Submission No 20

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Catholic Bishops of New South Wales

Date Received: 13 August 2019

Speaking the truth in love
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13 August 2019

The Hon. M.S. Mallard M.L.C.
Sent via email: committee.socialissues@parliament.nsw.gov.au

Dear Mr Mallard

Re: Reproductive Health Care Reform Bill 2019

Please find enclosed a submission to the Standing Committee on Social Issues on behalf of myself and the Catholic Bishops of New South Wales.

The Catholic community is the largest religious denomination in Australia with more than one in five Australians identifying as Catholic. There are more than 1,800,000 Catholics in NSW alone. We operate 11 hospitals and more than 60 aged care and nursing homes. More than 310,000 students are educated in approximately 600 Catholic schools in NSW, with thousands more studying at our two Catholic universities.

As Australia's largest non-government operator of hospitals, aged and community care services, the Catholic Church provides about 10 per cent of the country's health care services, including considerable services to pregnant women and babies.

We have a long and proud history of providing holistic care for mothers and children in this state. Our position is borne of experience.

This submission is necessarily yet unfortunately rushed, due to the lack of notice provided to the general public about the intention to introduce the *Reproductive Health Care Reform Bill 2019* (**Bill**), its expedited passage through the Legislative Assembly, and the two-week timeframe from the announcement of this inquiry to its reporting date.

Most Rev. Anthony Fisher OP, DD BA LlB BTheol DPhil
Archbishop of Sydney

Polding Centre, 133 Liverpool Street, Sydney NSW 2000, Australia

While not within the Terms of Reference of this submission, we would like to record our dismay at the attempt to pass the Bill without the level of inquiry that was provided in other states that passed similar laws.

In Victoria, the government referred abortion law reform to the Victorian Law Reform Commission in September 2007, with a report tabled in May 2008 and a bill introduced in August 2008. In Tasmania, the inquiry process began some eight months before the passage of a bill. And in Queensland, numerous inquiries were held over a period of two years.

An inquiry that spans just two weeks on such an important issue provides a veneer of community consultation, rather than consultation in any meaningful form. This is not a criticism of this Committee, but rather the process that has led to this point.

Despite this, we are happy to place the position of the Catholic Bishops of New South Wales on the parliamentary record, as a testimony to the inherent dignity and value of all human life.

Yours sincerely in Christ,

Most Rev. Anthony Fisher OP, DD BA LlB BTheol DPhil
Archbishop of Sydney

Additional signatories:

Most Rev. Christopher Prowse
Archbishop of Canberra-Goulburn

Most Rev. Michael Kennedy
Bishop of Armidale

Most Rev. Michael McKenna
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Most Rev. Greg Homeming OCD
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Most Rev. William Wright
Bishop of Maitland-Newcastle

Most Rev. Max Davis
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Most Rev. Vincent Long
Bishop of Parramatta

Most Rev. Christopher Prowse
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Most Rev. Columba Macbeth-Green
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SUBMISSION TO THE SOCIAL ISSUES COMMITTEE

INQUIRY INTO THE
REPRODUCTIVE HEALTH CARE REFORM BILL 2019

13 AUGUST 2019

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Introduction

A note to women who have had abortions

It is estimated that this is at least one in four Australian women will have an abortion in their lifetime. This is not an insignificant number. So, at the outset of our submission, we wish to express a word of compassion to the women in New South Wales who have undergone an abortion. Making our own the words of St John Paul II, we say that the Church is aware of the many factors which may have influenced your decision, and does not doubt that in many cases it was a painful and even shattering decision. We understand that in many cases, abortion was not a result of your own choice, but a result of you being left to feel that there was no other choice[1].

In opposing the liberalisation of abortion laws in this country, we are seeking to create a society where no new mother is left isolated, but affirmed and encouraged in every way. Sadly, the present bill does nothing to offer distressed pregnant women alternatives: abortion is the only option offered.

Introductory comments

Human life begins at conception, and it is from this point that it is most appropriate to recognise the personhood of the new, unique human being. Even though some may dispute personhood from this early stage, "what is at stake is so important that, from the standpoint of moral obligation, the mere probability that a human person is involved would suffice to justify an absolutely clear prohibition of any intervention aimed at killing a human embryo."[2]

Every human life has inherent value that is not dependent on age or ability. This is not only a doctrine upheld by the Catholic Church in our teachings and practices; it is the basis of a civilised society and, as such, must be affirmed by governments in its laws and policies, and supported by the community. A determination that some lives are worth less than others is one that puts everyone at risk.

Attempts to choose a point after conception at which to ascribe rights is necessarily arbitrary, and any law that purports to do so must be completely rejected.

Even if the current state of the law is such that, despite the procuring of abortion being a criminal offence, those who participate in abortion are not punished, it does not follow that we should treat a moral wrong as moral neutral by defining it as another health matter. The law has a teaching value and the retention of abortion in the *Crimes Act 1900* reinforces the clear message that the taking of an innocent human life is wrong in all circumstances.

[1] John Paul II. Vatican. *Evangelium Vitae*. 25 March 1995. 19 March 2013. http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html no. 99.
[2] Ibid, no. 59.

Legislators should use our laws to promote practices that uphold the common good for all citizens, including the unborn, and we must all work together to create a world in which abortion is not treated as the default “choice” for mothers facing difficulties.

For this reason, our primary submission is that the Bill should be defeated.

We note, however, that the Terms of Reference for this inquiry are limited to the provisions of the Bill and for that reason, the remainder of this submission will focus on those provisions. In no way should it be taken that, in commenting on the provisions of the Bill, we are endorsing the practice of abortion or the decriminalisation of abortion in this state.

Executive Summary

The right to life is the first right of the human person, and the one on which all others are conditional. It is not recognition by the State that endows this right; it exists by virtue of the creation of a new life, and it is the role of the State to protect this right above all others. Any law that only recognises the right to life in some circumstances, and allows its taking in others, will always be unjust. The *Reproductive Health Care Reform Bill 2019* (**Bill**) is an unjust bill, because abortion always involves the taking of innocent human life.

We oppose this Bill, and ask the Committee and the Legislative Council to reject it.

It is a particularly extreme Bill, which goes far beyond a codification of present law, and instead paves the way for a dramatic extension of the practice of abortion. Deeply troubling aspects of the Bill include:

- **It allows unlimited abortion up to 5½ months**, a practice gravely out-of-step with current practices and community attitudes, and which would see the termination of viable babies;
- **It allows abortion for discriminatory reasons, including abortion intended to discriminate on the basis of sex or ability**, even though Australian opposition to sex-selective abortion is increasing;
- **It allows of late-term abortions, even up until the day of birth, for any reason including "social" reasons**, a practice which the overwhelming majority of Australians oppose;
- **It provides no requirement of counselling or psychological care for women**, even though 95 per cent of women seeking abortion cite mental health problems as the reason for the request;
- **It would require medical professionals to participate in abortion, either by performance or referral**, an unnecessary imposition that is a dramatic overreach of the state into the right of conscience;
- **It shields doctors who perform unauthorised abortions from criminal prosecution**, providing no protection for women in their care;
- **It provides no limits on self-administered abortion**, putting women at risk of self-harm;
- **It provides no protection for women subject to domestic violence or abortion coercion**, even though there is a demonstrable link between intimate partner violence and abortion;
- **It does not require record-keeping**, meaning that NSW will not have any transparency around the number of abortions or the reasons for them in this state;
- **It fails to prohibit the sale of foetal tissue for profit**;
- **It fails to require that a foetus who feels pain be given any pain relief prior to an abortion**;
- **It fails to require doctors to provide life-saving medical care to babies born alive following a failed abortion**, instead, leaving them to die unattended.

This is an extreme Bill. Its provisions are a particularly egregious attack not only on babies, but their mothers and on doctors who do not want to participate in these practices. We submit that there is no way that such a Bill can be made safe for women and children and, as such, must be rejected by the Committee and the Legislative Council in totality.

Section 5 – Abortion up to 22 weeks

Unlimited abortion to 5½ months does not reflect community attitudes

Section 5 of the Bill allows a medical practitioner to perform an abortion on a child up to 22 weeks (i.e., well into the second trimester) for any reason.

This does not accord with the attitudes of Australians to abortion. A study on attitudes to abortion in Australia found that only 12 per cent of Australians believe abortion should be legal in the second trimester for any reason, with an additional 57 per cent believing that legality should depend on the circumstances. 28 per cent believe abortion should be unlawful in the second trimester. Put simply, 85 per cent of Australians do not agree with unrestricted abortion in the second trimester, and so this provision puts the law dangerously out of step with community attitudes[3].

Unlimited abortion to 5½ months would permit the termination of viable babies

Unrestricted abortion at 22 weeks is also out of step with advances in medical technology. In the Consideration in Detail of the Bill, the Health Minister noted that the 22-week timeline was the "timing of the most likely viability point for a foetus."[4] However, viability is occurring earlier as technology progresses. In 1978, "viability" was set at 28 weeks, in the 1980s, it lowered to 24-26 weeks and by the 1990s, the survival rates of babies born at 23 weeks' became more common[5]. A 22-week threshold of viability will become redundant in the near future, and any proposed change to abortion laws should take into consideration expected advancements in treatment. It is telling that the proposed amendments to New Zealand's *Contraception, Sterilisation and Abortion Act 1977* currently being debated in its parliament place the relevant line at 20 weeks' gestation.

Furthermore, there has been at least one case where a foetus has survived prior to this time. The journal *Pediatrics* reported the survival of a baby born at 21 weeks and 4 days gestational age who, at age two years, "demonstrated unimpaired developmental scores for age."[6] Media reports of the same child, Lyla Stensrud, confirmed she was still thriving at age four[7].

While some may consider that one healthy child is insufficient to redefine viability, the authors of the study point out: "Clearly, 1 positive data point is insufficient to recommend aggressive obstetric and neonatal management of other 21-week pregnancies. However, neither may we ignore outcomes data

[3] de Crespigny, L., Wilkinson, D., Douglas, T., Textor M., & Savulescu, J. (2010). Australian attitudes to early and late abortion. *Medical Journal of Australia,* 193:9-12. **Error! Hyperlink reference not valid.**

[4] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 8 (Brad Hazzard).

[5] Arzuaga, B. & Lee, B. (2011). Limits of human viability in the United States: A Medicolegal Review. *Pediatrics*, 128(6): 1047-1052.

[6] Ahmad, K., Frey, C., Fierro, M., Kenton, A. & Placencia, F. (2017). Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation. *Pediatrics*, 140(6): 1-4.

[7] Kekatos, M. (2018, December 26). The most premature baby to EVER survive : Mom of miracle Lyla, who was born at just 21 weeks and weighed less than one pound, breaks her silence and reveals how she had to beg doctors to resuscitate her daughter, who is now a thriving 4-year-old. *Daily Mail*. Retrieved from: https://www.dailymail.co.uk/health/article-6497947/Smallest-preemie-baby-survivor-Lyla-Stensrud-born-21-weeks-one-pound-look-now.html

solely because they do not fit comfortably into established practice." Ultimately, the authors argue, that it would be reasonable to infer that active intervention would benefit babies born into the 21st week of gestation but that this will only be known if systematic reporting of foetal outcomes before 22 weeks is reported[8].

Unlimited abortion to 5½ months is out of step with current practices

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The ability for abortion to be performed up to 5½ months does not accord with current practices for abortion and the registration of deaths in New South Wales.

Currently, a stillbirth must be registered if it occurs after 20 weeks' gestation[9].

The existing NSW Health Policy Directive on abortions over 20 weeks' gestation provides:

> "In the assessment of need the treating practitioner should seek appropriate consultation and advice as dictated by the individual clinical scenario. Such consultation and advice should be documented by the treating practitioner. In some circumstances the Local Health Districts may provide opportunity for a case conference or multidisciplinary team, with a mix of skills and experience to provide advice to the treating medical practitioner so that he/she is able to undertake an informed assessment of need for termination of pregnancy. The provision of a case conference or multidisciplinary team is not a mandatory component of the assessment of need but serves to assist the treating practitioner in complex clinical situations. The multidisciplinary team may include experts in the areas of psychiatry or specialist mental health, fetal medicine, neonatology and the other specialty or specialties relevant to the woman's and fetus' condition."[10]

This section of the Bill is out of line with existing clinical practice.

In the parliamentary date, it was suggested by the Honourable Member for Sydney that the reason for setting the gestational limit at 22 weeks was to allow the identification of foetal abnormalities in the 18-20 week period, and then provide the mother with time to make an informed decision about abortion[11]. It is unclear how a raising of the gestational age at which abortion can be performed without limit contributes to the ability of the mother to make an informed decision. Indeed, a mother who has received a diagnosis of a foetal abnormality would receive better medical attention, more support and more information enabling her to exercise informed consent if the current clinical practices, applicable from 20 weeks' gestation, were maintained. With respect, the Honourable Member for Sydney's reasoning to reject this amendment does not appear to accord with his stated goal of informed consent following a diagnosis of foetal abnormality.

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[8] Ahmad, K., Frey, C., Fierro, M., Kenton, A. & Placencia, F. (2017). Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation. *Pediatrics*, 140(6): 1-4.

[9] *Births, Deaths and Marriages Act 1995 (NSW)*, section 12.

[10] NSW Health. (2014). Policy Directive, Pregnancy – Framework for Terminations in New South Wales Public Health Organisations. Retrieved from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_022.pdf

[11] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 2 (Alex Greenwich).

Unlimited abortion to 5½ months would allow gender- and disability-based discrimination

Allowing abortions well into the second trimester for no reason will also allow for discriminatory abortions, particularly on the grounds of sex selection and disability.

Sex-selective abortion disproportionately affects women. A study published in May reported that some 45 million girls were not born over the past half-century due to sex-selective abortions, most of them occurring in China and India[12]. But this discrimination is not limited to other countries. The Australian Bureau of Statistics also noted "statistically significant" fewer girls born to ethnic communities in Australia[13], as did a study from researchers at La Trobe University[14], indicating that abortion does occur in this country for reasons of discrimination on the basis of sex alone.

It is incongruent that assisted reproductive technologies are not permitted to be utilised for sex selection, but that sex selection for non-medical reasons is a permitted reason for abortion.

It is worth noting that the Australian public overwhelmingly rejects the use of IVF or abortion for sex selection, and that the level of disapproval has actually increased over the past decade. A recent, 10-year longitudinal Australian study found that "disapproval/strong disapproval of abortion for sex selection increased from 74 to 81% from 2007 to 2016, while strong disapproval alone rose from 44 to 55%," an increase the authors described as "statistically significant.[15]"

In a similar vein, abortion disproportionately discriminates against those with disabilities. Unlike sex selection, this is not a hidden practice, with many supporters of the liberalisation of abortion laws citing disability as a reason for their advocacy. However, discrimination on the basis of disability must also be rejected, not made easier as this section purports to do. Those members of our communities who live with disability are not aided by a law that uses their existence as a justification for liberalising abortion laws. A better approach would to be to invest in disability support and treatment, rather than sanctioning abortion on the grounds of a disability diagnosis.

[12] Chao, F., Gerland, P., Cook, A. & Alkema, L. (2019). Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels. *Proceedings of the National Academy of Sciences of the United States of America*. 116(19): 9303-9311.
[13] Jain P. (2015 August 28). Could gender-selective abortions be happening in Australia? *SBS News*. Retrieved from: https://www.sbs.com.au/news/could-gender-selective-abortions-be-happening-in-australia
[14] Edvardsson, K., Axmon, A., Powell, R. & Davey, M. (2018). Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015. *International Journal of Epidemiology*, 47(6):2025-2037.
[15] Kippen R. Gray E. & Evans A. (2018). High and growing disapproval of sex-selection technology in Australia. *Reproductive Health*. 15: 134.

Section 6 - Abortion after 22 weeks up until birth

Allowing unrestricted late-term abortion, including 'birthday abortions,' is egregiously out of step with community attitudes

This section allows abortion from 22 weeks' gestation up until the day of birth provided that two medical practitioners consider the abortion should be performed having regard to "all the circumstances," which include current and future physical, psychological and social circumstances. This goes far beyond the existing law, which requires the medical professional to have "an honest belief on reasonable grounds that [the termination] was necessary to preserve the woman involved from serious danger to their life, or physical or mental health which the continuance of the pregnancy would entail."[16]

Notwithstanding that late-term abortions are proportionately low, there is nothing in this Bill that ensures this will remain the case. Providing no meaningful limit on late-term abortion effectively opens the door for the practice to increase.

The wide-ranging nature of the circumstances under which late-term abortion is justified pursuant to this section means that this Bill is no less extreme than the *Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016* that was rejected by the Legislative Council just two years ago. These provisions only provide a veneer of limitation, rather than any practical limits on late-term abortions.

It is difficult to understand why such an extreme late-term abortion law would be considered by this Parliament considering the defeat of a similar bill so recently and, given that 6 per cent of Australians support third trimester abortion for any reason[17].

The Bill does not give women the specialist care they deserve

While an amendment was passed that requires a "specialist medical practitioner" to perform the termination, the relevant specialisation is limited to obstetrics and gyneacology. While such a person may be equipped to consider "all relevant medical circumstances"[18] in assessing whether an abortion should be performed, they would not be equipped to assess current or future psychological or social circumstances. Specialist care from those qualified in mental health must also be made available to women.

Further, it is unclear how any medical practitioner would be more qualified than anyone else to determine that current or future "social" circumstances necessitate an abortion, or indeed what "social" circumstances could ever exist that would justify the killing of an unborn child capable of surviving outside the womb. Abortion should not be permitted for social reasons.

[16] *R v Wald* (1971) 3 NSWDCR 25 at 29
[17] de Crespigny, L., Wilkinson, D., Douglas, T., Textor M., & Savulescu, J. (2010). Australian attitudes to early and late abortion. *Medical Journal of Australia,* 193:9-12.
[18] Cf section 6(3)(a)

A lack of independence requirements for doctors puts women at risk

Additionally, section 6 has no requirement that the medical professionals be independent, either from the mother of the child or from each other. Such a provision puts mothers at risk of undue influence.

Section 7 – Limited offer of counselling

19 out of 20 women seeking abortion report mental health problems; they deserve counselling

Section 7 provides a very limited obligation on medical professionals to offer counselling to women seeking abortions, only requiring information about counselling to be offered if the medical professional first determines that a discussion about counselling would be beneficial.

It is troubling that this obligation is a lot weaker than the positive obligation on medical professionals to refer for abortion if they are unwilling to perform the abortion themselves, particularly when we are aware of the link between a request for abortion and mental health.

While limited data is collected in New South Wales on abortion and the reasons for it, the data collected in South Australia is instructive. In its most recent data collection, SA Health reports that 95.6 per cent of women cite "mental health of woman" as the reason for the abortion[19].

The offer of counselling is also necessary after abortion. Academic studies confirming the link between mental health problems and abortion were cited by the Honourable Member for Mulgoa during the Consideration in Detail of the Bill[20], and as a Church, we also witness this through our ministries. Rachel's Vineyard[21] is one such ministry of the Catholic Church. It operates in 70 countries and holds more than 1000 retreats annually for those suffering from post-abortive grief.

Overwhelmingly, Australians believe that women considering abortion should be given, or at least offered, counselling. A study done on Australian attitudes to abortion revealed that 78 per cent of respondents believed a woman contemplating an abortion should first be given counselling about the risks and the alternatives. This included 72 per cent of those who described themselves as "strongly pro-abortion."[22] 86 per cent of respondents believed this counselling should be given by someone independent of the abortion provider[23]. In light of the above, doctors should be obliged to offer counselling, including publicly

[19] Pregnancy Outcome Unit, Prevention and Population Health Branch, SA Health. (2018). Pregnancy Outcome in South Australia 2016. Government of South Australia. Retrieved from: https://www.sahealth.sa.gov.au/wps/wcm/connect/4ccbba85-14c6-4b39-a19e-4e8cd54e9ea1/Pregnancy+Outcome+in+South+Australia+2016+V2.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4ccbba85-14c6-4b39-a19e-4e8cd54e9ea1-mMHjX75

[20] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 45 (Tanya Davies).

[21] https://www.rachelsvineyard.org/

[22] Fleming, J. & Tonti-Filippini N. (eds). (2007). Common ground? Seeking an Australian consensus on abortion and sex education. St Paul's Publications, Strathfield, 73.

[23] Ibid, 74.

funded counselling, to any pregnant woman in their care, as well as to any woman who has undergone an abortion.

Section 9 – Imposition on conscientious objection

Requiring medical professionals to participate in abortion is a dramatic overreach into conscience rights

The issue of conscientious objection is of grave concern to all Catholic medical professionals, and others who hold a belief that abortion is the taking of an innocent human life. Requiring medical professionals or anyone else to have any role in an action that they believe to be gravely immoral is an unjust imposition on the right to freedom of thought, conscience and belief.

Article 18(3) of the *International Covenant on Civil and Political Rights* states that this freedom "may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."[24] In its General Comment on this article, the UN Human Rights Committee states that any limitations must be "proportionate to the specific need on which they are predicated."[25]

The obligation of a medical professional to violate their conscience in such a way that would make them complicit in what they consider to be a grave evil does not meet this test of proportionality, because the advocates of this Bill have failed to demonstrate that information about abortion cannot be provided in another way that does not impede the consciences of doctors. Suggestions that a woman seeking an abortion will not be able to find one unless her doctor directs her to an abortionist are false. Women of child-bearing age in 21st century Australia are able to conduct an internet search for an abortion clinic, and many of these clinics advertise of Google. If there is concern that there are still a number of women of child-bearing age who would seek an abortion but who would not own a smartphone or have access to Google, there are other ways the state can provide information about abortion without coercing medical professionals into complicity.

A number of those who opposed a more fulsome provision related to freedom of conscience argued from the basis of limited service availability in rural and regional Australia[26]. However, if this section is passed as it currently stands, it would have the effect of driving practitioners with a conscientious objection to abortion out of obstetrics and gynaecology altogether, ultimately reducing the availability of services for pregnant women.

[24] UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, 171.
[25] UN Human Rights Committee (HRC), CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion), 30 July 1993, CCPR/C/21/Rev.1/Add.4
[26] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 66 (Kevin Anderson); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 69 (Leslie Williams)..

Denying conscientious objection rights will make medical professionals vulnerable to activists

Additionally, section 9(2) has the bizarre effect of requiring a medical professional to disclose a conscientious objection to abortion to anyone who makes an inquiry about performing an abortion on another person. If the drafting of section 9(1) is compared to the language of section 9(3), the legislative intention to allow any person – pregnant or not – to make inquiries about a medical professional's conscientious view is clear. Medical professionals should not be required to disclose their conscientious objection to those not seeking their assistance, particularly when it would leave them vulnerable to the action of activists who seek to target medical professionals with a conscientious objection.

Section 10 - Professional conduct or performance implcations

Removing criminal sanctions for unauthorised abortions puts women at risk

In outlining penalties for contraventions of the law, this section states that a failure to comply with sections 5, 6 or 9 is relevant for complaints and disciplinary procedures under the *Health Practitioner National Regulation Law* and the *Health Care Complaints Act*.

The illegal taking of a human life, potentially without the consent of the mother, should not be protected because it is done by a medical professional. The *Crimes Act 1900* provides for imprisonment for up to 25 years for intentionally causing grievous bodily harm (the definition of which includes child destruction, even if no other harm is done to the mother)[27], or up to 10 years if caused recklessly[28]. These same penalties should apply to a medical professional who performs an unauthorised abortion. This Bill should not shield them from a law that applies to everyone else.

A lack of explicit criminal sanctions would mean that cases such as Dr George Smart, who performed an abortion on a 17 year old woman who was seven months' pregnant without inquiring about her physical and mental health, and leaving her in need of emergency surgery, or Dr Suman Sood, who administered abortifacient drugs to a young woman at 23 weeks' gestation, causing her to give birth prematurely to a baby who did not survive[29], might not be considered to be crimes.

In responding to the lack of criminal sanctions, the Health Minister said:

> "… there are a number of regulatory actions that include investigation by the Health Care Complaints Commission [HCCC] and, where serious enough, prosecution by the HCCC for professional misconduct. It could end up in the NSW Civil and Administrative Tribunal [NCAT]. When NCAT makes a finding of professional misconduct, removal from the register or imposition of conditions on the doctor's practice could occur. When NCAT considers the matter sufficiently serious, orders to prevent any application to return to the register can also be made. If

[27] *Crimes Act 1900 (NSW)*, section 33(1).
[28] *Crimes Act 1900 (NSW)*, section 35(2).
[29] *R v Sood (Ruling No 3)* [2006] NSWSC 762.

professional medical practitioners went far beyond their ethical obligations they could be subject to criminal proceedings—depending on what occurred."[30]

With respect, the possibility of criminal proceedings, depending on additional circumstances, is insufficient given the gravity of harm to both mother and child that could result from a medical professional acting outside the law.

Child destruction is not equivalent to a failure to refer

This section not only has the effect of failing to provide any criminal sanctions to those medical professionals who would perform an abortion even outside the extremely permissive terms of the Bill, but makes the performance of an illegal abortion equivalent in gravity to a failure of a medical professional with a conscientious objection to abortion to refer a patient to an abortion provider.

The two are not equivalent. One is a crime; the other is the exercise of a legitimate and non-derogable right recognised in international law.

Section 11 - Termination on self

Unrestricted self-abortion puts women at risk

It appears that the intention of this section is to prevent a woman being prosecuted for a medical abortion performed by herself, however, it is not limited to such matters. It sanctions any form of self-harm or harm to an unborn child by its mother, at any stage of the pregnancy, for any reason.

This is not a provision that protects women, but rather subjects them to greater risk because of the serious risk of self-harm that could occur.

Schedule 2 – Amendment of Acts

Medical professionals who perform unauthorised abortions should not be shielded from prosecution

This Schedule repeals the relevant sections of the *Crimes Act 1900* that relate to abortion and replaces them with a criminal offence for performing or assisting with an abortion for someone who is not a qualified medical practitioner. This Bill provides an extra shield for medical professionals, regardless of the risk they pose to women.

[30] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 12 (Brad Hazzard).

Additional comments

In inquiring into the provisions of the Bill, the Committee must consider not only what the Bill contains, but what it fails to deal with. In many ways, what the Bill omits is even more concerning than its contents.

Mothers deserve meaningful support

Despite being named as a bill relating to "reproductive health," this Bill fails to address reproduction or health. It provides only for abortion, and does nothing to provide any meaningful support to women in terms of their reproductive health.

If it is to achieve its stated intention of providing choices for mothers, this Bill must address the underlying reasons that cause many mothers to believe that abortion is their only choice. These include, but are not limited to:

- Domestic violence. According to the Australian Bureau of Statistics' Personal Safety Survey[31], 48 per cent of women who report violence from a former partner were abused during pregnancy, as are 18 per cent of women who report violence from a current partner. Additionally, a number of those who spoke in favour of this Bill did so by citing it as a means to protect against domestic violence[32]. With respect, domestic violence should not be addressed through abortion. Given the high prevalence of reported links between pregnancy and intimate partner violence, a positive obligation should be placed upon medical professionals to determine if a pregnant woman in their care is at risk of violence.

- Abortion coercion. Medical professionals should be required to satisfy himself or herself that the woman seeking an abortion is acting voluntarily and is not subject to coercion. The requirement for a medical practitioner to be satisfied that a person is acting without coercion is not unprecedented; Victoria's euthanasia and assisted suicide laws require a medical practitioner to make a similar assessment[33]. The case of a young woman who was charged for procuring abortifacient drugs online and then self-administering them, often used as a case study by those seeking abortion decriminalisation, was on the facts one of abortion coercion, as the accused succumbed to pressure from her partner to terminate the pregnancy[34]. This type of undue influence on vulnerable women should be sanctioned.

[31] Australian Bureau of Statistics (2017). 4906.0 – Personal Safety, Australia, 2016: Impacts of Partner Violence – Children Witnessing or During Pregnancy. Retrieved from: 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

32 See, for example, New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 66 (Kevin Anderson); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 3 (Alex Greenwich); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 66 (Kevin Anderson); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 55 (Trish Doyle); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 66 (Kevin Anderson); New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 63 (Andrew Constance).

[33] *Voluntary Assisted Dying Act 2017* (VIC), section 20(1)(c)

[34] *Director of Public Prosecutions (NSW) v Lasuladu* [2017] NSWLC 11, para 10-11.

- Additional support. The Bill makes no reference to the provision of additional options for women: information about adoption, psychological, financial or other support.

Finally, it is troubling that the Bill completely erases women, naming them as the "person who is pregnant" instead. This apparent attempt at 'inclusive' language has the effect of diminishing the centrality of the woman the subject of this Bill.

Accurate record-keeping is essential to transparency around abortion

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At present, records on the number of abortions in NSW, the reasons for them and other pertinent information are not collected. Indeed, the relevant Medicare procedure could be applicable to abortion or miscarriage, and so we do not even know how many abortions occur in NSW.

This has had the result of a dearth of knowledge in this area and has contributed to the difficulty of the present debate. Better information would equip the state and medical bodies to provide better care for women and children.

As an example of how a lack of information affects outcomes, section 14 of the Bill requires a review about the use of the provisions for gender selection to be conducted within 12 months of its passage. However, current record-keeping practices do not provide the information that would be necessary to conduct such a review, and so any information presented to Parliament on this matter will necessarily be lacking.

The keeping of records on abortion is in accordance with public expectations, with 61 per cent of respondents to a study on attitudes to abortion agreeing that there should be a formal public inquiry into abortion in Australia[35].

Abortion clinics should not profit from the sale of foetuses

New South Wales law prohibits trade in human tissue[36]. However, recent reports in the United States indicate the existence of a profitable market for aborted foetuses, either in whole or in part[37]. In keeping with Australia's prohibition on the sale of human tissue, there should be an explicit prohibition on the sale of foetal remains from abortion.

[35] Fleming, J. & Tonti-Filippini N. (eds). (2007). Common ground? Seeking an Australian consensus on abortion and sex education. St Paul's Publications, Strathfield, 81.
[36] *Human Tissue Act 1983* (NSW), section 32.
[37] Center for Medical Progress (2017, April 26). *Planned Parenthood "Lamborghini" Exec Haggles Again Over Baby Parts Prices*. [Video file]. Retrieved from: https://www.youtube.com/watch?v=6LPlHjP1DVw

Late-term abortion causes the baby pain

While there is some dispute amongst the scientific community about the point at which a foetus can feel pain, it is clear that during the third trimester of pregnancy at least (and potentially before), a foetus is able to feel pain[38]. It is troubling that this Bill provides no obligation for pain relief to be administered to the foetus.

Babies born alive deserve life-saving care; they should not be left to die

It is troubling that an amendment requiring life-saving care to be given to a baby born alive following a failed abortion was not passed by the Legislative Assembly[39]. While present law would mean that a medical professional would likely not be sanctioned for providing such life-saving care[40], it is not clear that there would be a positive obligation on them to provide such assistance[41]. A child born alive deserves medical care, irrespective of the circumstances of that birth.

Conclusion

We submit that the *Reproductive Health Care Reform Bill 2019* should be rejected by the Legislative Council because abortion is not the best option for women, children or society.

Even those who are determined to vote in favour of the decriminalisation of abortion can see that there are aspects of this Bill that are so extreme, and so out-of-step with Australian attitudes and good medical practice, that it should be rejected.

[38] Lee, S., Ralston, H. & Drey E. (2005). Fetal Pain: A systematic multidisciplinary review of the evidence. *Journal of the American Medical Association*. 2005;294(8):947–954

[39] New South Wales. *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 25 (Division).

[40] *Children and Young Persons (Care and Protection) Act 1998* (NSW), section 174(1).

[41] *Health Practitioner Regulation National Law* (NSW), section 139C(c) includes a refusal or failure, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner in the definition of "unsatisfactory professional conduct," and the case of *Lowns and Anor v Woods and Ors (1996)* Aust. Torts Reports 81-376, 63 found a medical professional to be negligent for failing to provide care when asked. However, neither the statute nor the case deal with a positive obligation to provide care when it is not requested by the patient or their guardian.