Submission No 43

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

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The New South Wales Standing Committee on Social Issues
NSW Legislative Council

By email

Re: Reproductive Health Law Reform Bill 2019

Thank you for the opportunity to comment on this bill.

I note the haste with which this bill has been rushed through the Legislative Assembly. As a specialist obstetrician in practice for forty years, I have major concerns with some aspects of the bill, however given the short timeframe within which the public has been given to comment, I restrict my comments to two key areas. I will make myself available to appear at any public hearing, if required, where I am happy to orally supplement these submissions.

Qualifications

1. I am a medical doctor practising as an Obstetrician and Gynaecologist in New South Wales. I am a Visiting Medical Officer at Liverpool District Hospital and Sydney Southwest Private Hospital and a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and a consultant in the high risk obstetric unit at Liverpool Hospital.

2. I have a Bachelor of Medicine and Bachelor of Surgery degrees and am an Adjunct Lecturer in the School of Medicine at the University of Notre Dame Australia and Campion College.

Specialist medical practitioner required only after 22 weeks

3. In my forty years of practice, I have participated in some three thousand fetal and perinatal clinical meetings. These meetings discussed at length and in depth lethal fetal anomalies as well as varying degrees of severity, prognosis and outcomes of non-lethal anomalies. Despite the expertise, experience and sincerity of the involved clinicians, there was often differences of opinion, especially in relation to non-fetal anomalies.

4. Some non- lethal conditions can stabilise, some can spontaneously regress, and some can have minimal impact on a child and parent after surgical correction. Unfortunately I have witnessed cases when a termination was performed for an abnormality detected on radiological investigations and subsequent autopsy revealed no abnormality.

5. Clause 5(1) states that, "A person who is a medical practitioner may perform a termination on a person who is not more than 22 weeks pregnant." And clause 6 (1) 1 states, "A specialist medical practitioner may perform a termination on a person who is more than 22weeks pregnant if..."

6. A decision to terminate a pregnancy at 21 weeks is virtually indistinguishable to terminating a pregnancy at 23 weeks. Yet for the latter a specialist medical practitioner is required. This 22 week cut-off is illogical and potentially harmful to the woman. I know of no medical practitioners, who are not specialists, who have the necessary expertise in perinatal pathology and feto-maternal medicine to advise and perform termination of pregnancies based on many non-lethal fetal abnormalities.

7. Terminations of pregnancy for fetal structural abnormalities can have the potential to be problematic from about 16 weeks gestation. Some structural abnormalities are lethal, others require specialist oversight to determine the outcome and effects on the neonate. These life-defining decisions should not be left to medical practitioners but rather specialist medical practitioners commencing no later than 16 weeks gestation.

8. Furthermore, occasional difficulties in interpreting and advising outcomes in relation to many non-lethal fetal abnormalities should require four specialist medical practitioners to review. This will not result in extra suffering nor increase complication rates. Four specialist medical practitioners can come to a decision as quickly as two, delay is not a problem since complication rates for a termination at twenty weeks are similar to those at 22 weeks. More importantly there is less scope for error and the woman will be reassured by the additional oversight.

9. Accordingly, the need for a specialist medical practitioner to perform abortion only after 22 weeks is a dangerous proposition. At the very least, a specialist medical practitioner should be involved in any termination from 16 weeks onwards.

Approved facilities

10. My other concern is that at clause 6(d)(ii), the bill requires only terminations after twenty two weeks to be performed in approved health facilities. However this is a problem because complication rates for terminations at twenty weeks are similar to those at twenty two weeks and twenty four weeks. Again this distinction is illogical and potentially harmful to the woman.

11. The vast majority of terminations performed after sixteen weeks are medical terminations. A medical termination is a non-surgical procedure occasionally involving feticide (ie, an injection of a lethal substance directly into the fetal heart) with administration of termination drugs.

12. They can occasionally proceed over several days and require twenty four/seven surveillance. Hence approved health facilities should be mandatory to provide continuous and specialist best practice management during these distressing and often problematic times.

13. These inadequacies or ambiguities in the drafting of the bill are also evident in clause 6(2), where it provides '…'does not require that any ancillary services necessary to support the performance of a termination can be carried out only at the hospital or approved heath facility at which the termination is, or is to be, performed."

14. Ancillary services can include feticide (injection of a lethal substance directly into the fetal heart) and administration of termination drugs. These ancillary services have the potential to cause significant harm to the woman. They require specialist management in a hospital facility that can provide immediate and appropriate resuscitation and surgical intervention.

Emergency

15. Clause 9(4) states that a doctor with a conscientious objection must still perform abortion in an emergency, however I note with concern that the term emergency is not defined in that section or in schedule 1. In my experience, an emergency can only be defined as relating to the "imminent threat to the life of the mother".

16. I would not wish to see this section broadly construed to encapsulate social and economic emergencies.

Conclusion

In conclusion, this bill falls far short of best practice management and is a disservice to the women who the bill purports to be assisting.

Yours sincerely,

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