Australian Government
National Rural Health Commissioner

Office of the National Rural Health Commissioner Submission to the Senate Inquiry on the Human Rights (Children Born Alive Protection) Bill 2022

March 2023

Acknowledgement of Country

The National Rural Health Commissioner (the Commissioner) and her Office acknowledge the Traditional Owners and Custodians of Country throughout Australia. The Commissioner recognises and deeply respects the strength and resilience of First Nations people and their continuing connections and relationships to community, rivers, land, and sea.

The Commissioner and her Office pay respect to Elders past, present and emerging and extend that respect to all Traditional Custodians of this land and First Nations people reading this submission.

The Office of the National Rural Health Commissioner

The *Health Insurance Act 1973* (the Act) provides the legislative basis for the appointment and the functions of the Commissioner and the Office of the National Rural Health Commissioner.

In accordance with the Act, the functions of the Commissioner are to provide independent and objective advice in relation to rural heath to the Minister responsible for rural health.

This submission was prepared by Adjunct Professor Ruth Stewart, National Rural Health Commissioner.

Human Rights (Children Born Alive Protection) Bill 2022

The Commissioner thanks the Community Affairs Legislation Committee for the opportunity to comment on the proposed Human Rights (Children Born Alive Protection) Bill 2022 (the Bill).

The Commissioner holds serious concerns about both the intent and the applicability of the Bill.

Intent of the Bill

The Bill introduces a duty of care for health practitioners to provide medical treatment to children born alive, whether their birth is spontaneous or the result of a termination. Within the Bill, medical treatment is defined as life-saving emergency treatment or palliation. If passed, the Bill would require practitioners to choose whether they do all that they can to keep the child alive or make the child comfortable but not attempt to support life. However, the Bill also attaches a responsibility to report failure to provide medical treatment to the Australian Health Practitioner Regulatory Authority (AHPRA). This of itself is likely to weigh the balance towards the provision of medical treatment rather than palliation. Practitioners will seek to reduce personal liability, and this may sway the risk and benefit weighted decision-making further towards resuscitation than would otherwise be the case (AMA, 2017; MBA, 2020). In *Good medical practice: a code of conduct for doctors in Australia*, the Medical Board of Australia (2020) articulates this tension. Recognising that doctors "do not have a duty to try to prolong life at all cost" but have a duty to know when not to initiate and when to cease attempts at prolonging life while ensuring that patients receive appropriate relief from distress (MBA, 2020). The risk of penalty for the practitioner may in their perception outweigh the risk of needless suffering for the baby during resuscitation. This is in a scenario where the chances of longevity are low, the chances of a healthy life even lower and the costs to the health system are very high (Berger, et al., 2021; Boland, et al., 2021).

The intent of the Bill must also be to reduce a woman's autonomy in that a woman may choose to continue a pregnancy or not, but other actors will decide whether her child when born will be resuscitated.

Health practitioners specified in the Bill

The Bill applies to the actions of specific health practitioners. A health practitioner is defined in *Part 1 (3), paragraph 4* in the Bill as:

> "*a person who, under a law of a State or Territory, is registered or licensed to practice in any of the following health professions (or a recognised specialty in any of the following health professions): (a) Aboriginal and Torres Strait Islander health practice; (b) medical; (c) nursing.*"

If the intent is to target health practitioners most commonly involved in attending pregnant or birthing women, the list should include midwives. Midwifery is an independent profession and is not covered by reference the broad reference to nursing. Furthermore, if the intent is the inclusion of Aboriginal and Torres Strait Islander Health Practitioners, as it is not clear in the Bill's wording, then the inclusion of these practitioners is unnecessary. If Aboriginal and Torres Strait Islander Health Practitioners

attend a birth or termination, they would be accompanied by another health practitioner with skills relevant to the care of pregnant or birthing people and would be acting under the direction of or delegation of a midwife, doctor or nurse, and therefore would not be liable for that care. Neonatal resuscitation is not included in the skill set of Aboriginal and Torres Strait Islander Health Practitioners. There must be risks to the maintenance of an adequate national workforce of Aboriginal and Torres Strait Islander Health Practitioners in knowing that despite acting according to the direction of a colleague they could be liable to reporting to AHPRA for not providing medical treatment to a "child born alive".

The usefulness of the concept of a *child born alive* in current health care practice

The term 'child born alive' was brought into common law by judge William Staunford (1509-1558) and set down by Edward Coke in The Institutes of the Lawes of England (Anon., 2002). The concept follows language used for cases of murder in English law identifying three salient characteristics: a reasonable creature, *in rerum natura* (in natural being), and in the King's peace (Anon., 2002; Savell, 2006). The status of reasonable creature is founded in Aristotlean and Christian concepts of personhood (Himma, 2003; Muling & Gilland, 2013). Aristotle held that the rational soul which infuses a being with personhood is present in the foetus. Some Christian traditions also hold to this tenet but there is disagreement within Christian concepts, and between the Christian and Aristotelian concepts of when personhood begins (Muling & Gilland, 2013). Aristotle proposed personhood commenced at the time of quickening, that is when foetal movements are first felt by the mother, whilst in some Christian traditions, personhood is created at conception.

William Staunford had explained that "the thing killed must be in part of the world of physical beings (*in rerum natura*)." This is understood to imply in the case of a foetus that it has been completely expelled from the uterus; that is 'born' (Anon., 2002).

The term '*in the King's peace*' refers to being under protection of the King's peace as opposed to being, for example an outlaw.

There is no debate about whether a foetus or conceptus that has been expelled from the uterus is *in rerum natura* and in the King's peace. There is however unresolved debate about the stage of development at which of the embryo and foetus attains personhood (Kevin, 2018; McGee, et al., 2018). The proposed Bill uses the presumption that a child born alive has personhood (refer to *Part 2 (8)*). McGee et al (2018, p. 594) argue that consensus has not been reached, either in philosophical or popular discourse on the personhood of a fertilised egg, an embryo or a foetus: "in the absence of philosophical and popular consensus surrounding the morality of abortion, abortion should be decriminalised." This argument is valid for the imposition of this Bill. Given there is no agreement on the personhood of an embryo or foetus, then there is no adequate basis to criminalise the withholding of medical care for that embryo or foetus when it is born.

In 2019 the New South Wales Government passed the Crimes Amendment (*Zoe's Law*) Bill in 2019 which is an act to amend the *Crimes Act 1900* to prohibit conduct that causes serious harm to or the destruction of an unborn child; and for other purposes (Parliament of New South Wales, 2019).

This Bill does not call upon the concept of *child born alive* nor does it address when a fertilised egg, embryo or foetus attains personhood. One may infer from this that such decisions were considered too contentious. There is a marked difference in the purpose of *Zoe's Law* and this proposed Bill. *Zoe's Law* extends the responsibility of a person who engages in any conduct that causes grievous injury to a pregnant person by adding responsibility for serious harm to or the destruction of an unborn child.

This Bill seeks to establish a duty for health professionals to provide medical care or treatment to a child born alive as a result birth or expulsion from the uterus by any means including termination of pregnancy. Once a duty is established a corresponding onus to fulfil that duty is created. In *Part 3 (9), paragraph 2* of the Bill, it instructs that:

> *"if a health practitioner engages in conduct that contravenes the duty owed to provide medical care or treatment to a child born alive as a result of a termination, a health practitioner registration board must treat the conduct in the same way as the board would have treated the conduct had the live birth not been the result of a termination."*

At issue here is the personhood of the fertilised egg, embryo or foetus and when after birth (expulsion from the uterus) it might be deemed a child born alive. There is neither philosophical nor popular consensus on this matter. This Bill would be impossible to implement. The Australian Government would be well advised to consider the approach of the New South Wales legislators and not enter into the unresolved debate on when personhood is attained by a conceptus, an embryo, or foetus.

The problem of legislating for potentially futile care

The Australian Institute of Health and Welfare (2022) uses this definition of stillbirth:

> *"A stillbirth is the death of a baby before birth, at a gestational age of 20 weeks or more, or of a birthweight of 400 grams or more. A neonatal death is the death of a liveborn baby within 28 days of birth. Perinatal deaths include both stillbirth and neonatal deaths.*
> *Stillbirths and neonatal deaths may include late termination of pregnancy (20 weeks or more gestation). Stillbirths and perinatal death rates are calculated using all live births and stillbirths in the denominator. Neonatal mortality rates are calculated using live births only."*

Surviving the perinatal period is less likely with earlier gestation and lower birthweights. The great majority of perinatal deaths recorded in Australia are for babies weighing less than 1,500 grams and between 20 and 27 weeks of gestation (AIHW, 2022). At present, health professionals premise decisions about intervention and use evidence of the prognostic indicators of survival of a liveborn baby given its gestation and birthweight (AMA, 2017; MBA, 2020). If the Bill was introduced, there would be pressure to move away from nuanced case by case interpretation of benefits and risks of resuscitation for each individual baby as the Bill would establish a duty to provide medical treatment and attach penalties for the failure to provide it. It is quite possible that the Bill would increase a clinician's tendency to resuscitate even when the evidence indicates resuscitation would be futile. Resuscitation has costs that are physical, emotional and financial which are felt variously by the baby, the mother and family, clinicians and the health system (Berger, et al., 2021; O'Donnell, 2008). Legislators should consider these in their deliberations on the proposed Bill.

Practitioners may feel that their personal risk of penalty renders irrelevant any consideration of the limits of medicine in prolonging life or recognition that efforts to prolong life may not benefit the baby. In this way the Bill would encourage practice that may be counter to the Code of Conduct as set by the Medical Board of Australia (2020).

Attempts to resuscitate the smallest of these babies have some very real physical limitations (Berger, et al., 2021; Haase, et al., 2021; O'Donnell, 2008). For example, long term respiratory support requires endotracheal intubation (insertion of a tube into the windpipe). Endotracheal tubes are only made to size 2 for babies close to 500 grams and even these tubes are too large and cannot be inserted (Berger, et al., 2021). The tubes are not made in a smaller size because even at size 2 it is difficult to have adequate gas transmission through these exceptionally small tubes as the walls of the tube need to be thick enough so that they do not collapse in on themselves; this does not allow adequate

intraluminal space for gases to pass through at the necessary volume and rate (Berger, et al., 2021). There are similar limitations for the insertion of intravenous lines into babies under 1000 grams (O'Donnell, 2008).

Summary

In summary, the National Rural Health Commissioner considers this Bill to ill-advised in intent, difficult to administer or interpret and likely to drive unwarranted medical intervention that counters health professionals' standards, code of conducts and ethics.

References

AIHW, 2022. *Australia's mothers and babies.* [Online]
Available at: https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/baby-outcomes/preliminary-perinatal-deaths
[Accessed 6 March 2023].

AMA, 2017. *Position Statement: Code of Ethics 2004. Editorially Revised 2006. Revised 2016.* [Online]
Available at: https://www.ama.com.au/articles/code-ethics-2004-editorially-revised-2006-revised-2016
[Accessed 7 March 2023].

Anon., 2002. *M (in Bouvier's Law Dictionary).* [Online]
Available at: http://www.supremelaw.org/ref/dict/bldm1.htm
[Accessed 14 March 2023].

Berger, J. N. et al., 2021. Survival and short-term respiratory outcomes of <750 g infants initially intubated with 2.0 mm vs. 2.5 mm endotracheal tubes. *Journal of Perinatology,* 42(2), pp. 202-208.

Boland, R. A., Cheong, J. L. Y., Stewart, M. J. & Doyle, L. W., 2021. Temporal changes in rates of active management and infant survival following live birth at 22-24 weeks' gestation in Victoria. *Australian and New Zealand Journal of Obstetrics and Gynaecology,* 61(4), pp. 528-535.

Haase, B. et al., 2021. Comparison of nostril sizes of newborn infants with outer diameter of endotracheal tubes. *BMC Pediatrics,* 21(1), p. 417.

Himma, K. E., 2003. A dualist analysis of abortion: personhood and the concept of self qua experential subject. *Journal of Medical Ethics,* 31(1), pp. 48-55.

Kevin, C., 2018. Defining the edge of legal personhood: A history of recent campaigns for recognition of pregnancy loss in two Australian states. *Women's Studies International Forum,* Volume 69, pp. 135-142.

MBA, 2020. *Good medical practice: a code of conduct for doctors in Australia.* [Online]
Available at: https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
[Accessed 10 March 2023].

McGee, A., Jansen, M. & Sheldon, S., 2018. Abortion law reform: Why ethical intractability and maternal morbidity are grounds for decriminalisation. *Australian & New Zealand Journal of Obstetrics & Gynaecology,* 58(5), pp. 594-597.

Muling, M. & Gilland, D. A., 2013. Which relationality? Whose personhood? The Christian understanding of the person, 'after-birth abortion' and embryonic stem cell research. *Studies in Christian Ethics,* 26(4), pp. 476-486.

O'Donnell, C. P. F., 2008. 'Resuscitation' of extremely preterm and/or low-birth-weight infants - Time to 'call it'?. *Neonatology,* 93(4), pp. 295-301.

Parliament of New South Wales, 2019. *Crimes Amendment (Zoe's Law) Bill 2019.* [Online]
Available at: https://www.parliament.nsw.gov.au/bills/Pages/bill-details.aspx?pk=3660
[Accessed 6 March 2023].

Savell, K., 2006. Is the 'born alive' rule outdated and indefensible?. *Sydney Law Review,* 28(4), pp. 625-664.