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The Victorian Abortion Law – One Year On

After a brief account of the Victorian Law Reform Act 2008, this article reports on three responses to this law in the last year. Because Section 8 of this law restricts the healthcare practitioner's usual right of conscientious objection, this article also discusses conscience and conscientious objection.

An Overview of the Abortion Law

The Victorian *Abortion Law Reform Act 2008*[1] was passed by Victoria's Lower House, the Legislative Assembly, by a margin of 49 to 32 on 12 September 2008. It was passed by Victoria's Upper House, the Legislative Council, by a margin of 23 to 17 on 10 October 2008. It received Royal Assent on 22 October 2008, and therefore became law the day after.

The law allows abortion on demand until the 24th week of pregnancy. (At this point, the pregnancy has continued for almost 6 months. The baby is almost completely formed, and close to 30 centimetres or 12 inches in length.) From then until birth, it still permits abortion with the sole requirement that 2 doctors agree it is appropriate.

Abortion can be surgical or chemical (i.e. caused by the administration of drugs).[2] The law allows a pharmacist or nurse to dispense drugs to cause chemical abortion until the 24th week of pregnancy, without consulting a doctor. From then until birth, it still permits a pharmacist or nurse who works in a hospital to dispense drugs to cause chemical abortion with the sole requirement that 2 doctors agree it is appropriate.

Section 8 of this legislation restricts the healthcare practitioner's usual right of conscientious objection. When a woman requests advice from a healthcare practitioner with a conscientious objection to abortion, Section 8(1) requires that practitioner to "refer the woman" to another practitioner. Sections 8(3) and 8(4) require that "in an emergency" a doctor or nurse with a conscientious objection to abortion must still either perform or assist at an abortion.

Let us note the difficulties with both these requirements. From the perspective of a doctor with a conscientious objection to abortion, referral to another practitioner is like saying, "I can't rob the bank for you myself. But I know someone down the road who can."[3] In other words, referral involves becoming complicit in the abortion. It is therefore something that healthcare practitioners with an objection to abortion rightly refuse to do. Meanwhile, concern about the second requirement is focussed on how "emergency" might be defined. In February 2000, doctors at the Royal Women's Hospital in Melbourne aborted a 32-week foetus officially named Jessica who was believed to have dwarfism. Even though the child could have been induced and born alive, the abortion was justified by the claim that her mother was "distressed to the point of being suicidal."[4] Healthcare practitioners are rightly concerned that a case like this might be defined as an "emergency," and therefore that their involvement in such an abortion would be demanded.

While this bill was still being debated, the Victorian Scrutiny of Acts and Regulations Committee noted the first of these problems. They observed that "some practitioners may hold a belief that abortion is murder and may regard a referral to a doctor who will perform an abortion as complicity in murder." They therefore noted the conflict between this requirement of referral and the right to freedom of belief affirmed in the Victorian *Charter of Human Rights and Responsibilities*. For this reason, they sought "less restrictive means" of allowing access to abortion without unduly limiting the right of healthcare practitioners to freedom of belief.[5]

Sadly, these concerns were simply dismissed. Section 48 of the *Charter* states that it does not affect any law related to abortion. This was surely never intended to suggest that the rights of healthcare practitioners might simply be dismissed in laws about abortion. Even so, this section of the *Charter* was used in a rather legalistic fashion to do precisely that. We should note too that as this bill was debated, amendments were moved to remove Section 8 from it. After all, the law would still achieve its intended purpose without these impositions upon healthcare practitioners. However, these amendments, like all amendments to this bill, were defeated.

IN THIS ISSUE

Responses to the Abortion Law

This section considers three responses over the last year to the Victorian abortion law: that of the Catholic Church, the March for the Babies, and the Conscience Laws and Healthcare seminar:

The Catholic response was organised around the anniversary of the date when the abortion act became law. On 22 October 2009, the Catholic bishops of Victoria issued a statement, *A People of Life and a People for Life*.[6] The statement reiterated that "abortion is always wrong." It also noted "the deep harm that abortion is doing to women." It recommitted the Church to building a new culture of life, particularly by standing in solidarity both with women who face an unplanned pregnancy and women who have already been harmed by abortion.

On 25 October, the Archbishop of Melbourne Denis Hart presided first at Mass and then at an inter-faith prayer service at St Patrick's Cathedral. Three speakers presented at an afternoon seminar. Dr Eamonn Mathieson from the Catholic Doctors Association of Victoria spoke of the Victorian legislation as "the most extreme abortion laws in Australia and arguably the Western world." Bernadette Black, Barnardos 2009 Mother of the Year and founder of The Brave Foundation which supports young women who face an unplanned pregnancy, spoke of her own experience of being pregnant and then a single mother as 16.[7] We also heard from her son Damien, who is now 16 himself. It is good that this fine young man is able to experience all the opportunities of life. It is sad that many lives like his are now extinguished through abortion. Finally, Gwen Winterscheidt and Rosemary Woods from Queensland spoke about the Care and Concern network in Brisbane which supports pregnant women and young mothers.[8]

The March for the Babies[9] was on 10 October 2009, the anniversary of the date when the abortion act was passed by the Legislative Council. Nearly two thousand people walked from the Fitzroy Gardens to the steps of Victoria's Parliament House, where they heard from a number of politicians, religious leaders, pro-life workers, and entertainers. Because this law leaves women without any support and offers them only abortion, it was described by the Presbyterian minister who spoke as the most misogynistic law passed in Victoria in living memory. Before she sang 'Baby Mine,' one of the entertainers asked for a newborn girl named Justice to be brought to the stage. "This campaign is all about justice," she said. "Well, this is Justice." It was a poignant reminder why so many people were marching for the babies.

The seminar Conscience Laws and Healthcare was organised by Doctors in Conscience, and held at the Park Hyatt, East Melbourne on 25 July 2009. Speakers included Martin Laverty (CEO, Catholic Health Australia), Senator Julian McGauran, Francis Sullivan (Secretary General of the Federal AMA), Dr Lachlan Dunjey, ACU lecturer Jo Grainger, and lawyer Nigel Preston.[10]

In his presentation, Francis Sullivan explained the difference between the Victorian legislation and the Australian Medical Association's *Code of Ethics*. When a doctor's moral judgement prevents them from providing treatment, the AMA Code requires them to inform their patient of this "so that they may seek care elsewhere."[11] Unlike Victorian law, then, the AMA Code does not require the doctor to refer their patient to another: it is the patient who must seek alternative care. In this way, the AMA Code respects the doctor's conscience, whereas the Victorian legislation does not.

We should note too that the AMA *Code of Ethics* provides the "less restrictive means" which the Victorian Scrutiny of Acts and Regulations Committee sought. Access to abortion is not imperilled if doctors with a conscientious objection do not provide referrals. In Victoria, a patient does not need a referral to see an abortion provider. And patients can locate abortion providers quickly and easily through the phone book or an internet search.

At the same seminar, Martin Laverty reported on legal advice received by Catholic Health Australia that Section 8 of the abortion law breaches the United Nations' *International Covenant on Civil and Political Rights*, which Australia ratified in 1980. Article 18 of this Covenant states: "Everyone shall have the right to freedom of thought, conscience and religion." As we have seen, the Victorian law restricts this right unnecessarily and without sufficient cause. The Victorian *Abortion Law Reform* Act 2008 therefore causes Australia to fall down in its international human rights obligations. It is as serious as that.

Conscience and Conscientious Objection

Because abortion kills unborn children and harms women, a loose coalition of individuals and community groups including the Catholic Church will continue to push for changes to Victoria's abortion law. This is a medium to long term commitment which is linked to cultural transformation and the ongoing task of changing minds and hearts one person at a time. Because Section 8 of the law conflicts with already-existing community standards, there is a much better prospect of change here in the short to medium term. Even this will probably not occur overnight. As calls for change continue, it is therefore also timely to think again about the meaning of conscience and the significance of conscientious objection:

Because the word 'conscience' has several meanings, it is possible to speak of conscience /1, conscience/2, and conscience/3.[12] Conscience /1 is the deep innate sense within us that some things are right and that other things are wrong, that we are capable of telling the difference between right and wrong, and indeed that we are called both to learn about right and wrong and to live accordingly by doing good and avoiding evil. Especially as they ponder these dimensions of conscience, Christian people recognise powerful connections between the conscience and God. To reflect on these dimensions of conscience is also to experience both a sense of wonder and even amazement that such capacities exist within us,

and a great sense of responsibility to live according to the dictates of conscience.

Conscience /2 is the process of forming our conscience. It is the hard work of coming to know what precisely is right, and what precisely is wrong. Ultimately, it is a lifelong task. This aspect of conscience is based on a realist epistemology which recognises that there are real standards of right and wrong, and therefore that some things are really right while other things are really wrong. The task of conscience, then, is not to invent its own standards of right and wrong, but instead to discover these real standards.

Finally, conscience/3 is moral judgement. It is deciding what is right or wrong in a certain situation, and then following one's conscience. Along with many other systems of thought, the Catholic Church holds that "a human being must always obey the certain judgement of his conscience."[13]

Judgements of conscience often engage us very deeply and very personally. Especially because of this, one way in which we show respect for the dignity of each person is to respect the informed judgements of their conscience, and, unless there are very serious reasons for doing so, not to compel them to act against their conscience. This above all is why we recognise a right to conscientious objection. This right really pertains in all things. However, it is often stated explicitly in guidelines about matters which are morally contentious (i.e. matters about which different people may come to different moral evaluations.) Thus, for example, this right to conscientious objection is explicitly recognised in guidelines from the National Health and Medical Research Council (NHMRC) about such matters as organ and tissue donation both from living donors and after death, the use of assisted reproductive technology, and research involving human embryonic stem cells. These guidelines usually contain three statements. Firstly, they affirm the right of each person not to be required to engage in activities about which they have a moral objection. Secondly, they insist that an individual should be able to exercise this right without penalty or disadvantage. (Thus, for example, their opportunities for career development or promotion should not be restricted.) But thirdly, they caution that this right should not be exercised in ways that may place patients at risk of harm or abandonment. I offer two examples from NHMRC guidelines, one involving human embryonic stem cell research, the other involving organ and tissue donation from living donors:

> Those who conscientiously object to being involved in conducting research with embryos, foetuses or embryonic or foetal tissue should not be obliged to participate, nor should they be put at a disadvantage because of their objection.
>
> While an individual health professional must not be required to participate in an activity that the person believes to be wrong, the exercise of conscientious objection should never put a patient receiving care at risk of harm or abandonment, or undermine confidence in others who have chosen to participate in a widely accepted professional activity such as organ donation.[14]

The contrast between these guidelines which affirm conscientious objection, and the demand of involvement through referral to another practitioner required by Section 8(1) of the Victorian abortion law should be obvious. Once again, this highlights the inappropriateness particularly of this aspect of the Victorian law. It is incongruous that the right to conscientious objection is recognised for so many other morally contentious issues, but is unnecessarily curtailed for abortion, which is surely the most morally contentious issue of them all.

Finally, we should note that the Catholic *Code of Ethical Standards* also affirms a right to conscientious objection. It reads:

> No staff member may be required to participate in an activity that in conscience the person considers to be wrong. A Catholic organisation should ensure that conscientious objection may be exercised without threat of penalty. The exercise of conscientious objection should never put the person receiving care at risk of harm or abandonment, nor conflict with the ethical standards of the Catholic organisation.[15]

At this time, along with many other individuals and community organisations, the Catholic Church is involved in a battle to recover the proper right of healthcare professionals to conscientious objection – a right which has been unjustly curtailed by the Victorian *Abortion Law Reform Act 2008*. Especially at this time, we should take particular care to ensure that this right to conscientious objection is properly respected in all our healthcare institutions. It is one way that we show our respect for our staff. It is also one way that we witness to the importance of the right of conscientious objection.

ENDNOTES

[1] Victorian *Abortion Law Reform Act 2008*, Victorian Legislation and Parliamentary Documents, http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/BB2C8223617EB6A8CA2574EA001C130A/$FILE/08-58a.pdf

[2] For more on chemical abortion, see "Chemical Abortion in Australia" by Marcia Riordan in this issue of *Chisholm Health Ethics Bulletin*.

[3] London consultant pathologist Michael Jarmulowicz used this analogy in his explanation of why he would not refer a patient to another doctor for an abortion. See "You May Have Missed…," *Catholic Medical Quarterly* 58, no. 1 (Feb 2009): 42-43 at 42.

[4] Carol Nader, "'It took over my life': abortion case that brought years of pain," *The Age* 13 December 2007.

[5] Scrutiny of Acts and Regulations Committee, *Alert Digest* No 11 of 2008, cf Victorian *Charter of Human Rights and Responsibilities Act 2006*, Australasian Legal Information Institute, http://www.austlii.edu.au/au/legis/vic/consol_act/cohrara2006433/s48.html

[6] *A People of Life and a People for Life*, Catholic Archdiocese of Melbourne, http://www.cam.org.au/latest-news/pastoral-letter-a-people-of-life-a-people-for-life.html

[7] Bernadette tells her story in *Brave Little Bear* (Australia: Inspire Publishing, 2006).

[8] For more about this seminar, see Fiona Power and Marcia Riordan, "Building a Culture of Life," Catholic Archdiocese of

Melbourne, http://www.kairos.com.au/index.php?option=com_content&view=article&id=1934:building-a-culture-of-life&catid=22:local-news&Itemid=31

[9] For more about this, see http://www.marchforthebabies.org.au/

[10] For the conference brochure and videos of these presentations, see Catholic Archdiocese of Melbourne Life Marriage and Family Office, http://lmf.cam.org.au/index.php?option=com_ docman &Itemid=52. For an article by Senator McGauran on this issue, see Julian McGauran, "Labor's Attack on Conscience," Quadrant Online, http://www.quadrant.org.au/magazine/issue/2009/10/labor-s-attack-on-conscience

[11] Section 1.1p of the AMA *Code of Ethics* states: "When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere." For this, see Australian Medical Association, http://www.ama.com.au/node/2521

[12] This terminology is taken from Timothy E. O'Connell, "Conscience," *Principles for a Catholic Morality* Revised Edition (New York: HarperCollins, 1990), 103-118. Other helpful works on conscience include Richard M. Gula, *Reason Informed by Faith* (New York: Paulist Press, 1989), 123-162; Norman Ford, *Christian Conscience* (Deakin, ACT: Catholic Health Australia, 2009), Timothy E. O'Connell, *Making Disciples: A Handbook of Christian Moral Formation* (New York: Crossroad, 1998); and Charles M. Skelton, *Achieving Moral Health: An Exercise Plan for Your Conscience* (New York: Crossroad, 2000).

[13] *Catechism of the Catholic Church*, #1790, 1800.

[14] These guidelines are from the NHMRC's *National Statement on Ethical Conduct in Human Research* 3.6.7; and its *Organ and Tissue Donation by Living Donors* 2.5b. Other guidelines about conscientious objection can be found in the NHMRC's *Organ and Tissue Donation After Death* 2.5c to 2.5f; and its *Ethical Guidelines for the Use of Assisted Reproductive Technology in Clinical Practice and Research* 5.9. All these documents can be accessed via the NHMRC website.

[15] Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* (Red Hill, ACT: CHA, 2001), II.7.19.

All on-line documents accessed 20 November 2009.

Kevin McGovern ✠

"Law Reform" and Abortion in Queensland

Trying to fully understand what was behind the recent amendments to the Criminal Code in Queensland and the continued pressure to change the law on abortion is something like trying to do a jigsaw puzzle. However, in this case there are one or two foreign pieces that really do not contribute to the true picture, but are introduced as a distraction.

The Background

The best place to begin is to describe the law regarding abortion as it presently stands in Queensland.

The relevant Sections of the Queensland *Criminal Code 1899* are the following:

> s.224 *"Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime …"*
>
> s.225 *"Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered to her, is guilty of a crime …"*
>
> s. 226 *"Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of misdemeanour …"*[1]

The other relevant paragraph is the one which has been at the centre of the recent debate. The following is as it existed before the recent amendments:

> s.282 *"A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case."*[2]

Some commentators suggest this section was to give doctors a defense against a charge of assault when they operated on a patient who was unconscious or otherwise unable to give consent.[3]

However, in 1986 in *R v Bayliss and Cullen*,[4] Justice McGuire in the Queensland District Court, following the example of other decisions in other jurisdictions, interpreted this section of the *Criminal Code* to render a surgical abortion lawful when done to preserve the life or health of the mother.

The second piece of the puzzle is the radical decriminalisation of abortion in Victoria in October 2008.[5] As soon as the law in Victoria was passed, there was an immediate call for similar legislation to be presented and passed in Queensland.

On 17 October 2008, the *Abortion in Queensland* Conference was held at the University of Queensland. The event was a joint initiative of Children by Choice, Family Planning Queensland, Dr Caroline de Costa of James Cook University Department of Obstetrics and Gynaecology, and Dr Darren Russell of Sexual Health in Cairns.

The conference brought together many of the key pro-abortion advocates in Queensland. As one would expect, one of the first recommendations was that abortion be removed from the *Criminal Code* in Queensland. This would be achieved by the repeal of ss. 224-226 cited above. This group determined that they should push for the achieving of this goal during this current term of the Queensland Labor Government.

Another significant event occurred just a month before this conference. It is another importance piece of the jigsaw, but one that was basically ignored by the media. It was a court case in the Supreme Court known as *State of Queensland v B*.[6]

The case involved a 12 year old girl who was almost 18 weeks pregnant. She was a patient of a public hospital. The hospital approached the Court in its *parens patriae* jurisdiction for authorisation of the termination of B's pregnancy. However, the medical advice was that the termination should proceed by the administration of *misoprostol* rather than surgical abortion, as the latter was deemed to be of higher risk to the girl.

Justice Wilson permitted the medical termination of the pregnancy under the heading of duty of care towards the child. During the course of the judgment, Justice Wilson considered s. 282 of the *Criminal Code* and stated that as the case did not concern a surgical abortion, then s. 282 was not applicable.

It was because of this case that questions were raised as to the legality of performing medical abortions (i.e abortions caused by the administration of a drug) in Queensland. Such abortions were being performed regularly in Queensland public hospitals, particular in cases where the child was diagnosed as suffering from a disability.

Obstetricians and Gynaecologists in one public hospital received legal advice that the comment made by Justice Wilson in *State of Queensland v B* was probably correct and that the abortions they were performing were not covered by section 282. This led to them refusing to perform medical abortions and saying they would refer such cases interstate. They announced their decision through *The Australian* newspaper. Their action spread to other hospitals in Queensland.[7]

Another piece of the jigsaw puzzle was the very strange case of a woman and her boyfriend in Cairns, Queensland. It is alleged that the couple illegally brought a drug, the equivalent of RU486, into Australia and that the woman used it to terminate her pregnancy. The police evidently discovered this when raiding the couple's home regarding an unrelated matter which did not involve the couple.

The couple were charged and a prosecution commenced. The case allegedly involves the self-administration of a drug illegally obtained with the intention of procuring an abortion. Even in some places where abortion has been decriminalised, such an act would still be illegal. This piece of the jigsaw was really a "foreign" piece and not relevant to the debate over medical terminations in hospitals. The case has received great publicity and the pro-abortion forces have been vocal in using it to call for the laws against abortion to be abolished.[8]

Finally Dr Caroline de Costa, who had been administering RU486 to procure the termination of pregnancy for women in northern Queensland, announced she would no longer prescribe the drug until the law on abortion was clarified. It was not quite clear whether she was doing this on the basis of the judgment given in *State of Queensland v B*, or because of the prosecution of the couple in Cairns.

The pro-abortion groups with the support of the leadership of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists used the above events to exert great pressure on the Queensland government to decriminalise abortion altogether.

The Government's Response

I am informed that the Queensland government had been aware that there were possible "problems" regarding the legality of medical abortions in Queensland before any of the events related above occurred. They were already considering some responses to that situation. The government focussed its attention on s. 282 of the *Criminal Code*.

To put it simply, the government decided to amend s. 282 of the *Criminal Code* by adding "medical procedure" to the existing reference to surgical operation.[9] They argued that this would give protection for the existing practice of medical terminations carried out in Queensland hospitals.

There is no doubt that the primary intention behind the amendments to s. 282 of the *Criminal Code* was to allow for medical abortion.

However, the government, on the basis of the legal advice it had received, was able to argue that the amendments were not simply about abortion. Indeed, the amendments do not mention abortion at all, just as the original s. 282 does not mention abortion. The government argued that just as the original s. 282 gave doctors protection when performing surgical procedures in good faith, so the new amendments gave doctors protection when prescribing medical treatments in good faith. Such treatments might have nothing to do with abortion.

In his speech introducing the legislation to parliament, the Attorney-General referred to a range of conditions which in the past were treated by surgical procedures, but which today would often be treated by a medical treatment. However, doctors supposedly enjoyed no protection in providing such treatment. As a result of the amendments, "protection for surgical and medical procedures is a general defence for proper medical practice and is not specific to terminations."[10]

The Attorney-General also argued that as regards medical terminations, the amendments only served to clarify the law as most had understood it since 1986 i.e. that the legislation was not an attempt to further liberalise the practice of abortion as it existed in Queensland.

This was then the situation confronting the politicians who had to vote on the amendments.

Ethics and the Amendments to s. 282

Although the occasion for the amendments was the controversy over medical terminations, the fact was the amendment itself could be voted on in order to give doctors security that they were protected against charges of assault when providing ordinary medical treatment. Even pro-life doctors admitted that it would be good to have that situation clarified.

A pro-life Member of Parliament could therefore in good conscience vote for the amendments even though the unwanted side-effect of that amendment could be that it would be interpreted as extending to medical terminations. If he or she had the opportunity, they should also make their opposition to abortion clear, which several of the Members did.

It would also be open to a Member of Parliament to judge that the amendment was not necessary for the sake of protecting doctors. After all, no doctor has ever been prosecuted for providing good medical treatment when the conditions of s.282 of the *Criminal Code* have been met. Therefore a pro-life Member of Parliament might decide to oppose the amendment. One independent Member of Parliament took this approach.

However, if a large number of Members had taken this approach, another scenario might have emerged. It is possible that opposition to the amendments would have brought on a full scale debate on the decriminalisation of abortion. If pro-life Members of Parliament were not sure of their numbers, then such an action could have led to a worse situation.

This would give a pro-life Member of Parliament another reason why he or she could vote for the amendments in good faith, namely to avoid the complete decriminalisation of abortion. Some commentators do not seem to have appreciated this fact.

As it was, it would appear that neither side was sure of the numbers if it came to a full scale debate on the decriminalisation of abortion, and therefore prudently sought to avoid it, although for opposite reasons.

Although I respect the position adopted by the independent Member for Gladstone, Liz Cunningham, I believe that it would be unfair to paint all the other Members of Parliament as having supported abortion. That is a misrepresentation of the facts and intention of many of those who did not oppose the amendments.

Some Positive Elements to the Amendments

The amendments to s.282 actually did more than simply insert "medical treatment" alongside "surgical operation". The amendments explicitly exclude medical treatment or a surgical operation on an unborn child simply for the "benefit" of the mother. In other words, they exclude the amendments being interpreted as permitting abortion for social reasons.

A side-effect of the controversy has been that doctors have been advised that the practice of medical terminations on the grounds of the predicted disability of the child could still be illegal according to the law in Queensland. In order for the termination to be justified, the doctors would have to establish that a woman's mental health would be endangered by the birth of a child with disability. This might have the good effect of causing doctors to approach such terminations with more caution and less discrimination against those with disability.

Finally, in its definition of "patient" the amendment includes "unborn child on whom the surgical operation is performed or of whom the medical treatment is provided." This would certainly seem to add weight to the claim that when a doctor is treating a pregnant woman the doctor has two patients.

ENDNOTES

[1] For the amended Queensland *Criminal Code 1899* "reprinted as in force on 1 November 2009," see Queensland Legislation, http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CriminCode.pdf

[2] See, for example, "Queensland's abortion laws," The Brisbane Times, http://www.brisbanetimes.com.au/queensland/queenslands-abortion-laws-20090810-efi8.html

[3] Nicole Dixon, *Abortion Law Reform: An Overview of Current Issues* (Queensland Parliamentary Library, 2003).

[4] Qld Lawyer Reports 9 (1986) 8.

[5] Victorian *Abortion Law Reform Act 2008*, Australasian Legal Information Institute, http://www.austlii.edu.au/au/legis/vic/consol_act/alra2008209/

[6] State of Queensland v B [2008] QSC 231 (26 September 2008), Australasian Legal Information Institute, http://www.austlii.edu.au/au/cases/qld/QSC/2008/231.html

[7] Jamie Walker, "Ruling to shift abortions interstate," *The Australian,* 21 August 2009;_"More hospitals drop abortion," *The Australian*, 25 August 2009.

[8] On this case, see, for example, Jamie Walker and Viva Hyde, "Murder hunt led to abortion pair," *The Australian,* 5 August 2009; Sarah Elks, "No drug evidence in abort case," *The Australian*, 4 September 2009; and Adele Horin, "Right to choose abortion wins strong support," *The Australian*, 4 October 2009.

[9] The amendment became the *Criminal Code (Medical Treatment) Amendment Act 2009*, Queensland Legislation, http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC033.pdf

[10] Hon. CR Dick, Attorney-General, *Hansard*, Queensland Parliament, 1 September 2009, p.1778.

All on-line documents accessed 5 November 2009.

Ray Campbell ✠

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Chemical Abortion in Australia

Abortion providers and advocates want Australian women who face an unexpected pregnancy to have the option of choosing a chemical RU-486 abortion, instead of a surgical abortion. This article looks at this proposal, and discusses its possible repercussions. There is considerable controversy over this method of abortion, with promoters saying that it is safer, easier and private, whereas opponents call it DIY abortion or home-alone abortion and question its safety.

What RU-486 is, and how it Works

RU-486 is also known as either Misfepristone or Mifepristone. It is marketed as Mifeprex in the United States, and Mifegyne in Europe. RU-486 induces a chemical abortion by blocking progesterone, the hormone needed for the continuation of pregnancy. A second drug

Misoprostol (Cytotec), a powerful prostaglandin, is given around 24-48 hours later to cause uterine contractions which expel the embryo or foetus.[1] Used in combination, these drugs are said to be 96% successful in terminating a pregnancy.

The recommended practice with RU-486 and Misoprostol is to leave women to take the abortifacient chemicals and then miscarry alone over the next few days, including dealing alone with the risk of severe haemorrhage. This returns abortion to the backyard. The desire for the privacy of chemical abortion places women at much greater risk.

Because of the risk of abnormality in a surviving child, surgical abortion is regarded by the practitioners as mandatory if the chemical abortion fails. This raises issues about consent and the right of these women to refuse.

Alternative to Surgical Abortion

Abortion advocates are demanding that Australian women have access to the full range of "reproductive health care," and should have the same range of termination options available to them as do women overseas. They claim that a woman's right to choose means that women should be able to choose a chemical (RU-486) abortion over surgical abortion should they wish to do so. Promoters claim that some women prefer to avoid an anaesthetic and/or surgery, and may view chemical abortion as more "natural" and more like a miscarriage. Angela Walker writes that "access to safe medical [chemical] and surgical abortion is a right that women have fought for and are still to fully achieve. They're kept fighting because the right to decide if and when to bear children is a cornerstone for women's equality in society."[2]

Advocates are saying that it is all about providing women with a greater range of choices, but some are admitting that there are also other reasons for promoting RU-486. As Christopher Gacek observes, it was hoped that RU-486 would bring abortion into mainstream medical practice whereas it currently tends to be isolated to a particular group of practitioners. This particular group is ageing, and is having trouble all around the world recruiting other generations to take their place. It was also hoped that it would allow general practitioners and other healthcare workers to become involved in abortions. In addition, if people other than surgeons became involved, it would expand the geographical area in which abortions were performed, making it harder for protestors and others to target the abortion clinics or interfere in any way with the procedure.[3]

Abortion providers and advocates confirm this. As Caroline Westoff, an obstetrician and gynaecologist told the *New York Times*, "One of my real, and I think realistic, hopes for this method is that it will help get abortion back into the medical mainstream and out of this ghettoised place it's been in."[4]

Development of RU-486

RU-486 was first developed by Etienne-Emile Baulieu and others at Rousell Uclaf in France, investigating anti-ulcer drugs. They soon realised that RU-486 had anti-progesterone properties. Controversial from the beginning, RU-486 was first licensed for use in France in 1988. Initially, Roussel Uclaf claimed that it was not going to market RU-486 due to pressure from pro-life groups. It is perhaps more likely that they feared boycotts on their other products. However, the French government had shares in the company and intervened to ensure that the drug was made available.

Roussel Uclaf transferred its commercial rights to market the drug in America to the Population Council, a New York-based population control group. As Christopher Gacek notes, "Eventually Danco Laboratories ("Danco"), a company chartered in the Grand Cayman Islands, was created to market and distribute RU-486 in the United States."[5] RU-486 is the only drug that Danco makes and distributes, and the company has been created entirely for that purpose, presumably to minimise risks to the parent company.

The US Food and Drug Administration (FDA) licensed RU-486 in the United States in 2000, under pressure from the Clinton Administration. The decision was controversial at the time, and opponents argued that the decision had more to do with politics than science.

They argued that due process had not been followed and that scientific requirements to prove the safety and effectiveness of RU-486 had been circumvented. Researchers warned that adequate clinical trials had not occurred, and the data from the French trials was questionable. Concerns were also raised by Searle, the manufacturer of the second drug Misoprostol, that its use to induce uterine contractions was "off label." They were concerned that Misoprostol had been developed to treat ulcers, and the appropriate clinical trials had not been performed to ensure the drug's safety when used to end a pregnancy. Despite all this, approval was given by the FDA.[6]

Risks to Women?

The FDA *Patient Information Sheet* advises that after using Mifepristone, 5-8 percent of women will still need a surgical procedure to end the pregnancy or to stop too much bleeding. Women still need access to emergency medical help in the 2 weeks following administration of the drug. And they may experience vaginal bleeding or spotting for an average of 9-16 days afterwards. In some cases, this may last up to 30 days.

Of the patients who took RU-486 in the US trials, 99% experienced as least one of the following: abdominal pain (cramping) 97%, nausea (67%), headache (34%), diarrhoea (23%), dizziness (12%), fatigue (9%), back pain (9%), uterine haemorrhage (7%), fever (4%), viral infections (4%), vaginitis (4%), and rigors (chills/shaking) (3%).

The FDA estimates that it only receives adverse events reports (AERs) for 1-10 percent of drug complications,[7] as reporting is not mandatory but voluntary. In addition, any adverse events associated with the use of RU-486 are more likely to be reported to the manufacturer, in this

case Danco. Yet by 15 November 2004, the FDA reported having received 676 adverse events reports concerning RU-486 abortions, including 17 ectopic pregnancies, 72 cases where blood transfusions were needed, and 7 serious infections. Since the publication of an article by two obstetrician-gynaecologists, Peggy Gary and Donna Harrison, who analysed all the available AER cases in the US,[8] the FDA is no longer releasing the information on RU-486 fatalities, even under the Freedom of Information Act. However, the FDA has had to revise the information provided on its website.

The affects of RU-486 on future fertility are not well documented. It is difficult to find information about follow-up studies to determine whether women who have used RU-486 suffer increased risks of infertility. The risks in relation to cancer are also not yet known. Like the oral contraceptive pill, the long-term effects will only become evident in time, and even then only if there is interest in doing the long-term studies.

Deaths Associated with RU-486

Although chemical abortion is being promoted as a safe alternative to surgical abortion, there is some evidence that it may not be as safe for women as has been claimed. A report in the *New England Journal of Medicine* suggests that the death rate from chemical abortion may be up to 10 times higher than surgical abortion.[9] The death rate for surgical abortion (under 8 weeks) is reportedly around 0.1 in 100,000, whereas the death rate from RU-486 induced abortion is thought to be 1.0 in 100,000.

Some of the deaths in the US were due to fatal toxic shock syndrome associated with *Clostridium sordellii* infection. This occurred in women who had previously been healthy.[10] There is some evidence that RU-486 may interfere with the patient's immune system, leaving otherwise normal healthy women vulnerable to infection.

There have been at least 14 deaths linked to RU-486 overseas that have been made public. A death occurred in the original drug trial in Canada in 2001, and the program was shut down. Five deaths are known to have occurred in the United States: Brenda Vise (aged 38) in 2001, Holly Patterson (aged 18) and Vivian Tran (aged 22) in 2003, Chanelle Bryant (aged 22) in 2004, and Oriane Shervin (aged 34) in 2005. There are also reports that at least two other women have died in the United States.

Women are also known to have died after taking RU-486 in Europe. They include: one in France as far back as 1991, Rebecca Tell Berg in Sweden in 2003, two unnamed women in the United Kingdom in 2004, and another young woman, Manon Jones in 2008. There have also been reports of a death in Cuba after administration of RU-486. Exeglyn, the manufacturer and distributer of RU-486 in Europe, recently admitted to the Italian Agency of Pharmaceutics (the Italian agency for drug regulation) that there had been 29 deaths around the world linked to RU-486. This is twice the number previously reported.[11]

Earlier this year, the Italian Agency of Pharmaceutics decided to allow use of RU-486, but limited its use to women under 7 weeks gestation, who must remain in hospital until the abortion is complete. This is usually for two or three days. Presumably, they believe that this may prevent some complications. After 7 weeks gestation, RU-486 has a higher failure rate even when used in combination with prostaglandins like Misoprostol. Unless a woman is given an ultrasound, it is difficult to be sure of gestational age, which may put her more at risk of complications related to gestational age or ectopic pregnancy. One of the issues is whether ultrasound is required to establish the gestational age.

RU-486 in Australia

Access to RU-486 was largely restricted in Australia until 2006 when a campaign led by pro-choice women in Federal Parliament saw the then-Health Minister, Tony Abbott, stripped of his power to oversee such decisions, and this authority given instead directly to the Therapeutic Goods Administration (TGA). Since then, a number of abortion providers have applied to the TGA to import and prescribe RU-486, but it is still not widely available in Australia. Cairns obstetrician, Caroline de Costa, a prominent advocate of abortion, was one of the first Australian doctors to be given permission to prescribe RU-486. Recently, however, Marie Stopes International, one of the largest abortion providers in the world and with clinics across Australia, has been given permission to prescribe RU-486. This may make it more widely available in this country.

Her Body, Her Choice, Her Problem

Many pro-choice activists view abortion as a corner stone of feminism and women's equality. They believe that they have "a right to have access to safe legal abortion" or to the full range of "reproductive choices." Yet in their rush to promote RU-486, they may be setting women's equality back by years.

All too often, "her choice" becomes "her problem." As Richard Stith argues, legalised abortion was supposed to grant enormous freedom to women, but it actually ends up freeing men and trapping women.[12] Abortion makes women sexually available to men. In an interesting paper, he notes that radical feminist Catharine MacKinnon predicted that legalised abortion would not give women greater sexual equality with men but just the opposite. MacKinnon wrote that "under the conditions of gender inequality [abortion] does not liberate women: it frees male sexual aggression. The availability of abortion removes the one remaining legitimized reason that women have had for refusing sex besides the headache."[13] She argued that this was the reason the Playboy Foundation had supported abortion from the beginning.

Men can choose sex, but should she become pregnant, today's woman is left to fix the problem. In the past, he would have been expected to marry her or at least to offer to marry her. Now, it becomes her choice, solely her decision, her problem. Should she "choose" to keep the child, the child is her choice, her problem. She should not expect any support or sympathy from the community because she "chose" the child when she could have

"chosen" abortion. Alternatively, should she "choose" abortion, and find that she is not okay afterwards, it is still her problem, because she "chose" it. Women's decisions are not made in isolation. Often, they are made under enormous pressure and even at the demand of others, especially partners and even parents. Now Australian women will be offered "the privilege of choosing" another method of abortion, and are more likely to be left home alone to fix their own problems. RU-486 does nothing to address sexual exploitation. RU-486 is not a magic solution to unplanned pregnancy. Women need alternatives *to* abortion, not more methods *of* abortion. They deserve the compassion and support of the community, not abortion.

ENDNOTES

[1] An embryo is considered a foetus at eight weeks.
[2] Angela Walker, "Full access to RU-486 is a woman's choice," *Green Left Weekly* 807 (16 Sept 2009) at www.greenleft.org.au /2009/807/41488
[3] Christopher Gacek, "Politicised Science: The manipulated approval of RU-486 and its dangers to women's health," *Family Research Council*, 1-31 at 5 at http://downloads.frc.org/EF/EF07A29.pdf
[4] Margaret Talbot, "The Little White Bombshell," *New York Times Magazine* (11 July 1999), 1-10 at 3 at www. nytimes.com /1999 /07 /11/ magazine/the-little-white bombshell.html?pagewanted=all
[5] Christopher Gacek, 7.
[6] Ibid, 16. See also Medic8, http://www.medic8.com/medicines/Misoprostol.html, and FDA, www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111315.htm
[7] Christopher Gacek, 16. See also "How does the FDA find out about adverse events?" at http://www.pbs.org/wgbh/pages/frontline/shows/prescription/etc/links.html
[8] Christopher Gacek, 17. See also Margaret M Gary and Donna J Harrison "Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient," *Annals of Pharmaco- therapy* 40 (February 2006) at www.theannals.com
[9] Michael Greene, "Fatal Infections Associated with Mifepristone-Induced Abortion," *New England Journal of Medicine* 353, no. 22 (1 Dec 2005): 2317-2318.
[10] M Fischer et al, "Fatal Toxic Shock Syndrome Associated with *Clostridium sordellii* after Medical Abortion," *New England Journal of Medicine* 353, no. 22 (1 Dec 2005): 2352-2360.
[11] "Italian Health Ministry: 29 Killed by RU-486," (30/7/2009), Zenit News Service, http://www.zenit.org/article-26592?l=english
[12] Richard Stith, "Her Choice, Her Problem: How abortion Empowers Men," *First Things* (Aug/Sept 2009) at http://www.firstthings.com/article/2009/07/her-choice-her-problem. See also Catharine A. MacKinnon, "Privacy vs Equality: Beyond Roe," in *Feminism Unmodified: Discourses on Life and Law* (Cambridge: Harvard University Press, 1987), 93-102.
[13] Catharine MacKinnon, 99.
All on-line document accessed 15 November 2009.

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Ovarian Hyperstimulation Syndrome and Egg Donation

The legalization of egg donation for medical research has resulted in the use of assisted reproductive techniques for the creation of embryos for research. This carries significant risks for the women undergoing these procedures and has brought humankind to a major ethical and moral crossroads.

The assisted reproductive technologies (ART) are various methods used to achieve pregnancy through artificial means. More recently, these technologies have been employed in the creation of human embryos solely for the purpose of research, particularly embryonic stem cell research. The ongoing developments in reproductive technologies have raised significant ethical, scientific and legal issues.[1] From a scientific perspective, the health risks associated with ART are most significant.

Assisted reproductive techniques include, but are not limited to, in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), frozen embryo transfer (FET), and gamete intra-fallopian transfer (GIFT). Of these, IVF is the most common procedure and is often used in conjunction with ICSI. In it multiple eggs are retrieved from the body of a woman and combined with sperm outside the body to achieve fertilisation. The Catholic Church does not approve of this procedure. If fertilisation is successful, the fertilised egg continues to develop to form an embryo which is then transferred back into the uterus with the aim of achieving a pregnancy. In most cases, multiple embryos are created to allow subsequent attempts at implantation in case of failure, as well as for future use by the couple. These unused embryos are frozen and stored until needed for future pregnancies.[2]

Ovarian Hyperstimulation Syndrome

All of the above assisted reproductive techniques involve ovarian hyperstimulation or superovulation, to allow multiple eggs to mature simultaneously within the ovary.[3] This in turn improves egg retrieval and the chances of achieving pregnancy in a given cycle. Various pharmacological agents are used for the purposes of ovarian stimulation, such as clomiphene citrate, gonadotrophins and aromatase inhibitors.[4] When the eggs have matured, these agents are discontinued and ovulation is induced. These eggs are then retrieved from the ovaries and fertilized outside the body to form embryos. As ovarian hyperstimulation requires the ovaries to function above the normal physiological range in response to a rapidly changing hormonal milieu, it has been associated with certain risks and adverse effects. The most significant of these is ovarian hyperstimulation syndrome (OHSS).

OHSS commonly occurs after the induction of ovulation following ovarian stimulation for the maturation of multiple eggs. It is considered to be the most serious complication of ovulation induction, with significant morbidity and mortality. It is characterised by fluid shift from the blood stream to the extravascular compartment.[5] The symptoms of OHSS vary in intensity and are classified as mild, moderate and severe. In its most severe

form, OHSS is characterised by ovarian enlargement, ascites (fluid in the abdomen), hypovolemia characterised by low blood pressure and weak pulse, cerebrovascular thrombosis, respiratory, renal and hepatic dysfunction/failure. This syndrome has a complex pathogenesis and often results in a cascade of events that can prove fatal despite appropriate treatment.[6]

Accounts of the epidemiology of OHSS are fraught with ambiguity. This is largely due to the diversity in classification of the syndrome, as well as the heterogeneity of ovulation stimulation protocols. This renders the pooling of estimates into a composite measure of incidence complicated. The World Health Organization (WHO) has estimated the incidence of severe OHSS to be 0.2-1% of all stimulation cycles,[7] whereas the incidence for moderate cases is estimated to be 3-6%.[8] There is concern that rates of occurrence may rise due to the increasing availability and use of assisted reproductive technology.

OHSS is a life-threatening condition. It is therefore essential that women at risk of developing OHSS be identified and monitored throughout their treatment. It is also crucial for physicians to have a high index of suspicion with regard to symptoms in women undergoing assisted reproduction. Some factors have been identified which may increase a woman's risk of developing OHSS. These include previous history of OHSS, young age at time of therapy, low birth weight, and polycystic ovarian syndrome.[9] Aside from these pre-existing conditions which may predispose a woman to develop OHSS, the ART being used and the degree of ovarian stimulation during treatment may also contribute to increased risk.

The most important iatrogenic factor that has been associated with OHSS is the level of estrogen in the blood at the time of ovarian stimulation.[10] During the cycle, exogenous hormones are given to the woman to stimulate the ovary and induce the maturation of multiple eggs. This results in increased estrogen secretion by the ovary. High levels of estrogen during stimulation are associated with increased risk of OHSS. It has been suggested that reducing the dose of the exogenous hormones without compromising the cycle, may be a preventive measure for OHSS. Furthermore, the presence of increased numbers of mature and immature eggs in the ovary is also associated with higher risk of OHSS.[11] For routine ovulation induction without IVF, lower doses of exogenous hormones are used, as the goal is to mature only one or two eggs for natural fertilization. However, for IVF and other ART cycles, the women are given higher doses of hormones in order to mature 15-20 eggs for harvesting and fertilization. Although this is done to improve the yield and successfully achieve pregnancy, it does put the woman at significantly higher risk of developing OHSS. Research has shown that high estrogen level and the concurrent presence of 20-30 maturing eggs in the ovary may increase the risk of OHSS by an alarming 80%.[12] The combination of these two parameters has shown high sensitivity and specificity for the prediction of OHSS risk and may be used for risk identification and reduction in susceptible individuals.[13,14]

Egg Donation and Embryonic Stem Cell Research

Undeniably, the desire to have children is a natural, beautiful and often over-powering emotion. Driven by this desire, and despite the many ethical concerns, some people are willing to take on the risks associated with assisted reproduction to partake in this blessing. Recently, however, assisted reproductive techniques have been used for the creation of embryos solely for the purpose of research. In June 2009, New York became the only state in the USA to pay women for eggs donated for embryonic stem cell research.[15] Women there might therefore choose to undergo perilous ovarian stimulation so as to receive monetary benefits from donating their eggs for embryonic stem cell research. This raises two issues: firstly, the ethical and moral implications of using human embryos for research - a detailed account of which is beyond the scope of this article. Secondly, the health risks to women who undergo this process for the sake of research. There are several important questions related to this: how aware women are of the risks of ovarian hyperstimulation prior to intervention? What constitutes informed consent in this instance and how will the legalization of egg donation impact upon vulnerable women in society?

Australian Context

In 2002, the Commonwealth *Prohibition of Human Cloning Act* and the *Research Involving Human Embryos Act* were passed in Australia.[16] The first of these Acts prohibited human cloning (both reproductive and therapeutic), along with various other practices.[17] However, the second of these Acts permitted destructive research on 'surplus' IVF embryos, which were 'left over' from previous IVF cycles. The Australian Catholic Bishops Conference stated that this second law had "crossed a new and dangerous line" by "allowing the intentional destruction of human life." It "created for the first time in Australian political and legal history, a class of human life which is statutorily expendable."[18]

In 2005, a review of this legislation chaired by the late Justice John Lockhart was conducted. It proposed even greater liberalisation of these laws. The so-called Lockhart Review[19] made 54 recommendations. It accepted that reproductive cloning "should continue to be prohibited." (Recommendation 2) It continued to permit destructive research on excess ART embryos which had already been created. (Recommendation 14) It did not permit the creation of human embryos for "the purposes of research" by the "fertilization of human eggs by human sperm." (Recommendation 13) However, it did permit the creation of "human embryo clones" through human somatic cell nuclear transfer (SCNT) "for research, training and clinical application, including the production of human embryonic stem cells." (Recommendation 23) As the Review notes in its Glossary, SCNT involves "moving the nucleus and its genetic material from a somatic cell" into "an egg cell from which the genetic material has been removed." If this modified cell is then activated to begin to divide and

develop as an embryo, this is a "human embryo clone," a genetic copy of the person from whom the somatic cell was derived. As we have noted, the Review envisaged that these human embryo clones would be used for "research, training and clinical application, including the production of human embryonic stem cells." Indeed, it insisted that these clones could not be "allowed to develop for more than 14 days." In other words, the Review envisaged not reproductive cloning but so-called 'therapeutic' cloning.

The Review noted that "a significant argument against the use of somatic cell nuclear transfer was that it requires the use of donated human eggs." It noted the difficulties of both "attracting women to donate oocytes for research" and of "obtaining meaningful consent" from them. It acknowledged that "the donation of eggs is riskier for the donor than the donation of other tissues." Further, it noted that "the healthiest eggs would be those of young women." It therefore accepted that "the potential exists for coercion of young women to donate eggs (such as through social disadvantage, family or workplace pressures.)" But despite all this, the Review recommended that egg donation be permitted, albeit under "strict ethical guidelines" and without the use of monetary incentives.[20] Its conclusions about egg donation were summarised as Recommendations 31, 32 and 33.

"In order to reduce the need for human oocytes," the Review also recommended the "transfer of human somatic cell nuclei into animal oocytes" – that is, the creation of human-animal hybrids. (Recommendation 24) Again, this was so-called 'therapeutic' cloning "for research, training and clinical application, including the production of human embryonic stem cells." Again, these embryos could not be "allowed to develop for more than 14 days."

Based on the recommendations of the Lockhart Review, in 2006, Federal parliament enacted the *Prohibition of Human Cloning for Reproduction and the Regulation of Human Embryo Research Amendment Act*.[21] Proposed originally by Senator Kay Patterson, this legislation legalises so-called 'therapeutic' cloning, while continuing to prohibit human cloning for reproduction. It permits the creation through SCNT of embryos to be used and ultimately destroyed solely for the purpose of research. In a last-minute change of heart, however, Parliament amended the proposed legislation to exclude the creation of animal-human hybrids through the transfer of human somatic cell nuclei into animal oocytes. In other words, they did not accept the Review's Recommendation 24. Meanwhile, the permitting of so-called 'therapeutic' cloning through SCNT encompasses legalising egg donation from healthy women for this purpose. The legislation makes no provision to ensure the protection of vulnerable women who are at risk of exploitation. Not only are their bodies at risk from the adverse effects of this process but also their spirits, which may forever bear the burden of their decision.

The legalization of egg donation has the potential to put women at risk. If more and more women choose to undergo this process, the incidence of potentially lethal iatrogenic complications such as OHSS will increase. It may also lead to the commoditization of the human body, whereby, monetary values will be assigned to parts of the human body as women are paid to donate their eggs. Isasi and Knoppers contend that "the inherent moral value of human reproductive materials - symbolic of human life itself - situates them outside the economic realm. To treat human oocytes as merchandise will inevitably undermine fundamental moral, social, cultural, and historical attitudes toward human life in general."[22]

In response to the Lockhart Review, the Australian Catholic Bishops Conference issued *A Statement on Human Embryo Cloning and Destructive Embryo Experimentation* on 11 October 2006. In this statement, the bishops' conference clarified the Church's position on stem cell research. Firstly, they stated that "the Catholic Church is not opposed to stem cell research. On the contrary, we are strong supporters of research based on adult stem cells, as well as those which are derived from umbilical cord blood." Secondly, however, they expressed concern over the new legislation, stating that "these new Bills seek to take us… to creating a new class of human embryos, never to be used for reproduction, but only for research… The destruction of viable human embryos, however they are created, is never to be condoned… To create a human embryo with the express purpose of destroying it for research is to enter into a dangerous and perverse form of human experimentation."[23]

In their most recent statement on the issue of embryonic stem cell research, the United States Conference of Catholic Bishops stated:

> "It now seems undeniable that once we cross the fundamental moral line that prevents us from treating any fellow human being as a mere object of research, there is no stopping point. The only moral stance that affirms the human dignity of all of us is to reject the first step down this path. We therefore urge Catholics and all people of good will to join us in reaffirming, pre-cisely in this context of embryonic stem cell research, that "the killing of innocent human creatures, even if carried out to help others, constitutes an absolutely unacceptable act."[24]

A fertilized human embryo is capable of life if a supportive environment is made available. It has the potential of growing into a productive, vibrant human being. Would any of us procreate to donate our offspring for research or willingly donate our newborn baby for scientific experimentation? We talk about children's rights and human rights - how can we then violate the most sacred right of all, the right to life, of those who are incapable of defending themselves and have been entrusted to our care by God?

ENDNOTES

[1] For the Catholic Church's most recent authoritative statement about ART, see Congregation for the Doctrine of the Faith, *Dignitas Personae, Holy See,* http://www.vatican.va/roman _ curia/congregations/cfaith /documents/rc_con_ cfaith _ doc_

20081208_dignitas-personae_en.html. As this Instruction notes, the Church excludes on ethical grounds "all techniques of heterologous artificial fertilization, as well as those techniques of homologous artificial fertilization which substitute for the conjugal act." (#12) The Church's ethical concerns about ART are not discussed extensively in this article as they were discussed recently in this journal in Kevin McGovern, "The Instruction *Dignitas Personae," Chisholm Health Ethics Bulletin* 14, no. 3 (Autumn 2009): 1-4.

[2] Reproductive Technology Council, Assisted Reproductive Technology (ART) Glossary, RTC, http://www.rtc.org.au/glossary/index.html. The Catholic Church rejects on ethical grounds IVF, ICSI and the freezing of embryos. See *Dignitatis Personae, #14-19.*

[3] Catherine M. DeUgarte, Alan H. DeCherney, and Alan S. Penzias, "Chapter 58. Assisted Reproductive Technologies: In Vitro Fertilization & Related Techniques," in CURRENT Diagnosis & Treatment Obstetrics & Gynecology, 10th ed, eds. A. H. DeCherney and L. Nathan, AccessMedicine, http://www.accessmedicine.com/content.aspx?aID=2393257

[4] J. O. Schorge et al., "Chapter 20. Treatment of the Infertile Couple," in Williams Gynecology, eds. J. O. Schorge, J. I. Schaffer, L. M. Halvorson, B. L. Hoffman, K. D. Bradshaw, F. G. Cunningham, AccessMedicine, http://www.accessmedicine. com/content.aspx?aID=3158038

[5] Abraham Golan and Ariel Weissman, "Symposium: Update on prediction and management of OHSS: A modern classification of OHSS," *Reproductive Bio Medicine Online* 19 (2009): 28-32. RBM, www.rbmonline.com/Article/3959

[6] Annick Delvigne, "Symposium: Update on prediction and management of OHSS: Epidemiology of OHSS," *Reproductive Bio Medicine Online* 19 (2009): 8-13. RBM, www.rbmonline.com/Article/3923

[7] H. Binder *et al., "Update on ovarian* hyperstimulation syndrome: Part 1-Incidence and pathogenesis," *International Journal of Fertility and Women's Medicine 52 (*2007): 11–26.

[8] Annick Delvigne, "Epidemiology of OHSS." [9] Ibid.

[10] Mohamed Aboulghar, "Prediction of ovarian hyperstimula- tion syndrome (OHSS): Estradiol level has an important role in the prediction of OHSS," *Human Reproduction 18 (2003)*: 1140–1141.

[11] K. Jayaprakasan *et al., "Estimating the risks* of ovarian hyperstimulation syndrome (OHSS): implications for egg donation for research," *Human Fertility 10* (2007): 183–187.

[12] R. H. Asch *et al., "Severe ovarian* hyperstimulation syndrome in assisted reproductive technology: definition of high risk groups," *Human Reproduction 6 (*1991): 1395–1399.

[13] P. Aramwit, K. Pruksananonda, N. Kasettratat, and K Jammeechai, "Risk factors for ovarian hyperstimulation syndrome in Thai patients using gonadotropins for in-vitro fertilization," *American Journal of Health-System Pharmacy 15* (2008): 1148–1153.

[14] E. G. Papanikolaou *et al., "Incidence and* prediction of ovarian hyperstimulation syndrome in women undergoing gonadotropin-releasing hormone antagonist in-vitro fertiliza- tion cycles," *Fertility and Sterility 85* (2006): 112–120.

[15] Rob Stein, "N.Y. to Pay for Eggs for Stem Cell Research," The Washington Post, http://www.washingtonpost.com/wp-dyn/content/article/2009/06/25/AR2009062501931.html; see also Thomas Berg, "Scrambled Ethics," National Review Online, http://article.nationalreview.com/?q=YjVjMjMxY2Y5OGYw YzQ2ZWUzOTNhZDEwZWNlNWVlYWE

[16] *Prohibition of Human Cloning Act 2002* and *Research Involving Human Embryos Act 2002, Australasian Legal Information Institute, http://www.austlii.edu.au/au/legis/cth/consol_act/pohcfra2002465* and http://www.austlii.edu.au/au/legis/cth/num_act/rihea2002347

[17] For a concise summary of this Act, see "Prohibition of Human Cloning Act 2002 – summary of principal provisions," FindLaw Australia, http://www.findlaw.com.au/article/7470. htm

[18] Australian Catholic Bishops Conference, "Parliament creates an expendable class of human life with stem cell laws," ACBC, 200212053[1].pdf

[19] *Legislation Review: Prohibition of Human Cloning Act 2002 and the Research Involving Human Embryos Act 2002*, NHMRC, [12] http://www.nhmrc.gov.au/_files_nhmrc/file/research/embryos/review/legislation_review_reports_full_doc_19dec05.pdf [20] ibid, xviii.

[21] *Prohibition of Human Cloning for Reproduction and the Regulation of Human Embryo Research Amendment Act 2006*, Commonwealth of Australia Law, http://www.comlaw.gov.au/comlaw/Legislation/Act1.nsf/0/71AC9EAE45677788CA2572440012F18A/$file/1722006.pdf

[22] Rosario M. Isasi and Bartha M. Knoppers, "Monetary payments for the procurement of oocytes for stem cell research: In search of ethical and political consistency," *Stem Cell Research* 1 (2007): 37–44.

[23] Australian Catholic Bishops Conference, "A statement on human embryo cloning and destructive embryo experiment- ation," ACBC, 200611101646.pdf

[24] United States Conference of Catholic Bishops, "On Embryonic Stem Cell Research," USCCB, http://www. usccb.org/prolife/issues/bioethic/bishopsESCRstmt.pdf. The quote at the end is from John Paul II's *Evangelium Vitae (The Gospel of Life)*, #63.

All on-line documents accessed 15 November 2009.

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