Submission No 33

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Australian Christian Lobby

Date Received: 14 August 2019

Submission to: *Inquiry into Reproductive Health Care Reform Bill 2019*

AUSTRALIAN CHRISTIAN LOBBY

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 160,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

acl.org.au | Like us on facebook.com/ACLobby | Follow us on twitter.com/ACLobby

ACL Truth made public
AUSTRALIAN CHRISTIAN LOBBY

Hon Shayne Mallard MLC,
Chair of the Standing Committee on Social Affairs
NSW Legislative Council

13 August 2019

Dear Mr Mallard,

The Australian Christian Lobby welcomes this opportunity to provide a submission on the *Reproductive Health Care Reform Bill 2019.*

In making this submission we wish to note the indecent haste in the introduction of this legislation to the NSW Parliament without a period of consultation with the voters of NSW. Similar legislation in other States – Victoria, Tasmania, and Queensland – was preceded by numerous inquiries. In South Australia, an inquiry is currently underway.

This current inquiry is also exceedingly short, giving the public of NSW less than one week to make submissions and only one week for the committee to consider those submissions. This may lead voters to question whether this issue is being taken seriously by the Parliament.

The ACL believes that human life begins at conception and there is no arbitrary point at which abortion can be considered anything other than the taking of a human life. Nevertheless, we wish to make a submission which considers the rights of both the mother and the child and ensures that this issue is treated with the gravity that it deserves.

We are pleased to answer any questions you may have or provide further information.

Yours sincerely,

Dan Flynn
Chief Political Officer

Kieren Jackson
NSW State Director

ACL National Office ABN 40 075 120 517
Eternity House, 4 Campion St, Deakin ACT 2600 | Phone: (02) 6175 0200 | Email: natoffice@acl.org.au | **acl.org.au**

Executive Summary

Abortion is always the destruction of an innocent human being, living in the womb. Accordingly the ACL urges this committee to reject this Bill.

It is our concern that this legislation is out of step with community attitudes. It is not a reality that women are in any way disadvantaged by the existing laws, but they might be seriously harmed by legislation which allows abortion up to birth with no safeguards.

We make the following observations about the Bill:

- Viability is moving downward. That should be reflected in all aspects of law concerning unborn children. The current law in NSW requires a still birth occurring after 20 weeks to be registered, yet the Reproductive Health Care Reform Bill 2019 allows abortion up to 22 weeks. Laws proceed from factual and logical physical realities as well as moral values. The law should convey consistency.
- Sex-selection of babies is highly prevalent in some cultures and the preference is mostly for boys. These trends, amongst certain ethnic groups, are also happening in Australia. There is also growing pressure to allow sex-selection for 'family balancing'. It is abhorrent that a healthy child is aborted on the basis of sex. The proposed Bill has no safeguards against sex-selection, opening the way to 'Daughter slaughter'.[1]
- Abortion for fetal abnormality is already widespread without there having been any community debate or establishing protocols to help parents make informed decisions. Many mothers find themselves on the abortion fast track without any consideration of options such as perinatal palliative care or information from support groups for the particular disability. The current practice is eugenics by default because of the absence of any protocols. Women who have abortions due to fetal abnormality exhibit greater tendencies to depression after the abortion.
- Only 6% of the population of Australia support abortion in the last trimester. There is no support for late term abortions.
- Any baby born alive during an abortion procedure must be given the medical care appropriate to a child of its stage of development. It is neglectful of human dignity to allow a born child to succumb without care and comfort.
- It is inhumane to not cause pain to sentient beings. Unborn babies feel pain.
- An amendment should be made requiring independence of the medical professionals from each other and from the mother to be demonstrated or that the case be referred to a hospital ethics committee for late term abortions.
- Pre-abortion counselling should be provided to all women seeking abortions. Any counselling process should also allow a period of a minimum of 72 hours between counselling and the termination of a pregnancy.

---

[1] https://www.spectator.com.au/2019/08/daughter-slaughter/

- Doctors, nurses, and counsellors must be free to exercise their conscience. If they believe abortion is not good for the woman, and is destroying a defenceless human life, they must not be forced to comply with abortion by referring the woman to someone else.
- There is no equivalence between a medical practitioner who exercises freedom of conscience and an abortion performed by a medical professional that is not authorised by the Bill.
- Any pregnancy in a child under the age of 16 years must be investigated for possible child sexual abuse. Parents are still the custodians of the child and ought to be informed of a pregnancy.
- In order to provide good medical care it is imperative that NSW record and publish anonymised abortion statistics. The statistic should be presented in a manner that facilitates comparison with other state legislatures

Introduction

ACL believes that human life begins at conception. This fundamental right is outlined in the Preamble to the UN's Declaration on the Rights of the Child which states:

> *The child, by reason of his physical and mental immaturity, needs special safeguards and care including appropriate legal protection, before as well as after birth.*

ACL acknowledges that abortion is an emotive issue and for many women a deeply sensitive one. Women who find themselves unexpectantly pregnant may feel overwhelmed at the prospect of having a child and may be deeply conflicted and vulnerable. Many may feel abortion is the only option. These women should be treated with respect and sensitivity. It is estimated that one in four women in Australia have had an abortion. For some women that may have been a free choice, but for those women who feel compelled to have an abortion due to material circumstances, failure of support from loved ones or job insecurity, we must commit to do better.

THE PROBLEMS WOMEN FACE ARE NOT SOLVED BY ABORTION

Abortion is not a good thing. It is not a rite of passage, but often the last resort of desperate women. A 'woman's right to choose' is the loudest message of the pro-abortion lobby, but where abortion is the only choice offered to women, it is not a free choice.

Meshel Laurie, presenter on Channel 10's *The Project* told viewers:

> *"what I think gets lost in the abortion debate every time, is that nobody wants there to be abortion," Laurie said. "I hate the fact that there is abortion. It breaks my heart."*[2]

Women facing an unplanned pregnancy may feel overwhelmed at the prospect of having a child and may feel conflicted and vulnerable. There are many reasons for this, such as financial insecurity, lack of support from a partner, an unstable domestic situation, family violence and more. In the absence of appropriate support, many may feel abortion is the only option. These women should be treated with respect and sensitivity.

However, rather than allowing abortion, a just and compassionate society will assist women who find themselves in difficulty because of pregnancy to be supported, socially and financially. Choosing abortion in the absence of other support is not a free choice. There is a strong likelihood that the difficult circumstances will not be eradicated by an abortion.

Solutions for unplanned pregnancies must be woman-centred and consider the holistic welfare of the woman. Abortion does not solve a woman's problems; it ignores them and provides a panacea for society to avoid dealing with them.

It is of particular concern that 26% of people surveyed reported knowing at least one woman who had been coerced into having an abortion by another person.[3] If this other person was a partner or family member, this is domestic violence.

---

[2] https://www.news.com.au/entertainment/tv/current-affairs/meshel-laurie-i-hate-the-fact-that-there-is-abortion/news-story/4fcf5b7b91f1dcdf32ce4cafc2570ff5 Story aired on 25 May 2018. Accessed 29 August 2018

[3] YouGov Galaxy Poll, Abortion Study, August 9. 2018 Response to A5: Know anyone who had an abortion due to pressure from another person.

All women should be given support and true choice. A just and compassionate society will assist women who find themselves in difficulty because of pregnancy to be supported, socially and financially. A just and compassionate society will not discard the lives of its youngest and most vulnerable members – its children.

Commentary

SECTION 5 – TERMINATION UP TO 22 WEEKS

Viability is moving downward. That should be reflected in all aspects of law concerning unborn children. The current law in NSW requires a still birth occurring after 20 weeks to be registered, yet the Reproductive Health Care Reform Bill 2019 allows abortion up to 22 weeks. Laws proceed from factual and logical physical realities as well as moral values. The law should convey consistency.

Section 5 of the Bill allows abortion by a medical practitioner on a child up to 22 weeks, for any reason. Laws proceed from factual and logical physical realities as well as moral values. The law should convey consistency. The date of 22 weeks gestation is anomalous in a number of ways:

1. **A child born after 20 weeks must have its birth registered** – Currently in NSW, a stillbirth at 20 weeks gestation must be registered.[4]

2. **Modern technology has brought us to an inconsistent situation that defies any basis in reason**: in one room a child may be aborted and left to die at twenty-four weeks of age, in another room in the same hospital a whole team of specialists will work for countless hours and celebrate the survival of a child of equivalent age. The sole distinguishing factor between these two babies is whether or not another human being desires the child to survive.

3. **Advances in medical technology are constantly revising the time of viability downward:** Health Minister Hazzard noted that the 22-week timeline was the "timing of the most likely viability point for a foetus."[5] Viability is moving downwards. In the second half of the twentieth century medical advances saw the date of 'viability' move from 28 weeks of gestation down to 23 weeks. A 2015 study published in the New England Journal of Medicine[6] found "that a significant number of babies who were born at 22 weeks, just over five months of gestation, survived after being medically treated in a hospital. Previously, 22 weeks was considered too early to resuscitate a baby because survival rates were so low."[7] This has been further tested with the survival of a number of children born before 22 weeks. A little girl was born at 21 weeks and four days in San Antonio, Texas, in 2014.[8] "In her school, she is keeping up with all the other 3-year-olds. She loves playing with other kids. She loves everything I think a normal 3-year-old likes.[9] While this is only one case, the authors of the report argue that it would be reasonable to infer that active intervention would benefit

[4] Births, Deaths and Marriages Act 1995, section 12
[5] Hansard, 8 August
[6] https://www.nejm.org/doi/full/10.1056/NEJMoa1410689
[7] https://www.newsweek.com/babies-born-22-weeks-can-survive-medical-care-new-study-finds-329518
[8] https://www.dailymail.co.uk/health/article-5064367/Most-premature-baby-born-thriving-three-years-on.html
[9] https://edition.cnn.com/2017/11/08/health/premature-baby-21-weeks-survivor-profile/index.html

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.[10]

4. **Out of step with public opinion.** The Australian community does not support abortion in the second trimester. A study on attitudes to abortion reported in the *Medical Journal of Australia* reported that only 12% of Australians believe abortion should be legal in the second trimester for any reason, with an additional 57% believe that circumstances will determine legality. 28% 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[11]. A recent poll in Queensland showed that two-thirds of voters (66%) believe that an unborn child at 20 weeks of pregnancy is a human person with human rights.[12] In most European countries, even those considered to have liberal abortion laws, access to abortion after 12 weeks gestation is more restricted.[13] ACL would advocate for a similar approach to be taken in NSW.

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."[14]

While any abortion is the taking of a human life, limiting abortion to 20 weeks would bring the law into line with existing clinical practice. There is however an argument to bring it back further as in many European jurisdictions.

[10] Op.cit 5 https://www.nejm.org/doi/full/10.1056/NEJMoa1410689
[11] https://www.mja.com.au/system/files/issues/193_01_050710/dec11141_fm.pdf
[12] Galaxy Research, Abortion Study, Prepared for the Australian Family Association, May 2016, p.5. Retrieved 16/09/2016 from http://www.family.org.au/reports/May_2016_Abortion_Galaxy_poll.pdf. 8
[13] Luis Acosta, "Abortion Legislation in Europe", The Law Library of Congress, January 2015. https://www.loc.gov/law/help/abortion-legislation/abortion-legislation.pdf
[14] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_022.pdf

Sex selection

Sex-selection of babies is highly prevalent in some cultures and the preference is mostly for boys. These trends, amongst certain ethnic groups, are also happening in Australia. There is also growing pressure to allow sex-selection for 'family balancing'. It is abhorrent that a healthy child is aborted on the basis of sex. The proposed Bill had no safeguards against sex-selection, opening the way to 'Daughter slaughter'.[15]

It is widely known that some cultures have a preference for male children who will carry on the family name and traditions. It has recently been documented that in an area of India covering 132 villages there have been no girls born for three months.[16] This is not a demographic anomaly – it is the result of targeted sex-selection abortion. The extent of this gendercide is reported by Nature magazine:

> *"Some 45 million girls worldwide were never born because of the use of sex-selective abortions during the past half-century. China and India account for the vast majority of these 'missing' girls, with 23.1 million and 20.7 million, respectively".*[17]

It may be convenient to believe that this is confined to other countries, but a study conducted by Latrobe university noted that there were fewer girls being born into certain ethnic communities in Australia, demonstrating that sex-selection abortion does occur in Australia.[18] Melbourne doctor Mark Hobart, was disciplined by the Medical Board of Victoria when he was accused of having committed an offence under the state's controversial Abortion Law Reform Act of 2008. His patient and her husband requested a sex-selection abortion after an ultrasound determined their fetus was female. They wanted a boy, because they already had a daughter, the husband told Dr Hobart, who, as a practising Catholic, had a conscientious objection to providing the abortion. Under Victorian law, he was obliged to refer the patient to a doctor he knew would terminate the pregnancy.[19]

It is worth noting that the Australian public rejects the use of IVF or abortion for sex selection, and that the level of disapproval has actually increased over the past decade. A study in the *Journal of Reproductive Health* concluded that:

> *Australians generally disapprove of the use of sex-selection technology. If legislation is to be guided by community attitudes, then the prohibition against sex selection for non-medical purposes through assisted reproductive technology should be maintained.*[20]

Failure to include provisions for banning sex-selection abortions undermines any rhetoric claiming to promote abortion as motivated by concern for women or for girls.

Eliminating the disabled

---

[15] https://www.spectator.com.au/2019/08/daughter-slaughter/

[16] https://www.msn.com/en-au/news/world/no-girls-born-for-past-three-months-in-area-of-india-covering-132-villages/ar-AAEIfUK?ocid=spartanntp

[17] https://www.nature.com/articles/d41586-019-01225-3

[18] https://www.latrobe.edu.au/news/articles/2018/release/gender-bias-leads-to-more-male-births

[19] https://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5

[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6125943/

Abortion for fetal abnormality is already widespread without there having been any community debate or establishing protocols to help parents make informed decisions. Many mothers find themselves on the abortion fast track without any consideration of options such as perinatal palliative care or information from support groups for the particular disability. The current practice is eugenics by default because of the absence of any protocols. Women who have abortions due to fetal abnormality exhibit greater tendencies to depression after the abortion.

Abortion for fetal abnormality is already widespread without there having been any community debate or establishing protocols to help parents make informed decisions. How many women have been advised that "there is a risk" that their baby has a serious abnormality only to find that the diagnosis was incorrect? In her book *Defiant Birth: women who resist medical eugenics,* Melinda Tankard Reist has documented the testimonies of women who resisted pressure (sometimes amounting to coercion) to abort.[21] She described how these women were "disparaged and treated as pariahs for departing from accepted medical wisdom they have chosen non-compliance with medical/social prejudice and defiantly said yes to their babies, and no to the cult of perfection."

This is not a simple ethical issue. It is contaminated with discrimination against the disabled and involves agreeing with the arguments of eugenicists, that some lives can legitimately be ended for reasons of genetic purity. This issue also opens the question of what defines 'serious or fatal fetal abnormality'? Do we abort for a cleft palate, of a mal-formed limb? Is it possible to simply discard a foetus and try again, as though abortion were no more than a matter of pressing 'control z' on pregnancy? These questions often assume an obvious case for abortion and make pregnant women vulnerable to coercion and mean that they are at greater risk of being unsupported in a decision to continue with the pregnancy. Does a baby that will live only days or hours not still deserve all the love that can be crammed into that time?

The issue of abortion in on the grounds of foetal "abnormalities" raises many profound ethical and medical questions, which cannot be avoided by saying the decision should be left to the woman. Some of these questions are:

- The issue of the interests and the value of those with "abnormalities". ACL submits the term abnormalities itself is problematical because it has a pejorative import which can lead to a conclusion that the interests of the child are deserving of less consideration than a child without "abnormalities";
- The issue of the provision of adequate information to a woman of the support services available should she carry the child to term and the impact on the lives of women who have children with disabilities;
- The provision of adequate information as to treatment available for foetal conditions. Foetal surgery is a new and fast developing field, which gives parents hope in relation to conditions such as spina bifida.[22]
- The possibilities of error in diagnosis or prognosis. For example, the mother of International recording artist Andrea Bocelli was advised to have an abortion because of potential disability. Andrea has praised his mother for resisting abortion.[23]

[21]

[22] https://www.statnews.com/2019/05/28/new-fetal-surgery-spina-bifida-may-be-safer/

[23] https://www.telegraph.co.uk/news/worldnews/europe/italy/7810902/Andrea-Bocelli-praises-mother-for-rejecting-doctors-advice-to-abort.html (Accessed 11 May 2019)

Informed consent is therefore critical in relation the issue of foetal conditions. Parents of children detected with disabilities while in utero can only provide informed consent if they are provided with adequate information about the disability – including contact with disability support groups. For example, information about life with Down Syndrome, and a meeting with children and adults who live with the condition may assist parents to understand the benefits such children bring to the lives of their families.

There are significant consequences for women terminating a pregnancy for fetal abnormality.

> *"(It) is a complex decision and can leave long-term psychological consequences such as depression, post traumatic-stress and complicated grief for women and their partners. A women's self-esteem often suffers because she failed to bare a healthy child. She may feel she has failed herself and those around her."*[24]

For those babies who are only expected to live days or weeks, it would be better for mother and baby to be referred to an excellent perinatal palliative care service to assist with preparation for the baby's death.[25] For those babies diagnosed with disabilities there are many services to assist the child and the parents, but unfortunately there is no encouragement to seek information before being fast tracked on the abortion conveyor belt. The pressure to abort is great and women are particularly vulnerable at this time, consequently 90% of babies with Down syndrome are aborted.

In the case of foetal abnormality, informed consent also requires advice as to the likelihood of depression after abortion. There is literature emerging which shows a very high level of depression, anxiety and difficulty coping for women and men who have had terminations due to foetal abnormality.[26]

SECTION 6 – TERMINATION AFTER 22 WEEKS

Unrestricted late-term abortion

Only 6% of the population of Australia support abortion in the last trimester. There is no support for late term abortions.

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."[27]

While it might be argued that there are not many abortions after 22 weeks, the proposed legislation allows for an increase. Providing no meaningful limit on late-term abortion effectively opens the door for the practice to increase. A look at the Victorian legislation demonstrates this to

---

[24] https://www.drirena.com/pregnancy-termination-for-fetal-abnormality-is-this-the-best-choice-for-you/
[25] https://www.jognn.org/article/S0884-2175(16)30279-9/fulltext
[26] M.C.A. White-Van Mourik, J.M.Connor; M.A. Ferguson-Smith; "The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality" in Prenatal Diagnosis Vol.12 No.3. March 1992 https://www.ncbi.nlm.nih.gov/pubmed/1589421 (Accessed 11 May 2019)

[27] *R v Wald* (1971) 3 NSWDCR 25 at 29

be the case. Associate Professor Joanna Howe and Professor Suzanne Le Mire of the University of Adelaide Law School, write:

> *The NSW bill is based on the Queensland model, which in turn was based on the Victorian laws, so the situation in that state is a relevant case study. Since abortion was decriminalised in Victoria in 2008, post 20-week abortions have increased by 39 per cent. In Victoria in 2011, for example, an abortion was carried out at 37 weeks and 10 healthy, viable babies of healthy mothers between 28- and 31-weeks' gestation were also aborted for ''psycho-social'' reasons. In Victoria between 2009 and 2016, there were 304 babies who were born alive in the abortion process who were then left to die on the operating table.*[28]

The obvious conclusion is that late term abortions of healthy viable infants will increase. Nobody wants this. Certainly not the majority of Australians. This is not acceptable. Only 6% of the population believe abortion should be permissible after 23 weeks.[29]

Baby born alive

Any baby born alive during an abortion procedure must be given the medical care appropriate to a child of its stage of development. It is neglectful of human dignity to allow a born child to die without care and comfort.

Associated with the practice of late term abortion is the possibility of a baby born alive. As quoted above, Howe and Le Mire identify that in Victoria between 2009 and 2016 there were 304 babies born alive during an abortion process and they were left to die on the operating table. We submit that this is not the practice of a civilized society. To leave a child who may be capable of life outside the womb to die without any medical assistance is barbarous.

The Bill is not clear that there would be a positive obligation on medical professionals to provide any assistance to a child born alive. A child born alive deserves medical care, irrespective of the circumstances of that birth.

Pain relief for the foetus

It is inhumane to cause pain to sentient beings. Unborn babies feel 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. Some specialists believe that real pain is felt from the 20 weeks.[30] Doctors who specialise in inter-uterine surgery regularly administer anaesthesia to their pre-born patients.[31] For this reason, provisions around late-term abortion should also include an obligation to administer pain relief to the foetus.

Restricted understanding of specialist medical practitioner

While an amendment was passed that requires a "specialist medical practitioner" to perform the termination, the only relevant specialisation is that of obstetrics and gynaecology. This person may

---

[28] https://www.smh.com.au/lifestyle/health-and-wellness/doctors-rights-to-object-to-abortion-should-be-protected-20190802-p52dc9.html

[29] YouGov Galaxy Poll, Abortion Study, August 9. 2018. In response to A^: Stage of pregnancy at which to allow abortion.

[30] https://www.justthefacts.org/see-the-science/foetal-pain/

[31] *Annie Murphy Paul, 'The First Ache,' New York Times Magazine, 10 February 2008,* http://www.nytimes.com/2008/02/10/magazine/10Fetal-t.html

be competent in considering "all relevant medical circumstances"[32] but will have no expertise in assessing the psychological circumstances, much less any future social circumstances. It would appear necessary that a specialist in mental health should be required to make a determination relating to a late-term abortion being performed for "psychological" reasons.

We submit that neither and obstetrician/gynaecologist nor a mental health specialist can evaluate social circumstances – especially as they may develop in the future.

Independence of medical professionals

An amendment should be made requiring independence of the medical professionals from each other and from the mother to be demonstrated or that the case be referred to a hospital ethics committee for late term abortions.

Additionally, section 6 has no requirement that the medical professionals be independent, either from the mother of the child or from each other. The second doctor does not have to even see the patient or look at her file. The second doctor does not have to be independent. Even more telling, there is no legal penalty if the two-doctor rule is not observed. A law without a penalty is no law at all.

SECTION 7 – INFORMATION ABOUT COUNSELLING

Pre-abortion counselling should be provided to all women seeking abortions. Any counselling process should also allow a period of a minimum of 72 hours between counselling and the termination of a pregnancy.

Section 7 provides a 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 know that abortion can have a psychological impact on the mother. Academic studies confirming this were cited by the Honourable Member for Mulgoa during the Consideration in Detail of the Bill[33]

Because women facing unplanned pregnancies may be vulnerable and conflicted, it is important to provide assistance in the decision-making process through access to an independent counsellor. A counsellor may assist in:

i. Balancing the interest of the child with that of the woman;
ii. Identifying the existence of abortion coercion by partner or family;
iii. Providing information about the risks of abortion including abortion grief;
iv. Provide information relevant to treatments available to the child in the womb;
v. Assist in overcoming the problem of sex-selection abortion.

---

[32] Cf section 6(3)(a)

[33] Hansard, 8 August

The need for pre and post abortion counselling is advocated by the Royal ANZ College of Obstetricians and Gynecologists (College). In paragraph 2 of its paper on terminations, the College says:

> *"Recommendation 2: A woman's physical, social, emotional and psychological needs should be taken into account in the course of decision-making, and pre- and post-termination counselling by appropriately qualified professionals be made available."*[34]

Assisting a woman identify her values may also provide a safeguard against post-abortion trauma. This can include:

- 3.5 times greater incidence of clinical depression;[35] and
- High rates of PTSD (up to one fifth) at three months post abortion.[36]

Counselling would assist the woman in her decision making. Any counselling process should also allow a period of a minimum of 72 hours between counselling and the termination of a pregnancy.

SECTION 9 – CONSCIENTIOUS OBJECTION

Freedom of conscience

Doctors, nurses, and counsellors must be free to exercise their conscience. If they believe abortion is not good for the woman, and is destroying a defenceless human life, they must not be forced to comply with abortion by referring the woman to someone else.

Doctors, nurses, and counsellors must be free to exercise their conscience. If they believe abortion is not good for the woman, and is destroying a defenceless human life, they must not be forced to comply with abortion by referring the woman to someone else. Further, 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

A significant concern with this Bill is the disregard it has for the fundamental right of conscientious objection. The Bill claims to offer health practitioners the option to exercise 'conscientious objection' but then requires them to refer the patient to someone that does not share that objection. This is not conscientious objection. It clearly requires the health practitioner to compromise their conscience.

This issue was addressed in another jurisdiction in relation to referral to another practitioner where the first health practitioner was ethically opposed to euthanasia. In a hearing on Euthanasia in the

[34] https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Use-of-mifepristone-for-medical-termination-of-pregnancy-(C-Gyn-21)-Amended-February-2016_1.pdf?ext=.pdf (Accessed 8 January 2019).

[35] Pedersen et. al., Scandinavian Journal of Public Health, Vol.36, No.4, 424-428 (2008) DOI:10.1177/1403494807088449 and Cougle et.al., '*Depression associated with abortion and childbirth: A long-term analysis of the National Longitudinal Study of Youth cohort*' Medical Science Monitor 2003; 9(4):CR105-112 as quoted in https://www.abortiongrief.asn.au/documents/Recent%20Research.pdf?1 Accessed 30 August 2018

[36] Sharain Suliman et al, '*Comparison of pain, cortisol levels and psychological distress in women undergoing surgical termination of pregnancy under local anesthesia vs. intravenous sedation*'. BMC Psychiatry 2007, 7:24.

ACT Legislative Assembly, a question was asked of Ms Gabrielle McKinnon, Human Rights Law and Policy, ACT Human Rights Commission. Ms McKinnon was asked:

> *"Do you think that any requirement to refer, from someone who refuses to participate, is too onerous or that there is some middle ground referral that under the Human Rights Act may not be considered too onerous?*

Her reply was:

> *"If I could take that a bit further, the idea is that certainly it would be a limitation on a doctor's rights to freedom of religion, and their ability to conscientiously object, to require them to participate in the carrying out of voluntary assisted dying**. It is certainly arguable that requiring them to directly refer to another doctor, knowing that the outcome of that would be that the person would have access to voluntary assisted dying, is likely to be also seen as a limitation."***[37]

While the discussion above was in relation to voluntary assisted dying, it applies equally to abortion. The obligation to 'refer' is seen as a limitation on a doctor's right to freedom of religion under the Human Rights Legislation in the ACT.

This submission argues that it is also a denial of a medical practitioner's right to freedom of thought, conscience and religion under Article 18 of the International Covenant on Civil and Political Rights (ICCPR) which states:

> *Everyone shall have the right to freedom of thought, conscience and religion*.

In the Church of the New Faith v Commissioner for Pay-roll Tax (Vic)[38] Mason ACJ and Brennan J said: *Freedom of religion, the paradigm freedom of conscience, is the essence of a free society.*[39]
Therefore freedom of conscience and the right of conscientious objection must be preserved. This is the position under the Australian Prudential Health Regulatory Authority's Code of Conduct.[40]
There should be consistency between NSW and national standards in this regard.
Doctors, nurses, and counsellors must be free to exercise their conscience. If they believe abortion is not good for the woman, and is destroying a defenceless human life, they must not be forced to comply with abortion by referring the woman to someone else.

For many doctors and nurses, abortion is a matter of deeply held conviction. For some, they will be unable to comply with the law at all, even with the risk of heavy penalties, therefore many will be forced out of their chosen profession rather than conform to the law.

SECTION 10 – PERSONAL CONDUCT OR PERFORMANCE

Inadequate criminal sanctions

Any legislation which does not carry commensurate legal sanctions will be ineffective. In outlining penalties for contraventions of the law, this section states that a failure to comply with sections 5, 6

---

[37] Select Committee on End of Life Choices in the ACT; transcript of evidence Friday, 18 May 2018; http://www.hansard.act.gov.au/hansard/2017/comms/elc02a.pdf

[38] (1983) 154 CLR 120.
[39] Ibid at 130.
[40] https://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx accessed 30 May 2019.

or 9 is relevant for complaints and disciplinary procedures under the *Health Practitioner National Regulation Law* and the *Health Care Complaints Act*. This appears to not be commensurate with the illegal taking of a human life – possibly without the consent of a mother.

This is also inconsistent with the provisions of The *Crimes Act 1900* which may result in imprisonment for up to 25 years for intentionally causing grievous bodily harm. This includes the crime of "child destruction" even if the mother is not harmed.[41], or up to 10 years if caused recklessly[42].

In the case of R vs Snood[43] where Dr Suman Sood, administered abortifacient drugs to a young woman at 23 weeks' gestation, causing her to give birth prematurely to a baby who did not survive, might not be considered to be crimes. In the Bill under consideration this would not be a crime.

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

It seems that the possibility of criminal proceedings, depending on additional circumstances, is inadequate when considering the harm that might result to both mother and child when a medical professional is acting outside the law.

Excessive sanctions against conscientious objectors

In the light of the leniency of sanctions highlighted above, the Bill treats conscientious objectors with the same severity as those who may cause harm, even death to the mother and the child.

These are not equivalent. One is a crime; the other is the exercise of a legitimate and non-derogable right recognised in international law. The right to conscientious objection for medical practitioners should be respected while an abortion performed by a medical professional that is not authorised by the Bill is subject to the grievous bodily harm provisions of the *Crimes Act 1900*.

Violence and coercion

It is of particular concern that there are no provisions in this Bill to ensure that women are not coerced into abortion, nor that their pregnancy was not the result of assault or domestic violence. In a recent survey 26% of people surveyed reported knowing at least one woman who had been coerced into having an abortion by another person.[3] If this other person was a partner or family member, this is domestic violence. It is an anomaly if we pursue domestic violence in one set of laws and ignore it in another. Mandatory counselling would assist in identifying these women and resolving the issues which drive them to abortion.

Abortion under 16 Years

---

[41] Crimes Act 1900, section 33(1)

[42] Crimes Act 1900, section 35(2)

[43] R v Sood (Ruling No 3) [2006] NSWSC 762

Any pregnancy in a child under the age of 16 years must be investigated for possible child sexual abuse. Parents are still the custodians of the child and ought to be informed of a pregnancy.

The proposed Bill has provisions for overruling the parents if the pregnant woman is a child under the age of 16. This clearly undermines parental rights.

Evidence suggests that there are serious complications for girls who abort rather than carry a pregnancy to term, including:

- 5 times more likely to seek help for psychological/emotional problems;
- Over 3 times more likely to report trouble sleeping;
- 9 times more likely to report marijuana use.[44]

Will the medical professional or social worker who overrides parental authority be available to care for the young woman post-abortion or in the event of any physical or mental complications arising from the procedure?

Failure to keep records

In order to provide good medical care it is imperative that NSW record and publish anonymised abortion statistics. The collected should be presented in a manner that facilitates comparison with other state legislatures

According to best estimates, one in four women in Australia will have an abortion at some point in her life. For any other medical procedure the essential data would be captured as a matter of course. Only Western Australian and South Australia collect data on abortions. Information for the rest of Australia is often extrapolated from this information.

In order to better understand the individual and public health impacts of termination of pregnancy, the World Health Organisation in its publication *Safe Abortions: health and technical guidance for health systems* supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.[45]

Better information is clearly vital to inform good health policy. Specifically, NSW should record:

- The number of annual abortions;
- The methods used;
- Gestational age of the foetus;
- Sex of the fetus;
- The age of the mother;
- How many abortions has had;
- The reasons why the mother chose an abortion, compared with parenting or adoption.

---

[44] Coleman, '*Resolution of unwanted pregnancy during adolescence through abortion vs. childbirth: Individual & family predictors and Psychological consequences*'. Journal of Youth and Adolescence 2006; as quoted in https://www.abortiongrief.asn.au/documents/Recent%20Research.pdf?1

[45]http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=D7E3A0C19778981968F9DE16C0ED6BB2?sequence=1 accessed 8 January 2019- Safe abortion: technical and policy guidance for health systems Second edition-especially chapter 2.

This information would be considered essential in policy development in order to provide good health care and social services, as well as a data informing the needs of women facing crisis pregnancies.

There is no way of accessing accurate information on the numbers of abortions in NSW. Any information available is extrapolated from relevant Medicare items which includes miscarriages as well as abortions.

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, but there is no data to inform that requirement and no provision to gather it.

Conclusion

Abortion is always the destruction of an innocent human being, living in the womb. Accordingly, the ACL urges this committee to reject this Bill.

It is our concern that this legislation is out of step with community attitudes. It is not a reality that women are in any way disadvantaged by the existing laws, but they might be seriously harmed by legislation which allows abortion up to birth with no safeguards.