Termination of Pregnancy (Live Births) Amendment Bill 2024

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SUBMISSION

Termination of Pregnancy (Live Births) Amendment Bill 2024

Dr Melissa Lai*

Dear Senate Committee members,

Thank you for the opportunity to make a submission to the Inquiry into the *Termination of Pregnancy (live births) Amendment Bill 2024*.

I am a Neonatologist (specialist in newborn medicine) and Director of Prolife Health Professionals Australia. We are the national peak body of healthcare providers who advocate for medical care that safeguards the lives of both the pregnant mother and her fetus (unborn or preborn infant).

I work as a Neonatologist at the Royal Brisbane and Women's Hospital. I also coordinate medical retrievals for the Neonatal Retrieval Emergency Service Southern Queensland (NeoRESQ), serve as the co-chair of the RBWH Neonatal Research Group and hold a Senior Lecturer Academic Title at the School of Medicine, University of Queensland. I was awarded my PhD on the effects of infant massage on preterm infant neurodevelopment in 2021. I have a strong track record of securing local and national grant funding for neonatal research and collaborate with internationally renowned research institutions to improve neonatal care (care provided in the newborn period).

In this submission I make the following recommendations to support the *Termination of Pregnancy (live births) Amendment Bill 2024*.

Please find attached my submission.

[redacted]

Yours sincerely
Dr Melissa Lai
BPharm, MBBS, FRACP, CCPU, PhD

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* All views are the author's alone and not that of her employer.

SUBMISSION

Termination of Pregnancy (Live Births) Amendment Bill 2024

Dr Melissa Lai*

Prolife Health Professionals Australia (PHPA)

PHPA is the national peak body of healthcare providers who advocate for medical care that safeguards the lives of both the pregnant mother and her fetus (unborn infant). Typically, health professionals enter the start of their training prolife, where the intentional ending of a human life will not have been considered. Currently Australia ranks amongst the highest countries for termination of pregnancy in the developed world, with 1 in 4 women undergoing a termination procedure. With increasing pressure to increase access to abortion across Australia throughout all nine months of pregnancy, the prolife health professional will face increasing pressure to conform and compromise their values. PHPA aims to support and equip prolife health professionals and future trainees.

Introduction

Induced abortion (termination of pregnancy) is the procedure of ending a pregnancy, with the simultaneous intention of ending the life of the fetus in that pregnancy. In Queensland, the *Termination of Pregnancy Act 2018* legalises abortion at any stage of pregnancy, provided it is performed by a medical practitioner, with additional requirements to consult with another medical practitioner after 22 weeks' gestation, to support a woman's request for termination.[1]

Prior to 22 weeks, medical termination of pregnancy (MToP) and surgical termination of pregnancy (SToP) are the options for ending the life of a fetus.[2] MToP may result in live birth as it involves induction of labour to expel the fetus from the uterus without prior feticide or surgical intervention. Feticide is the termination of pregnancy procedure that ensures the fetus is dead prior to birth, typically achieved by intracardiac injection of potassium chloride to cause asystole (cardiac arrest).[3] Feticide can be performed by a medical specialist with advanced ultrasound and *in utero* invasive procedural skills. The Queensland Clinical Guideline for Termination of Pregnancy recommends feticide for pregnancies at gestations

*All views are the author's alone and not that of her employer. At the time of writing, the author is a Neonatologist at the Royal Brisbane and Women's Hospital. Dr Lai also coordinates medical retrievals for NeoRESQ, is co-chair of the RBWH Neonatal Research Group and is a Senior Lecturer at the School of Medicine, University of Queensland. Dr Lai has a strong track record of leading local and nationally funded clinical trials, and was awarded her PhD on the effects of infant massage on preterm infant neurodevelopment in 2021. Dr Lai is also the National Director of Prolife Health Professionals Australia.

[1]Queensland Government. *Termination of Pregnancy Act 2018.*

[2] Queensland Government, Queensland Clinical Guidelines: Termination of Pregnancy (2019) 8.

[3]Rosser S et al, 'Late termination of pregnancy at a major Queensland tertiary hospital, 2010-2020' (2022) 217(8):410-4. *Medical Journal of Australia*

greater than 22+1 weeks,[4] as the risk for a failed abortion (i.e. an infant birthed alive instead of dead) is much greater at these later gestations.[5,6]

Live birth following a termination of pregnancy is uncommon but does occur, with a reported 35 infants in Queensland (20 to 28 weeks' gestation) born alive in 2022, with similar numbers since 2019.[7] Feticide is performed when fetuses are at or after 22+1 weeks' gestation. Because feticide is so effective at causing death, the risk of a live birth is unlikely, but is not zero.[4]

In neonatal care, 2 types of treatment are available, active or palliative. Active treatment refers to treatment that is provided to sustain life. At times in Neonatology, it is unclear whether active (life-saving) treatment will result in improved neonatal outcome, however it is provided until the infant's prognosis becomes more clear, at which time a decision may be made to switch to palliative care. This switch is sometimes referred to as "a redirection of care", towards providing palliative care. Palliative care (comfort care) refers to care that is provided where the focus is primarily to maintain the patient's comfort, until their natural death, which in this case would be thought to be within minutes to days, and less likely, weeks to months. This care is usually reserved for infants with a life-limiting condition (e.g. infant with significant malformations), or in a preterm infant, where the prognosis for long term survival into adulthood is unlikely.

Arguments supporting the Bill

Abortion survivors exist.[8] One such case is Melissa Ohden, an American woman, who survived an abortion at 32 weeks' gestation almost 40 years ago. Ms Ohden founded the Abortion Survivors Network, which seeks to educate the public about failed abortions and survivors while providing emotional, mental and spiritual support to abortion survivors, with now over 630 in the network. What this network highlights is that given the opportunity, viable fetuses without a life-limiting condition, that survive abortions, go on to live purposeful lives and contribute to society. An infant that survives an abortion and is of viable gestation, should be considered a patient and have a right to care by the appropriate physicians, in this case, have access to neonatal care in an intensive or special care nursery depending on the level of care required, regardless of whether they are wanted alive by the mother or the physician(s) who deemed it appropriate to proceed with the abortion.

Consider the hypothetical case of a third trimester pregnancy, where the mother has indicated she would like an abortion and is referred to a facility where late term abortions are provided. The mother spontaneously goes into labour and the facility is unable to proceed with the feticide, as labour precluded this procedure. A live infant is born and taken to the nursery for active treatment. Regardless of whether the mother or obstetric physician in this instance came to a mutual therapeutic decision that abortion was in the mother's best interests, it would be inappropriate for that infant not to receive neonatal care. Similarly, if a viable infant (with no reasons for needing palliative care) is born alive following a failed abortion, the same argument can be made that the infant should receive the same access to neonatal care. In this scenario, active treatment is the appropriate course. If the infant is not considered viable (less than 22 weeks' gestation) and is born alive following a failed abortion, they should receive palliative care until their natural death.

[4]Queensland Government, Queensland Clinical Guidelines: Termination of Pregnancy (2019) 8.
[5]Auger et al, 'Second-trimester abortion and risk of live birth (2023). *American Journal of Obstetrics and Gynecology*
[6]Springer et al, 'Fetal Survival in Second-Trimester Termination of Pregnancy without Feticide' (2018) 131 (3) *Obstetrics & Gynecology* 575.
[7]http:s//documents.parliament.qld.gov.au/tableOffice/questionsAnswers/2023/1496-2023.pdf
[8]Ohden M. 'The Abortion Survivors Network 2024 [Available from: https://abortionsurvivors.org/

In Neonatology, most of the counselling provided to mothers, is in the case of an imminent extreme to moderately preterm birth, where the fetus is viable and normally formed. Current clinical practice for the perinatal care of the extremely preterm infant is as follows. Between 22 and 24+6 weeks' gestation, counselling is provided by Neonatologists to discuss whether active or palliative care will be provided after the baby is born. This is because at this gestation, these infants are at high risk of complications from their extreme prematurity, which can result in a poor prognosis for long term survival. Should a preterm birth of a normally formed fetus be imminent, it is standard care to provide resuscitative interventions (active treatment) to infants born alive at or greater than 25 weeks' gestation.[9] Although the majority of parents after counselling, would request resuscitation (active treatment) be provided for infants born at 23 and 24 weeks' gestation, some families make an informed decision for palliative care. Currently, life sustaining interventions are not usually recommended for infants born at 22 weeks,[8] but have been considered in certain circumstances[10].

Just as any other infant who is born alive is given active or palliative treatment, infants born alive after a failed abortion, should also receive this same level of care. If a decision is made for active treatment, there would need to be considered the option of placing the infant for adoption.

A plausible hypothesis for why this gap in care exists, and why an amendment to the Bill is even required, can be explained by the following observation. Proponents who support "abortion care" conspicuously under-recognise the humanness of the fetus. Take for example, the Clinical Guideline for Abortion Care recently released by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[11] This 173 page document which outlines the evidence for providing abortion, only contains the word "fetus" 9 times. The 2 instances that refer to a live birth after an abortion refer to it as an adverse outcome. It follows then that the importance of providing the same level of care for an infant in this circumstance, would not be prioritised, hence the need for legislative intervention.

Recommendations

There is currently no legislation for providing neonatal care to infants born alive after a failed abortion according to the *Termination of Pregnancy Act 2018*.

For the reasons outlined above, the following recommendations are made:

1. Infants who are born alive after a failed abortion, who are of viable gestation and who have no need for palliative care, should be offered active treatment, and if required placed for adoption.

2. Infants who are born alive after a failed abortion, who have reasons to receive palliative care, should be offered palliative care.

3. Comprehensive data collection should be mandatory for all babies born alive following an abortion. Demographics of gestational age, sex, the reason for the abortion, the care provided after birth and if applicable, the time of death, should be recorded.

4. All pregnant women undertaking a second or third trimester abortion should be counselled of the risks of a live birth after a termination of pregnancy procedure, and the possible outcomes of the infant receiving treatment, whether palliative or active which includes adoption.

[9]Queensland Government, Queensland Clinical Guidelines: Perinatal care of the extremely preterm baby (2020)
[10]Victorian Government. Victoria Safer Care: Extreme Prematurity Guideline – clinical guidance (2020)
[11]The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Clinical Guideline for Abortion Care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand (2023).