Women's Sexual and Reproductive Health Coalition
Response to Termination of Pregnancy (Live Births) Amendment Bill 2024

The national Women's Sexual and Reproductive Health Coalition, chaired by SPHERE (the SPHERE Coalition), welcomes the opportunity to make this submission in response to the Termination of Pregnancy (Live Births) Amendment Bill 2024.

SPHERE is the National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care – a collaborative research centre comprising national and international experts in sexual and reproductive health.

The SPHERE Coalition is a cross-sectoral, multidisciplinary alliance comprising over 150 clinician experts and consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers with a shared vision for improving women's sexual and reproductive health.

On 20 March 2024, Mr Robbie Katter MP, Member for Traeger, introduced the Termination of Pregnancy (Live Births) Amendment Bill 2024 into the Queensland Parliament and referred it to the Health, Environment and Agriculture Committee for examination.

The stated objective of the Bill is to legislate protections for babies that are born alive as a result of an abortion. In this context, 'born alive' or 'live birth' is recognised as when a foetus that exits the mother demonstrates any sign(s) of life such as a heartbeat, muscle movement or pulsing of the umbilical cord. This definition applies regardless of gestational age and whether the foetus can survive outside of the womb. The Bill intends to clarify that babies born under these circumstances will receive the same medical care as any newborn would, and that the obligations of the health practitioner should be no different.

Access to pregnancy termination services is a reproductive and legal right in Australia and is a key priority of the National Women's Health Strategy 2020-2030. It is the view of the SPHERE Women's Sexual and Reproductive Health Coalition that the proposed Bill compromises this right and is potentially harmful to both women seeking abortion services and the practitioners that provide them.

The Coalition therefore strongly opposes the bill and strongly recommends that this Bill not be passed nor supported. We have significant concerns regarding the proposed Termination of Pregnancy (Live Births) Amendment Bill 2024 as it:

- demonstrates a poor and inaccurate understanding of second trimester abortion care and the complexities of foetal viability,
- is an infringement on the reproductive rights of pregnant women and may be detrimental to their health and wellbeing, and
- interferes with the responsibility and obligations of medical providers to offer patient-centred care and their ability to meet established medical and professional ethics standards in delivery of clinical services.

As such, we strongly recommend that this Bill not be passed nor supported.

Foetal Viability

Abortion is fully decriminalised in all Australian states and territories, however, most jurisdictions have gestational age limits (ranging from 14 to 24 weeks gestation) for abortions on request. Beyond these gestational limits, most jurisdictions require the approval of two doctors (Children by Choice 2021). Foetal viability (i.e. the potential to be able to survive outside the womb) is complicated and lacks uniformly applicable legal, medical and gestational age criteria on the basis of which it can be defined and applied (Bates 1983). Advances in neonatal intensive care have shifted foetal viability to lower gestational ages, however, reported survival rates between 22-24 weeks gestation vary across countries.

There is broad agreement in the medical community that this period of gestation is a 'grey zone', where a small proportion of foetuses have survived only through major medical intervention and most with ongoing disability (South Australian Law Reform Institute 2019). Life-sustaining interventions are generally only recommended for infants born from 23-24 weeks onwards in Australia (see, for example, Queensland Clinical Guidelines 2020), and come with major risks of serious health problems (affecting quality of life and ability to thrive) and early mortality due to insufficiently developed heart, lungs and brain (Askola 2018). Legislative approaches that mandate treatment for extremely premature neonates ignore the low and variable survival rates that are highly dependent on the availability of advanced neonatal medical care and expertise that cannot be feasibly financed or standardised across Australian jurisdictions.

Later Gestation Abortion

Later gestation abortions (i.e. after 14 weeks) are very uncommon. Data from South Australia, the only Australian jurisdiction that publicly releases abortion data, indicates that in 2018, 91% of terminations were provided at or before 14 weeks' gestation, with the remaining 9% provided beyond this gestational age. Among later gestation abortions, only 2% were performed at or beyond 20 weeks' gestation (South Australian Law Reform Institute 2019). Abortions occurring later in the second trimester are especially likely to involve complex medical circumstances, including serious or fatal foetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the fetus is one of a multiple pregnancy; or complex personal circumstances, including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, rape or incest, socio-economic disadvantage, drug addiction or mental health issues (Queensland Law Reform Commission 2018). Importantly, pregnancy terminations later in the second trimester are only undertaken after careful consideration and discussion amongst all relevant parties and in the most compelling of circumstances (South Australian Law Reform Institute 2019).

Interference with Medical and Professional Ethics Standards

Providers of abortion care, like all other medical providers in Australia, are bound by clear medical protocols that are in line with current evidence-based standards for abortion-related clinical care. As such, legally mandating measures for foetuses that have medical issues which are incompatible with life or with the mother's health is in contravention of current standards of medical and ethical care. A key objective of clinical practice is to provide care that is patient-centred. Patient-centred care includes the provision of medical care that is compatible with patients' personal goals, wishes and preferences related to the care provided. The proposed measures in the Termination of Pregnancy (Live Births) Amendment Bill 2024 reflect a poor understanding of the realities of clinical decision-making and are essentially irreconcilable with patient autonomy and patient-centred care. It

therefore interferes with the duties of providers to administer patient-centred care and their ability to meet established medical and professional ethics standards. Considering these points, this Bill is obsolete and unnecessary as there already exists a framework for providers to adhere to in their duty of care. The current framework and rigorous professional standards in place are sufficient in ensuring that appropriate care is administered to both mother and baby.

The Bill compromises the right to access abortion

If passed, the Bill may dissuade providers from performing late-term abortions due to fear of prosecution in the extremely rare event a baby is born alive. All practitioners are bound by a duty-of-care which informs when and how they may perform their duties in such a scenario. Any intervention taken should be decided by clinical practice and what is appropriate based on the circumstances of the abortion. However, if providers are legally forced to intervene regardless of context, this compromises their right to make clinical decisions that ensure the safety and health of parties involved, and may dissuade them from performing abortions to avoid being put in that situation.

This Bill therefore erodes the support and trust we have in our practitioners. As a result, this will limit women's access to vital services and may exacerbate the already prominent disparities faced by women living in rural and remote areas, including First Nations women.

References

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