**Submission No 41**

# INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

**Organisation:** Plunkett Centre for Ethics

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# Plunkett Centre for Ethics

**A joint centre of Australian Catholic University, St Vincent's Health Network Sydney and Calvary Healthcare**

## SUBMISSION TO THE NSW STANDING COMMITTEE ON SOCIAL ISSUES: INQUIRY INTO THE *REPRODUCTIVE HEALTH CARE REFORM BILL 2019*

1 As the unambiguously pro-choice feminist, Naomi Wolf, acknowledges, it is more truthful to speak of a woman's decision to have an abortion not as an 'intensely personal choice' (which as Wolf pointed out makes it sound as though she is 'deciding on a carpet' ) but as a genuinely grave decision about right and wrong. [1] In considering this Bill, the Committee should treat the matter as though it were such a genuinely *grave* decision.

2 There is a fundamental distinction between (a) an intentional termination of the life of a foetus and (b) an intervention aimed at curing a serious pathological condition of a pregnant woman in circumstances in which the intervention cannot be safely postponed until after the baby is viable (in which circumstances the foetus' death is foreseen but not intended). Note that both of these procedures can be referred to as 'abortion'. In this submission I use the terms 'abortion' and 'termination' to refer to the former.

3 The professional knowledge and expertise of a medical practitioner is limited to medically-required treatment for the promotion, improvement or maintenance of health, the avoidance of ill-health and disease, the relief of disability. In the main, doctors have no special training in, or expertise in, the 'psychological and social circumstances' of their patients. It follows that they are not competent:

a. to take into consideration woman's *current and future psychological and social circumstances* in order to determine whether a termination *should* be performed (see eg 6.3.b);

[1] Naomi Wolf. 'Our bodies, our souls: rethinking pro-choice rhetoric'. New Republic, 16 October 1995, 26-35

b. to determine *whether or not* it would be beneficial to discuss with the person accessing counselling about a proposed termination.[2]

4 The practice of abortion is controversial within the medical profession. Some practitioners are not willing to perform this procedure at all, some only in the first trimester, some only in the first and second trimesters, some up until birth. It follows that:

a. It is unreasonable to expect individual practitioners to *know* the readiness of other practitioners to perform an abortion in particular circumstances.
b. Given that the practice is controversial, reference to professional standards and guidelines 6.(3) c refer only to *how* it is done and not *whether* it is done.

5 Abortion 'on demand' should be legal only up to 12 weeks' gestation. (Chemical abortions are effective up to that date, and the law may not able to enforce a prohibition on such abortions.) Exceptions to a general prohibition to abortion after 12 weeks should be limited to cases where the procedure is thought to be needed to protect the life of the mother, to protect her from a serious threat to her health, or in cases of rape or incest. Some will argue that those exceptions are too limited. If that argument wins the day, then the duty of the state to protect human life requires a prohibition except on serious medical grounds.

6 The ethical requirement for truly informed consent to a procedure is hardly satisfied by the provisions of this Bill. Adequately informed consent requires the kind of appreciation of what is involved that only trained counsellors can elicit (counsellors who are, of course, independent of abortion providers). Freely-given consent requires the absence of coercion by anyone else. Once again, access to trained counsellors is needed. Such counselling should be made freely available and widely accessible.

7 Medicine is replete with the need to make judgements of conscience. But on the big ethical issues which are controversial within society and within medicine, in particular, that of deliberately bringing about death, a decent ('liberal', 'pluralist') society will give doctors the widest possible scope for the exercise of their deliberative and conscientious

[2] This used to be referred to as 'medical paternalism'.

judgement. Of course, there is a legitimate limit to the exercise of conscientious judgment in medicine: that is, that its exercise does not put the life or the health of a patient at significant risk. But inconvenience to a patient is not reason enough to coerce a doctor to do what he or she thinks is wrong. And, given that we generally think that assisting a person to do something wrong is itself wrong (think of assisting a person to cheat on an exam or assisting a person to rob a bank or assisting someone to [insert something you think is wrong]), we should take the same attitude to coercing a doctor to assist another to do what he or she thinks is wrong. Some doctors will have a conscientious objection to providing an abortion. Others will have a conscientious objection both to providing and facilitating access to abortion. In both cases the law should not coerce the doctor to act in violation of his or her sense of right and wrong.

8 Recommendations:

a. Part 2, S 5: Change to '… not more than 12 weeks pregnant.'
b. Part 2 , S 6: Change to '… after 12 weeks.'
c. Part 2, S 6: Delete subsection (b).
d. Part 2, S 7: delete (a).
e. Part 2, S 7: (b); delete 'if, in the medical practitioner's assessment, it would be beneficial and the person is interested in accessing counselling…'
f. Part 2, S 9: Delete subsection (3) and insert a new section as follows: A registered health practitioner who has a conscientious objection to participating in the provision of a termination has the right to refuse to participate in the provision of a termination.

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