Health and Other Legislation Amendment Bill (No. 2) 2023

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Introduction

The Health and Other Legislation Amendment Bill (NO. 2) 2023, specifically 'Part 6 – The Amendment of Termination of Pregnancy Act 2018',[i] poses a grave threat to Queensland women and unborn children. The following submission seeks to outline our concerns in three specific areas:

1. The Reality of the Unborn and the Medical Abortion Procedure
2. The Reality of Complications
3. Conscience Concerns for Nurses and Midwives.
4. Impact of this Legislation

1. The Reality of the Unborn and the Medical Abortion Procedure

A. Introduction

Most significantly, the Bill overlooks its primary victims – the unborn children who will lose their lives due to this expansion. To them, this Bill poses a definitive health risk. Tragically, not a single mention regarding their welfare. Undoubtedly, many women to whom these pills will be given may have no idea of the internal process.

In order to fully understand and appreciate some of the particular risks to women posed by the expansion of provision of medical abortion(in the form of MS 2 Step) to nurses, nurse practitioners and other health practitioners, we would like to present some information to the committee on the embryology of the developing unborn human life up to the relevant time of 63 days(9 weeks) of gestation and explain some of the pertinent circumstances which make medical abortion different from surgical abortion.

We believe that many, if most of the members of the committee will not be aware of the extent of development of the unborn by this time, and by extension, many of the parliamentary members who will be debating this Bill. In fact, to be ignorant of this is to be ignorant of the one of the most relevant aspects of abortion, but one which is barely acknowledged and often denied by its proponents.

B. Embryology: 1-9 Weeks

Embryology Milestones from 1- 9 weeks

Because the extent of the knowledge in this area is so vast and detailed now, we do not attempt to cover each week in detail but to give an overview. At the end of this section, a link to a very user-friendly site is provided for further information. We have not provided references because they are well-established facts and can easily be confirmed through this link and other similar sites.

It is to be noted that pregnancy is dated in two ways. One is to calculate weeks from the beginning of the woman's cycle in which pregnancy occurs; the second is to date it from conception. The difference is on average two weeks longer for the former method. Here, we are using the weeks from conception.

Week 1

Conception, the joining of twenty-three chromosomes from both an egg and a sperm determines the commencement of a new and unique human life. This is a scientific fact. Through this week, the conceptus is moved along the fallopian tube where conception usually occurs towards the uterine cavity whilst exponentially multiplying in cell numbers. At the end of this week, the conceptus has entered the uterine cavity.

Week 2

Due to hormones produced within the ovary, the woman's menstrual cycle is suppressed after two weeks into pregnancy and a pregnancy test can be performed. Towards the end of this week, the embryo is drawn into the lining of the uterine wall, called the endometrium, in a process called nidation(nestling) or implantation. This allows part of the embryo called the trophoblast to make contact with the maternal circulation, thus commencing the formation of the placenta. Throughout pregnancy, the placenta produces a hormone called progesterone which is vital to the success of pregnancy.

Week 3

The embryo's heart is forming, along with blood cells produced by the liver, also in formation. Towards the end of this week, the foundations of the entire nervous system, including brain and spinal cord are laid out in a structure called the neural plate which folds over on itself to form the neural tube. The nervous system is composed of tissue called ectoderm. Around 24 days the heart, rudimentary in appearance and without directional flow, begins to beat. This heart will beat 54 million times before birth! Initially at a rate of around 11bpm, it will increase to 170bpm towards birth.

Week 4

By the end of this week, forty pairs of tissue bundles called somites appear along the length of the embryo's body. This tissue is called mesoderm and forms the structures of the upper and lower limbs and trunk such as bones, tendons, muscles and other soft tissues as well as some organs.

Week 5

Around 30 days, the embryo has grown 10,000 times its original size at conception and is 6-7mm long. The brain has human proportions. Blood flows in veins but the maternal and embryonic circulations do not mix. The placenta has a very amorphous appearance, not like its later hemi-spherical shape at birth.

By 35days, the face becomes more recognizably human as the mouth, ears and nose take shape.

Week 6

The skeleton is formed initially from a mesodermal tissue called cartilage. Individual movements begin, initially very slow and the embryo will be able to respond to light touch. This latter fact was established from ectopic pregnancies where the embryo was still alive after being removed operatively from the fallopian(ovarian) tube where they usually are positioned. A thin paintbrush was used to touch various parts of the body to elicit responses.

Week 7

The brain is growing at an average rate of 250,000 neurons/minute and brain waves have been recorded as early as 45days, indicating synaptic development. Limbs and major organs are forming. The gastrointestinal system grows from the embryonic cell layer called the endoderm.

Week 8

The embryo is a well-proportioned small- scale baby measured 3cm from crown to rump and weighing just a gram! Every organ is present, but not necessarily in the place it will inhabit at birth. The kidneys begin to function to produce urine which is released into the amniotic fluid sac which is constantly being cleansed. It is around this time that the unborn becomes referred to developmentally as a foetus, derived from a Latin word meaning "little one." However, the whole story of prenatal development is an evolving one, resulting in a graduated but extremely calculated and controlled process of increasing complexity and function.

Week 9 (63 days)

The heart now has four chambers. The unborn is spontaneously moving arms and legs and even thumb sucking is observed by ultrasound, an experience delighting many new parents, and often a habit maintained after birth.

The absolutely staggering complexity of this prenatal voyage can be studied in more detail through this link:

www.lozierinstitute.org/voyage

C. The Medical Abortion Procedure

As the name suggests, MS 2 Step involves two steps, employing two separate chemical agents.

The first agent is called Mifepristone. This is an "antiprogesterone", acting against progesterone which is essential to the maintenance of the pregnancy at any stage. It blocks the action of progesterone within the placenta, thus causing the cellular death of the embryo or foetus through the lack of sustenance coming through the placenta. Mifepristone also sensitizes the uterus to the action of the second agent.

The second agent, taken 24-48 hours after Mifepristone is called Misoprostol. This is a strong contractor of uterine muscle, causing the unborn to be expelled from the uterus in a process similar to that of a miscarriage, often associated with bleeding and pain. The amount of bleeding and pain will vary depending on the stage of gestation and individual factors, but some degree of both is universal. It would be quite negligent for a woman not to be warned about this, or for it to be understated.

A woman may commence bleeding before Misoprostol is taken; if not, she will experience the abortion usually within four hours of taking Misoprostol. The bleeding can continue for 10-16 days on average. However, of itself, bleeding is NOT proof that the abortion has occurred or is completed.

It is still highly recommended that a woman has a pelvic ultrasound before a medical abortion to establish the gestational age with certainty as increased age is associated with increased bleeding risks, and to establish that the pregnancy is not ectopic. Medical abortion does not cause the death of an ectopically situated unborn, and in any case must be treated operatively as life-threatening bleeding can ensue if the ectopic pregnancy ruptures.

2. Reality of Complications

The percentages of complications arising from the use of these pills has been thoroughly documented. Dr. Gino Pecoraro, the president of the National Association of Specialist Obstetricians and Gynaecologists (NASOG), estimates that 5% of all medical abortions lead to complications. [ii]

Moreover, the Therapeutic Goods Administration (TGA), who astonishingly cut the red tape in August, paving the way for these amendments, stated in 2014 that when heavy bleeding occurs due to the pills, 'it usually reflects incomplete abortion and is observed in approximately 3 to 12% of cases.' Additionally, 'It can necessitate a blood transfusion in up to 0.2% of cases.'(iii)

These percentages represent a real risk, especially for Queensland women residing in remote areas who will be without critical access to necessary medical care and expertise should complications arise. Dr. Pecoraro emphasises the primary concern:

> "It's a dictum in medicine that you shouldn't be prescribing something if you can't deal with the complications of it. I'm just concerned that on the surface this looks like a wonderful thing to increase access to regional and remote disadvantaged women … but the first rule has to be to do no harm, and I'm not convinced we're not going to do harm."(iv)

Similarly, he provides a firsthand example of the severe dangers, recounting how he was summoned to save the life of a 40-year-old woman flown in from NSW after being prescribed the abortion pill, who experienced significant side effects and bleeding. He declares, "She nearly died." [iii]

Both medical and surgical means are employed to induce abortion in the first trimester (first three months) of pregnancy, but currently, medical abortion is only approved by the TGA and subsidized by Medicare to 63 days gestational age as an outpatient procedure.

Medical abortion is associated with higher risks of bleeding and incomplete abortion than surgical abortion. Under this Bill, health practitioners such as nurses will not be permitted to perform surgical abortions and must know how to deal with the consequences of a medical abortion.

It is generally accepted that 5% of medical abortions will result in excessive or prolonged bleeding requiring a blood transfusion and/or curettage to manage this(v). Ongoing bleeding may be an indication of incomplete abortion and is also an important source of infection. The failure rate varies with studies, but in the PI(Product Information) for MS 2 Step, it is given as 7% prior to 63 days, making follow up mandatory(vi).An incomplete medical abortion requires a surgical procedure called curettage.

It is also generally recommended that due to the risk of a serious degree of haemorrhaging that every patient (not just those in rural areas) be able to access 24 hour emergency care for incomplete abortion.(vii)

The whole process, including any unexpectedly heavy, painful and prolonged bleeding can be a considerable emotional and physical strain, but it is often downplayed to present medical abortion as an easy option because it occurs at home.

3. Conscience Concerns for Nurses and Midwives

The concerted drive to "normalise" abortion not only among certified doctors but now also with nurses, midwives and any other group to be targeted in the future is designed to integrate the provision of abortion into the health system.

Nurses and midwives enter the profession to heal people, not to end lives. This Bill will have profound implications for nurses and midwives who may grapple with a moral dilemma over providing medical abortion. A concerned individual commented on *The Australian's* article, 'I hope the nurses will have the option to refuse to prescribe these drugs on grounds of conscience — non-practising nurse and midwife'.(viii).

Presumably they will be required to work under the Termination of Pregnancy Act which requires them to report an inability to provide abortion on the grounds of conscience, and to refer to another whom they believe will do so. To whom do they report? In rural, remote and isolated areas, there are fewer other staff members to call upon, less who will be qualified to replace them, even if they wished to place the responsibility upon fellow staff members. In larger centres, there are more staff, and less onus is placed on the individual nurse/midwife or practitioner to comply with a request. Furthermore, what consequences will a refusal have for this person's career? Will they be sidelined because they do not wish to be involved in abortion?

Furthermore, in July 2023, News.com.au reported that less than 10% of GPs are registered to prescribe abortion medication(ix). If this medication is essential "healthcare", why are so few GPs willing to be registered to administer it? Again, perhaps because they entered the profession to save lives, not to end them.

4. Impact of this Legislation

It is clear from the information presented so far that increasing the availability of medical over surgical abortion increases the burden of morbidity from abortion due to the increased risks involved, and the necessity of managing them. It is difficult to know how this has affected health facilities so far in Queensland in general, even before this Bill takes effect.

Since the legalization of abortion in Queensland in 2018, followed during COVID when Telehealth services were funded by Medicare to facilitate referrals for medical abortion, there has been a substantial increase in the numbers of this type of abortion being performed. This is despite this government assuring the parliament during the debate on the Termination of Pregnancy Act that it would not increase abortion at all.

I have chosen the years 2017-2018 leading up to the legalization of abortion in October 2018, and the following 4.5 years from October 2018 to June 2023, the last month for when statistics are available and present them below. These are for medical abortion only which is listed as Item 10211K in the PBS (Pharmaceutical Benefits schedule)(x) .I have also presented the Australia-wide total for the same Item 10211K for comparison and the percentage that QLD has of the total.

October 2017-October 2018:	QLD 9173	Australia Total 21,008	43.7%
October 2018-October 2022	QLD 56,400	Australia Total 109,295	51.6%
November 2022-June 2023	QLD 11,403	Australia Total 26,326	43.3%

These percentages are surprising given QLD's population which is approximately 20% of the total population of Australia. It is difficult to obtain reliable statistics for the numbers of surgical abortions done through Queensland's state public and private facilities, but simply focussing on medical abortion, it is clear that that alone has continued to increase since legalisation.

It is not possible to know the distribution of medical abortion through the state from these statistics, but as there are more nurses, midwives and nurse practitioners in urban areas than rural ones, it is most likely that facilitating the provision of medical abortion by legislation is not necessarily going to "end the postcode lottery" but merely provides another source of people who, rather than work to support life are in effect made into abortionists.

This is yet another step to engage another sector of the workforce into the sad and life-destroying pursuit of abortion instead of engaging more assistance for women in supporting pregnancy.

Conclusion

For the reasons provided above Cherish Life Queensland believes The Health and Other Legislation Amendment Bill (NO. 2) 2023, specifically 'Part 6 – The Amendment of Termination of Pregnancy Act 2018', poses a grave threat to Queensland women and unborn children.

We welcome an invitation to the Public Committee hearing on Thursday 1 February to provide testimony in person.

Thank you,

President - Dr. Donna Purcell

Executive Officer - Matthew Cliff

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[i] Queensland Parliament. "Health and Other Legislation Amendment Bill (No. 2) 2023." Accessed January 10, 2024. https://documents.parliament.qld.gov.au/tp/2023/5723T2059-D911.pdf

[ii] Ison, Sarah. "Peak obstetricians' body warns women at risk after abortion pill access expanded." The Australian, 17 July 2023. https://www.theaustralian.com.au/nation/politics/peak-obstetricians-body-warns-womens-lives-at-risk-after-abortion-pill-access-expanded/news-story/6a8fda27ce238232c73c56d53c8f06d2

[iii] Product information for AusPAR MS 2 Step Mifepristone/misoprostol MD Health Pty Ltd 13th October 2014 pg 20

(iv) see (ii) above

(v) Therapeutic Goods Administration product information for MS 2 Step pg4 revised edition August 2022

(vi) Product Information MS 2 Step 22/5/2014 provided by the manufacturer for AusPAR by MS health Pty Ltd

(vii) see (v) above pg.2

(viii) Lydia Lynch, "Nurses, midwives to prescribe abortions pills in Queensland." The Australian, November 2023, https://www.theaustralian.com.au/nation/nurses-midwives-to-prescribe-abortion-pills-in queensland/news-story/ffc8c15b61242a3aa7372693b9e1e48b

(ix) Maiden, Samantha. "Every GP in Australia will now be able to prescribe abortion pill." News.com.au, July 11, 2023. https://www.news.com.au/lifestyle/health/every-gp-in-australia-will-now-be-able-to-prescribe-abortion-pill/news-story/8afeef62a0fd6dab350e922768b0f35c

(x)www.medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp