Submission No 17

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Christian Medical and Dental Fellowship of Australia

Date Received: 13 August 2019

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TRANSFORMING HEALTHCARE ™

12 August 2019

Attn: **The Hon Shayne Mallard MLC**
Chair
Standing Committee on Social Issues
Parliament of New South Wales

Dear Mr. Mallard,

Re: Reproductive Health Care Reform Bill 2019
Submission by the Christian Medical and Dental Fellowship of Australia

Thank you for the opportunity to express our concern about the content and process of the Reproductive Health Care Reform Bill 2019 (the bill). We are an organisation representing a significant number of Australian doctors and dentists, with members in every state.

Abortion is a serious issue and we are concerned that its legislation has been addressed in such a superficial and rushed manner. It is a common procedure, it being estimated that there is one abortion for every 2.8 births in NSW, and that one in three Australian women will have an abortion in their lifetime. While we approve of limited decriminalisation of abortion, we do not approve of the lack of concern for both the mother and child which is reflected in the current content of this bill, nor the disregard for conscientious objection of healthcare professionals. We believe that a full committee inquiry should be held to investigate the requirements of women who have an unwanted pregnancy, including support for women who do not want to abort as well as abortion legislation, as a significant public health issue.

Abortion is a highly emotive issue in our community, which is understandable as it involves the killing of a vulnerable human being. As healthcare professionals, we have firsthand experience of this process and have seen the distress that this situation creates. We believe we have important insights into the process which can contribute to the deliberations of members of parliament. We will make some general comments, then specific comments on the current bill.

What does abortion involve?

Despite the extensive discussion in parliament so far, there has been little explanation of what is involved in abortion procedures. The seriousness of these procedures is at risk of being overlooked, along with the potential complications, which explain why it is so important that safety of the woman involved be protected by this legislation.

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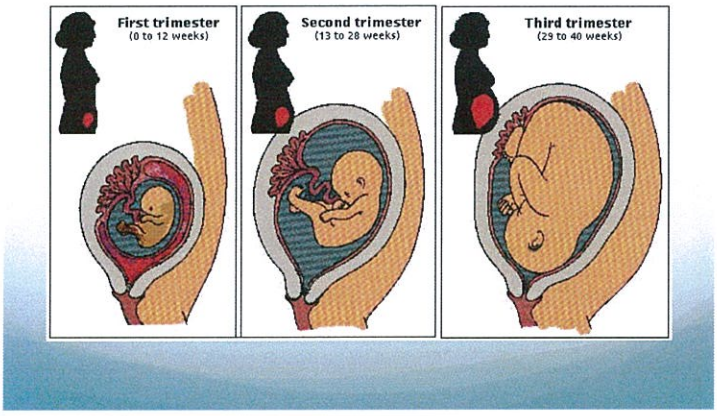
What does abortion involve?



Abortions can be medical, where medication is used to end a pregnancy, or surgical, where implements are used. Medical abortions can involve a number of different drugs:

- Mifepristone (RU-486). This drug is usually used in the first trimester (3 months) of pregnancy. While its action is not fully understood, its main action is by blocking the hormone progesterone in the uterus (womb). This interrupts the functioning of the placenta, so it produces less of the hormones needed to support the pregnancy. This leads to degeneration of the uterine lining and other changes, so that the woman's body shuts down the preparation of the uterus for the pregnancy. This disrupts the development of the child, and, in combination with the drug misoprostol, causes it to be expelled from the woman's body.
- Prostaglandin. This drug can cause abortion in a method similar to mifepristone.
- Methotrexate. This is a drug also used for cancer chemotherapy. It works by inhibiting the growth of the placenta, which is the 'support system' for the baby. The placenta stops functioning, hormones required to support the pregnancy therefore are not produced, and the baby stops developing. With the addition of misoprostol, the child is subsequently expelled from the uterus.

The technique used for surgical abortion depends on how far the pregnancy has developed.

- Suction curettage/vacuum curettage. This if the most common procedure, performed during the first **6 to 16 weeks gestation**. It involves dilating the cervix by inserting rods of increasing size to open it up, then a plastic tube is inserted into the uterus. The fetus and placenta are sucked out using a high-power vacuum. The walls of the uterus are then scraped with a curette to ensure that everything has been removed. Side effects can include cramping, nausea, sweating, and feeling faint. Less frequent side effects include possible heavy or prolonged bleeding, blood clots, damage to the cervix and perforation of the uterus. Infection can cause fever, pain, abdominal tenderness and possibly scar tissue.

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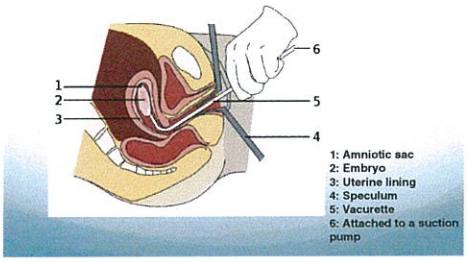
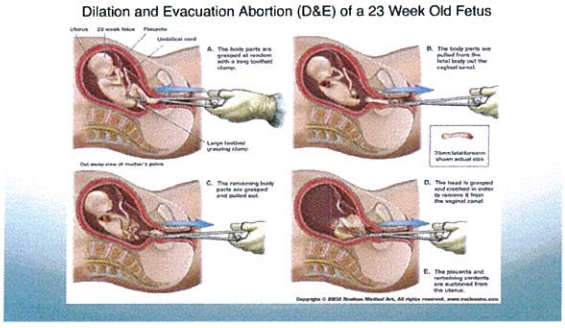
Vacuum aspiration or suction curettage



Dilation and evacuation. This technique is used after 14-15 weeks. The cervix is dilated as above, then instruments are used to crush and remove the fetus piecemeal. A combination of forceps, suction and curettage is often used. Common side effects include nausea, bleeding, and cramping which may last for two weeks following the procedure. Although rare, the following are additional risks related to dilation and evacuation: damage to uterine lining or cervix, perforation of the uterus, infection, and blood clots.

Dilation and Evacuation



Intact dilation and extraction. After 16 weeks gestation, this method can be performed. Labour is induced, as in a normal birth, and the cervix is primed to dilate. The doctor rotates the fetus so the head is under the woman's ribs. The body of the fetus is drawn out feet first, until only the head remains inside the uterus. The doctor can then use an instrument to puncture the base of the skull, which collapses the fetal head. Typically, the contents of the fetal head are then partially suctioned out, which results in the death of the fetus and reduces the size of the fetal head enough to allow it to pass through the cervix. The dead and otherwise intact fetus is then removed from the woman's body. This procedure is also known as 'partial-birth abortion'. The side effects are the same as dilation and evacuation. However, there is an increased chance of emotional problems from the reality of more advanced fetal development.[1]

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[1] Compiled using information from the following sources: "Induced Abortion." The American College of Obstetricians and Gynecologists. 2001; Paul M, et al. (1999). A Clinician's Guide to Medical and Surgical Abortion. New York: Churchill Livingstone; Creinin MD, et al. (2001). Medical management of abortion. American Journal of Obstetrics and Gynecology Practice Bulletin, no. 26, pg.1-13.

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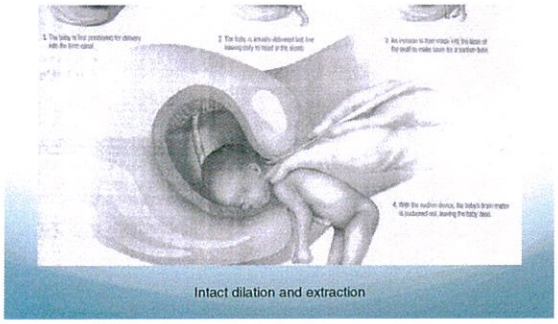
Late term abortion



Obviously, these procedures are distressing for both mother and child. We therefore make the following recommendations:

Need for counselling before and after the procedure

Abortion is consistently associated with elevated rates of mental illness compared to women without a history of abortion. The abortion experience directly contributes to mental health problems for at least some women and there are risk factors, such as pre-existing mental illness, that identify women at greatest risk of mental health problems after an abortion.[2]

The Royal Australian and New Zealand College of Psychiatrists recommends counselling pre- and post-termination of pregnancy (TOP). This is most recently articulated on its website in a letter to the Queensland Parliament's Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee in regard to the Termination of Pregnancy Bill 2018. Letter is Attachment 1, see excerpt below:

It is essential that women accessing termination services are offered pre- and post-counselling and support. Counselling should be affordable and accessible for all women. Some women will have particular care needs, including Aboriginal and Torres Strait Islander women, women who undergo terminations for foetal abnormality, women with serious mental illness and very young women. Accessible, affordable and appropriate mental health services are particularly important for these groups.
We note that the Bill is silent on these matters, and agree that counselling or psychiatric assessment should not be mandated for women accessing termination of pregnancy services. However, we urge the Queensland Government to ensure that there are adequate services to support women at every stage along the process, including those considering termination and following a termination. The RANZCP QLD Branch advises that counselling or other mental health support should be offered to all women accessing termination of pregnancy services. The 2013 Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of

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[2] Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med. 2018; 6:2050312118807624.

Pregnancy provides useful practice points for providing psychological support in the care of women requesting and accessing termination of pregnancy services.

The Clinical Guideline mentioned here, including the most current online version, gives the following advice regarding the care of women requesting and accessing termination of pregnancy services.

Table 13. Information and counselling

Aspect	Good practice points
Information	• Support the decision-making process by providing accurate, impartial and easy to understand information[3] including[16,17]: o Options to continue the pregnancy and parent the child o Options to continue the pregnancy and place the child for foster care/adoption o Information about methods of termination[17] o Post-termination considerations including contraceptive options and counselling support o Discuss birth registration requirements
Counselling	• Offer confidential, non-judgemental support and counselling[3,18,19] • Counselling should be provided by someone (e.g. social worker, psychologist, counsellor) who: o Is appropriately qualified and/or trained[3] o Is familiar with the issues surrounding termination o Has no vested interest in the pregnancy outcome[16] • Where feasible, offer counselling 'close to home' to aid the establishment of longer term counselling support • Consider the requirement for formal mental health referral especially if there is a history of mental illness[20]

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists also recommends counselling for women considering abortion. In their current document *Abortion C-Gyn 17 (2019),* they state that women should have access to professional counselling if required by patient choice. (Recommendation 2, page 3).

The availability of professional counselling can only be ensured if it is mandatory that abortion providers make it available. It needs to be offered to every woman requesting abortion, not merely considered by the medical practitioner, both before and after the procedure.

Clause 7 therefore needs to be amended to replace the need for assessment by the medical practitioner, to provision of counselling.

Need for fetal analgesia

Evidence suggests that the foetus is capable of sensory perception during mid-trimester. By then structures involved in pain perception have developed and babies have been shown to respond to stimuli. Surgeons operating on foetuses while still in the womb, routinely employ analgesia and anaesthesia. Procedures for termination, explained above, can involve piercing the skull and actual

dismemberment of the body to facilitate removal. Pain relief is humane, and, as with administration of all drugs, full explanation should be shared with the mother. [3]

Need to ensure safety of viable foetuses

We have members who have witnessed the birth of babies who are still alive after terminations and who are then left to perish. This is an inhumane practice with widespread effect on staff. It raises the likelihood that in one birthing room an otherwise viable baby is left to perish, while in the next, an emergency call summons staff to resuscitate.

It is well known that some foetuses survive the abortion process. Evidence includes:

- Excerpts from the West Australian Parliament Hansard where the Hon Nick Goiran has requested information regarding the number of live births following abortion procedures in that state. Many reports exist, please find Attachment 2 which records a speech from 19 September 2018 which begins as follows:

We know from answers to parliamentary questions that between July 1999 and December 2016, 27 Western Australian babies were born alive after surviving an abortion procedure. In addition, we know that 21 of these 27 infants were born at 20 weeks' gestation or later. Of those 21, six Western Australian babies were born at 26 weeks' gestation or later. Indeed, we can infer that one of those six was at 34 weeks or later. Most distressingly, Parliament has also been told that none of these Western Australian infants was afforded any medical treatment; in other words, they were left to die.

Individuals who have survived being aborted have reported their situation in the media. Examples include Americans Melissa Ohden, who survived abortion attempt in 1977 at 31 weeks, Gianna Jessen survived abortion attempt in 1977 when her mother was 7 1/2 months pregnant and Josiah Presley, who survived an abortion attempt in South Korea. Staff working in centres where abortions are performed have experienced babies being left in the ward pan room, crying, until death occurs.

There have been a few babies surviving from 22 weeks of gestation but chances increase with age. Rather than letting them perish, if unwanted by the birth parents, resuscitation and intensive care could be offered prior to adoption.

Need for conscientious objection

It will be clear from the descriptions above, that involvement in the abortion process will be distressing for healthcare providers. It is essential that the right of conscientious objection be protected and extended to everyone involved, from doctors to nurses, to students, to administrative staff and cleaners. At present this is not the case.

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[3] Brugger CE. (2012) The Problem of Fetal Pain and Abortion: Toward an Ethical Consensus for Appropriate Behavior. Kennedy Institute of Ethics Journal, 22(3):263-287.

Clause 9 requires a doctor with a conscientious objection to abortion to refer the woman to someone who does not have a conscientious objection to abortion.

Many practitioners with conscientious objection to abortion would agree that effective referral would make them complicit in the act, therefore removing any right of conscientious objection from this bill. *This clause should be deleted.*

It is recommended that legislation only require healthcare practitioners to respectfully inform patients about their conscientious objection and inability to refer for abortion, with no further requirement to act. Healthcare practitioners with a conscientious objection to abortion should be protected against professional disadvantage as a result of their conscientious objection.

Clause 10 associates nonreferral due to conscientious objection with professional conduct. This threatens the whole notion of allowing doctors to perform ethical medicine according to their own conscience. 10(1)(c) should be removed.

All Australians need freedom of religion, and doctors that can always practice medicine that is according to their conscience. We note that politicians have a conscience vote for this issue and used it to deprive doctors of the same opportunity.

Need for counselling for healthcare providers

In view of the distressing nature of abortion procedures, we also recommend that counselling be available for healthcare providers who are exposed to the distressing experience of witnessing an abortion. Moral distress has been documented in healthcare practitioners in this situation, for example one nurse reported:

'I had to take the specimen and put it, you know, put Formalin in it? . . . and when I took the lid off, urn, I could see a foot. And I just burst into tears . . . It just felt like somebody socked me in the gut, and I just thought, "Oh, I can't believe this!" And I just had to stop for a minute.'[4]

Need to address all needs in unwanted pregnancy

It is clear from the medical literature exploring the reasons why women seek abortions that socio-economic reasons are prominent. A study from 2013 found that women's motivations for seeking an abortion included financial reasons (40%), timing (36%), partner related reasons (31%), and the need to focus on other children (29%). Most women reported multiple reasons for seeking an abortion, but it was obvious that the inability to cope with a newborn child was

[4] Hanna, D. R. (2005). The lived experience of moral distress: Nurses who assisted with elective abortions. *Research and Theory for Nursing Practice, 19*(1), 95-124. Retrieved from http://ezproxy.library.usyd.edu.au/login?url=https://search.proquest.com/docview/207666165?accountid=14757

prominent.[5] The association between abortion and domestic violence is clear[6] (and another reason why counselling should be offered, not just considered), and raises the question of whether abortion is always a free choice, or the result of a lack of choice for some women. If women are threatened with being thrown out of home or deserted by a partner if they do not abort an unplanned pregnancy, they may have few options. Medical practitioners have reported a lack of resources, particularly in rural/remote NSW. The single mother's pension does not apply until after the birth, and women may be unable to work in late pregnancy, begging the question of how women can support themselves in such a situation.

Dr Deidre Little, an obstetrician on the north coast of NSW, reported that women often feel pressured and unsupported when an unplanned pregnancy occurs. She has set up her own not-for-profit clinic LilyRose to help.

"We really need to offer more to these women, no women should be left alone in these situations," Dr Little said. "If a pregnancy is unexpected, it can throw them into confusion. Their normal, clear decision-making processes — the way they normally make a decision — is upended because they feel rushed, pressured, scared and unsupported." Dr Little said women in regional areas lacked basic services, which added to the pressure of their pregnancy. "From the acute setting, where somebody may need emergency accommodation … there may be a situation of domestic violence, of verbal abuse that may have escalated," she said. "Our only women's refuge, Warina, is often full, so emergency accommodation is short. There can also be difficulty accessing counselling in a short space of time and also lining up legal assistance."[7]

Urgent research is needed to explore this possibility, and to discover what needs exist, and what resources are available for this vulnerable group of women.

We call for a parliamentary inquiry into the supportive care needs of women with unplanned pregnancy who wish to keep their child.

Need for more data

The debate over the last week has made it very clear that little is known about the current practice of abortions in NSW. South Australia is the only state in Australia which collects data about abortion procedures. When the abortion rate in NSW is quoted, it is usually extrapolated from SA figures, a significantly different demographic. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends collection of data in *Termination of Pregnancy C-Gyn 17*, page 4 (attachment 4).

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[5] Biggs, M. Antonia, Gould, Heather, and Foster, Diana Greene (2013), 'Understanding why women seek abortions in the US', *BMC Women's Health,* 13 (1), 29.

[6] Silverman JG, Decker MR, McCauley HL, Gupta J, Miller E, Raf A, Goldberg AB. Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict. AmJPublic Health. 2010;100:1415-1417.

[7] Mascarenhas C. Women in regional areas struggle with uplanned pregnancies; call for more support. ABC Mid North Coast, 8 Jun 2018. https://www.abc.net.au/news/2018-06-07/women-in-regional-nsw-struggle-with-unplanned-pregnancy/9840310 accessed 12.8.19.

4.5 ***Monitoring and research*** *in order to better understand the individual and public health impacts of termination of pregnancy, the College supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.*

The South Australian Department of Health collects data on all aspects of pregnancy. Attachment 5 is the latest report: *Pregnancy Outcome in South Australia 2016. Adelaide: Pregnancy Outcome Unit, Prevention and Population Health Branch, SA Health, Government of South Australia, 2018.* Information about TOP begins on page 45. Data collected on TOP includes number of terminations, types of clinicians and healthcare services involved, reported reason for termination, age of gestation at time of termination, method of pregnancy termination, and complications. Demographics include age of women, information about residential region, and previous pregnancy terminations. All reported information is anonymous.

One complication in the collection of TOP data is that there is no one Medicare item number for an abortion, so doctors who perform abortions use their discretion as to which Medicare item numbers to use. Four different item numbers are commonly used (35643, 16525, 16505, 16564) which can be used for miscarriages as well as elective terminations of pregnancy. As a result, Medicare Item number does not give accurate information about the number of abortions occurring. THEREFORE, SPECIFIC REPORTING MEASURES NEED TO BE MANDATED. (It is understood that ultimately resolving this issue is a Federal matter).

Review of the Act in one year regarding abortions for gender selection (section 14), and five years (section 16) have been recommended.

In order for the reviews of the act to be accurate, data collection is required.

One possible mechanism for this occurring is to require details of the TOP to be given at the time the birth is reported (to the Department of Births, Deaths and Marriages). Details such as gestation and weight of the child, noting any abnormalities present, and age of the woman, should be minimal requirements. Also, doctors are used to meeting mandatory reporting requirements, so reporting of each termination of pregnancy procedure would not need a new process to be implemented. Indication for termination would also be helpful to ensure that resources are made available to meet the needs of women with unplanned pregnancy.

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Further comments on the bill

We note that there are no penalties for medical practitioners who perform an abortion after 22 weeks without the assent of a second medical practitioner.

We appreciate your attention to these comments. We would be happy to expand our points in person if the occasion permits.

John Whitehall
President, CMDFA

Ernest Crocker
President, CMDFA NSW

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