

Speech by Dr John NEIL at Parliament House on 6/10/08 on behalf of DICAAB

Background. I am an Obstetrician who began training as a specialist in 1969 in the year of the Menhennit ruling. Issues were black and white in those days, but the ethics of abortion rapidly became more grey. This has always been a very difficult issue and these women need a lot of compassion and support in their choices.

I am old enough to have seen maternal deaths from severe infection after illegal abortion. We are not proposing a return to that situation. The existing common law is unsatisfactory and needs proper legislation, which this bill is not.

My purpose is to make clearer the clinical aspects which I find very confused in this bill.

1. The anti-conscience clause. It is ludicrous that a “registered medical practitioner” should have to perform an emergency abortion. Firstly it is coercive, and others will speak about this. Secondly, it is based on a false premise that an emergency abortion actually is ever necessary.

Coercion to make an “effective referral” is also unnecessary and prejudicial.

2. A confused grasp of the clinical. It is important to differentiate early induction of labour from late term abortion (currently > 20 weeks). I will illustrate.

Example: A woman is admitted to hospital with ruptured membranes rapidly followed by severe infection of the uterus and septicaemia. The unborn child is still alive. There is no question that induction of labour should occur immediately to save the life of the mother. There is no intent to kill the baby which happens as side effect.

On the other hand, a Down syndrome unborn baby is diagnosed at 21 weeks, and a late term abortion is carried out, in this case with the intent to kill the unborn.

Under the act, both are abortions but differ because of the intent. This distinction has been blurred in this Bill. The former case is of course an emergency, but has not got the same ethical implications.

3. Poor supports for the women in this dilemma. There is nothing in the Bill, and there is little support by the Victorian Government currently for women making these choices, compared to, say, South Australia. These would include effective counselling about options, and follow-up. There are some voluntary supports, and we know that if ultrasound of the unborn is included in the counselling, then the rate of abortion can reduce from 60% down to 25%. The current low threshold for seeking an abortion would be further lowered by the current legislation given the lack of support or counselling.

Psychiatrist Professor David Clarke’s, statement is important “...distress and upset may be common when a woman is considering termination, but should not in itself be an indication for abortion. The correct response is proper psychological assessment and care.”

Support through a pregnancy complicated by abnormality of the unborn child is rarely offered, but can make for much better resolution of the grief and closure.

Example. A woman was referred from country NSW to me late in pregnancy. Her unborn child was diagnosed with an under developed left side of the heart, in those days incompatible with life. This usually results in termination. She wanted the chance to keep her baby alive for up to an agreed 6 weeks at the RCH awaiting a heart transplant. A suitable donor heart never came. She however was convinced that she had done the best by her baby and had no regrets about her choice.

Grief together with regret is a potent combination for a woman to deal with.

4. Poor clinical practice is endorsed.

Great expertise is required to avoid disaster in both early and late abortion, not available with just any “registered medical practitioner” in the hypothetical emergency abortion.

5. Failure of recognition of the unborn child as a person.

Examples:

- We spend \$300,000 for newborn intensive care for a 24 weeks prem.
- We do intra-uterine surgery on the 24 week unborn.
- We laser treat the communicating placental blood vessels in twin to twin transfusion syndrome at 24 weeks and avert disaster for the twins.

In all these case we are treating with great skill the 24 week unborn as a person.

- Then in the case of an unwanted unborn child at 24 weeks we treat it as a non-person. This is despite viability of 24 weeks having been reached.

Thus there is a contradictory attitude to the status of the unborn depending on the mothers wishes, even this late in the pregnancy.

I believe it is important to stick with 20 week as the cut off for abortion, and not even get close to the issue of viability i.e. 24 weeks. Late term abortion should be those after 20 weeks and there needs to be an independent ethics tribunal involved in recognition of the seriousness of this decision and to provide for accountability.

The privilege and responsibility of parenting and co-creating a human individual is being very degraded by this Bill. Thus I concur with Jean Rostan, the French biologist, who said “...I believe that there is no life so degraded, debased or impoverished that it does not deserve respect and is not worth defending with zeal and conviction....I would measure society’s degree of civilization by the amount of effort and vigilance it imposes upon itself out of pure respect for life”.