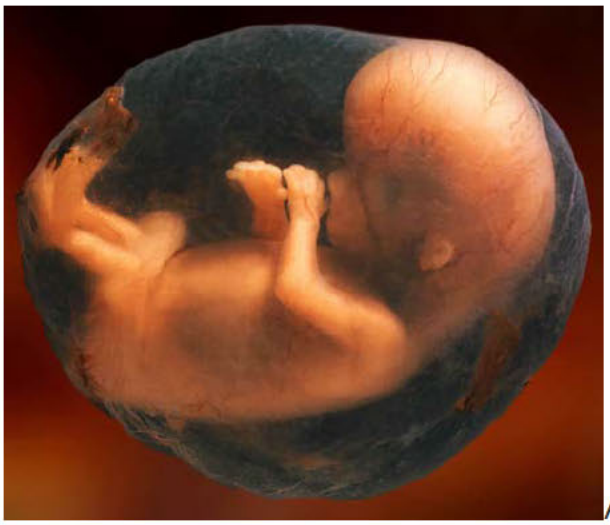
Mercatornet

ABORTION REGULATION

Putting the information into "informed consent"

When a woman approaches an abortion clinic it does not always mean she wants a termination.

Margaret Somerville | Mar 27 2012 | 15



Anna (not her real name) came to see me to discuss the research she was doing on abortion. We talked about the articles she'd read, when I asked her, "How did you become interested in this topic?" She hesitated, then said, "I've just had an abortion, and I'm terribly upset and I'd like to tell you about it." Her story is tragic.

Anna explained, “Everyone in Quebec thinks that abortion is normal; nothing to fuss or be upset about; the obvious and easy solution to an unplanned pregnancy.” But, when she unexpectedly found herself pregnant, she didn’t feel that way and sought support to continue the pregnancy. Everyone told her, however, to “get on with it” — have an abortion.

Anna first asked her mother whether she would help her if she had the baby. Her mother flatly refused, saying, “I do not want to waste my life babysitting.” Her male partner said he “wasn’t interested in a kid” and their relationship has since broken up. She tried to get an appointment with her gynecologist to discuss her options, but the first available one was two months away. She then contacted an abortion clinic, which gave her an appointment in two weeks, at which time Anna was nine weeks pregnant. She said, “I went to them to get information on abortion, to know more about my options, the consequences of an abortion. I was open to getting an abortion, because that was what everyone around me recommended I do. I saw abortion as an option, but was really not sure. I was hoping for some answers.”

Anna met, first, with a nurse for a “consent interview.” She said, “The nurse told me that at this stage of the pregnancy the fetus is just a bunch of cells. I also asked her if the abortion would have any impact on my health, my future pregnancies, and so on. She said abortions had no impact at all, no consequences at all, that all that I had read (to the contrary) were myths. The nurse said, ‘In two weeks, it will be as if all this never happened’.”

Anna changed into a hospital gown and was taken into an examination room where a technician proceeded to do an ultrasound. Anna asked what the fetus looked like and could she see the ultrasound. She said, “The technician told me she was not allowed to show me the images and I was unable to see the screen,” which showed the fetus. At nine weeks gestation (pictured), it would have had a beating heart. The technician then picked up the printout of the ultrasound, but dropped it on the floor. She scrambled to gather it up quickly, saying, “You don’t want to see this.” But that’s exactly what Anna did want.

Anna says she was left “waiting alone in a little room in the blue gown,” before a nurse took her to the operating room, “where they gave me the sedative injection. At that point I was just crying, I was just thinking of all the reasons people told me I had

to get the abortion, and that I did not have any help anyways, so I was crying. The doctor asked me if I was here on my own will and I said, 'Yes', while crying. So they gave me a double dose of sedative to calm me down. At that point, I felt it was pointless to protest further and that I couldn't back out at that stage and would just have to go ahead." So, she closed her eyes and let the abortion proceed.

Anna said that "the attitude in Quebec, that 'of course you should have an abortion, it is of no consequence', is not true." She explained, "I feel terrible. I can't go to work. I've started seeing a psychologist. I feel guilty." She mused, "I wonder why Quebec is like this."

So, what ethical and legal issues does this case raise?

First, whether we are pro-choice or pro-life, we should all agree that women do not have a free choice unless there are easily accessible, adequate support systems for continuing a pregnancy, as Anna says she wanted to do. She explained that she's 32 years old and believes having a child is a fundamental life experience for a woman and, now, she may not have that experience.

We discussed how she felt her choice was between the baby losing its life or her "losing her life," because no one would give her any support that would enable her to complete her studies and start a professional career, and she "just couldn't do everything that would be necessary alone." She queried why, each year, we spend so much taxpayers' money on bringing 50,000 immigrants to Quebec, but not supporting the pregnant women among the 30,000 who have an abortion, who, with support, would choose to have their babies.

It's a serious fault on our part, as a society, not to provide such support, which should include easy access to free counselling independent of abortion facilities, as is being proposed in Britain. Keep in mind that abortion clinics are a for-profit undertaking selling a "service".

The second issue is whether Anna gave her free and informed consent to an abortion. Ethically and legally, as the Supreme Court of Canada has ruled, informed consent requires that a person be given "all the information that would be material to a reasonable person in the same circumstances" in making a decision whether to

undergo any given medical procedure. This requires that the harms, risks and benefits of the procedure, and its alternatives, including doing nothing, are disclosed.

The law in some American states requires that women contemplating an abortion must be shown or, at the least, be offered the opportunity to see an ultrasound image of their fetus, as part of the information necessary to obtain their informed consent. We can contrast this requirement with a recent Canadian proposal to prohibit disclosing the sex of a fetus, which showing them an image of it would likely do, until after 30 weeks gestation to try to avoid sex-selection abortions.

Informed consent is not present if the information is inadequate — that's medical negligence (malpractice). And even non-material information must be disclosed if it is raised by a person's questions, which must be answered honestly and fully. Anna's request to see the ultrasound image is relevant in this latter respect. Consent is never present where intentionally false information is given, especially when it involves consequences and risks — indeed, this can give rise to the legal wrongs of battery and assault. Anna believes, as I do, that her experience at the abortion clinic raises issues with respect to all of these requirements.

Informed consent also requires that the consent be voluntary, that is, not affected by coercion, duress or undue influence. To help ensure the consent is "free", some American states legally require a "cooling off" period between deciding to have an abortion and its being carried out. Even assuming Anna's consent was present initially, because consent is an ongoing process, not a one-time event, the voluntariness of her continuing consent is questionable in the circumstances existing at the point at which she was given sedation. Consider, as an analogy, if Anna had consented to sexual intercourse in similar circumstances, would her consent have been sufficient for the other party to avoid a charge of sexual assault (rape)?

And, one of the most pernicious myths propagated in relation to abortion — one that we can see in the nurse's reassurance to Anna that in two weeks she will have forgotten about all of this — is that abortion will restore the woman to a situation as if the pregnancy never occurred. That is impossible, as many women like Anna come to realize too late.

Anna speaks about her consent in this way: "In that time of my pregnancy I had a lot of nausea and was on a real hormonal roller coaster. The difference between my

decision process in my ‘normal’ state and that ‘state’ are two worlds. I think that when a woman is pregnant, from my experience, she is much more vulnerable, and thus can be ‘pushed around’ more easily. This should be taken into account when a clinic is looking to have consent from a pregnant woman.”

I showed this article to Kathleen Gray from the Centre for Reproductive Loss in Montreal. She responded: “Anna’s story is so familiar, as we have heard many similar tragic stories over 20 years of counselling post-abortive women. These elements could apply to hundreds of women, especially the serious problems concerning the information they are both given and denied. Sadly, Anna’s story is not unique.”

As this case shows, abortion is not the simple quick-fix solution to an unplanned pregnancy that it’s often presented as being. It’s a life-affecting decision in more ways than one. Anna’s comment on reading this article, which I publish with her permission, was, “Thank you for this. I hope (the loss of) a life and my own suffering will help others.”

Margaret Somerville *is director of the McGill Centre for Medicine, Ethics and Law. This article was first published in The Ottawa Citizen.*

http://www.mercatornet.com/articles/view/putting_the_information_into_informed_consent)

APPENDIX B

BIOGRAPHY

Margaret Somerville

Margaret Anne Ganley Somerville is Samuel Gale Professor of Law Emerita (the first woman in Canada to hold a named Chair in Law), Professor Emerita in the Faculty of Medicine and the Founding Director Emerita of the McGill Centre for Medicine, Ethics and Law at McGill University, Montreal, where she taught from 1978 to 2016, when she returned to Sydney to become Professor of Bioethics in the School of Medicine at The University of Notre Dame Australia. She plays an active role in the world-wide development of applied ethics, in particular, the study of the wider ethical and legal aspects of medicine and science.

Professor Somerville graduated, with distinction, in Pharmacy from the University of Adelaide (1963); in Law, with First Class Honours and the University Medal, from the University of Sydney (1973); and was awarded a Doctorate in Civil Law by McGill University (1978). She has received Honorary Doctorates in Law from the University of Windsor, Ontario (1992); Macquarie University, Sydney, Australia (1993); St. Francis Xavier University, Antigonish, Nova Scotia (1996); the University of Waterloo, Waterloo, Ontario (2004); and The Royal Military College of Canada (2013); an Honorary Doctorate in Science from Ryerson University, Toronto, Ontario (2006); an Honorary Doctorate in Humane Letters from Mount Saint Vincent University, Halifax, Nova Scotia (2009); and an Honorary Doctorate in Sacred Letters from Saint Mark's College at the University of British Columbia, Vancouver, British Columbia(2010) .

She was elected a Fellow of the Royal Society of Canada in 1991. She is the recipient of many honours and awards, including the Distinguished Service Award of the American Society of Law and Medicine (1985); the *Pax Orbis ex Jure* Gold Medal of the World Jurist Association for support and dedication to the cause of world peace through law (1985); the Order of Australia (1990) in recognition of her international contribution to law and bioethics; the Arthur Kroeger College Award for Ethics (2002); was chosen by an international jury as the first recipient of the UNESCO Avicenna Prize for Ethics in Science (2003); awarded the Queen Elizabeth II Diamond Jubilee Medal in recognition of important contributions to achieving excellence in higher education in Canada (2013); and the Jean Echlin Award for Ethics in Palliative Care (2014).

Professor Somerville has an extensive national and international publishing and speaking record. She has wide experience in communicating with large audiences, especially through television and radio, on topics that raise complex legal and ethical problems for society and has been frequently involved in such work in Canada, Australia and abroad**.** She is deeply committed to the public's right to be involved in the decision making shaping our society. To this end, she authored *The Ethical Canary: Science, Society and the Human Spirit (2000), Death Talk: The Case against Euthanasia and Physician-Assisted Suicide (2002) (2nd edition 2014);* and *Bird on an Ethics Wire: Battles about values in the culture wars" (2015).* In 2006 she delivered the CBC Massey Lectures, *The Ethical Imagination: Journeys of the Human Spirit,* published as a book by House of Anansi Press (2006). She has edited *Do We Care? Renewing Canada's Commitment to Health,* Proceedings of the first Directions for Canadian Health Care conference; and co-edited *Transdisciplinarity: reCreating Integrated Knowledge.*

Professor Somerville has been a consultant on a broad range of topics to governments and non-governmental bodies, including the Global Programme on AIDS of the World Health Organization, UNAIDS, the United Nations Human Rights Commission in Geneva, and law reform commissions in Canada and Australia. She has been a keynote speaker at UNESCO conferences in Paris, Barcelona and Tehran and has been Vice President of the Canadian Commission for UNESCO's *Sectoral Commission on Natural and Social Sciences.* In 2005, she undertook a lecture tour of Iranian universities and was a chairperson at the World Jurist Congress in China. She was the founding Chairperson of the National Research Council of Canada Ethics Committee and has served on many clinical and research ethics committees, and many editorial boards, advisory boards and boards of directors, including the Canadian Centre for Ethics in Sport, WADA (World Anti-Doping Authority) ethics committee, NWMO (Nuclear Waste Management Organization) ethics committee, and the American Society of Law, Medicine and Ethics. She was a director of the Beaverbrook (Canadian) Foundation and the Molinari Foundation until she left Canada in 2016.

Her work has included research, speaking engagements and consultation on ethical and legal issues related to euthanasia; pain management; genetics and genomics; reproductive technologies; biotechnology; transhumanism and artificial intelligence; ecosystem health; aging populations; mental health and mental disability; human rights in health care, including in a global context; the pharmaceutical industry; public health; health care systems; medical malpractice; human medical research; animal research; AIDS; abortion; the allocation of medical resources; and the role that scientific and medical research and technology play in formation of societal values and the societal paradigm.