PHPA
Pro-life Health Professionals Australia
News

Response from PHPA to RANZCOG's statement regarding South Australian Termination of Pregnancy Amendment Bill 2025

There are several concerning elements in RANZCOG's statement to the Amendment Bill introduced by Hon Sarah Game MLC in the South Australian Legislative Council, that we wish to address.

As an esteemed peak body dedicated to the health and welfare of both mothers and infants in-utero, RANZCOG has historically trained practitioners to care for two patients. **Indeed, many obstetricians and gynaecologists join the specialty, driven by a desire to support and protect both lives under their care.** Yet with the evolution of state legislative reforms which enable abortion at all gestations, there has been a noticeable tension between the traditional ethical commitments of practitioners and the permissiveness of these laws.

We define elective abortion as any procedure used to separate mother and infant, with the intention of producing a dead infant. Abortion laws across Australia have become increasingly liberal in recent years, advocated and facilitated by RANZCOG and its representatives. Reports from major public tertiary hospitals indicate an increased use of late-term feticide procedures following change in legislation, with **abortions at later gestations being performed for non-medical and psychosocial reasons**[1,2].

Procedures involving intracardiac injection of potassium chloride or equivalent, to ensure fetal asystole before delivery, utilise the advanced in-utero skills of maternal-fetal specialists; skills that practitioners would never have envisaged would be used to terminate both normal infants and those with congenital anomalies that are not life-threatening, has now become accepted practice[2].

On 22nd September 2025, the statement published by RANZCOG in opposition to the South Australian *Termination of Pregnancy (Restriction on Terminations After 22 Weeks and 6 Days)* Amendment Bill 2025, inadequately provided sound reasoning why the Bill should be rejected.

The primary aim of the Bill is to reduce the number of unnecessary infant deaths, which raises the question, how is this not also a priority of RANZCOG?

The **Annual Report for the Year 2024 by the South Australian Abortion Reporting Committee published in April 2025**[3], outlines that 48 pregnancies were terminated after 22 weeks and 6 days. The reported reasons are summarised in Table 8 on page 10 of the report. The largest number, 34 cases, were for "physical or mental health of the pregnant person"; there were 15 cases for "fetal anomaly" and 1 case "to save the life of the pregnant person or another fetus". A footnote at the bottom of the table indicates that for the total number of 48 cases, multiple reasons may be reported per termination. Even if all cases listed under fetal anomaly or to save the life of the pregnant person or another fetus, *were also* for the physical or mental health of the pregnant person, it would leave at least 18 cases which did not have a fetal anomaly as the reported reason. This suggests that somewhere between 18 and 34 **cases of late terminations, involved fetuses who were normally developed**.

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[1] Malek M et al. Abortion care at 20 weeks and over in Victoria: a thematic analysis of healthcare providers' experiences. BMC Pregnancy Childbirth. 2024 Feb 6;24(1):112. doi: 10.1186/s12884-024-06299-0. PMID: 38321392; PMCID: PMC10845525.
[2] Rosser S et al. Late termination of pregnancy at a major Queensland tertiary hospital, 2010-2020. Med J Aust. 2022 Oct 17;217(8):410-414. doi: 10.5694/mja2.51697. Epub 2022 Sep 7. PMID: 36071581
[3] South-Australian-Abortion-Reporting-Committee-Report-2024.pdf

An emergency delivery (e.g. an emergency caesarean section) at greater than 22 weeks and 6 days, would result in some of these infants being born alive[4]. Only one case was reported to save the life of the pregnant person, which would normally be an emergency delivery. This suggests that for the other 18 to 33 cases (who were likely normally developed), in order to procure an abortion (separate mother and infant and produce a dead infant) a feticide would be required.

There is no medical reason why an in-utero infant, who is normal, should not be delivered in a manner that preserves their life, and have all attempts made to optimise their survival. This is what the Bill aims to achieve.

And yet RANZCOG's response was to reject it.

The following points summarise why RANZCOG's response is inappropriate and should be revised or withdrawn:

1. The statement opens with a sentence that is an oxymoron. **Abortion is not healthcare**[5]. The deliberate ending of a human life, as is the intention in elective abortions, is the opposite of healthcare.

2. The remainder of the first paragraph is replete with phrases which are designed to censure those who would suggest otherwise. "The decision… is deeply personal and complex" and "these decisions must remain between a woman and her healthcare provider, not be dictated by political intervention", are often used by abortion advocates with the intent to silence those who would recognise another human life is involved, that warrants consideration.

3. The second paragraph is also filled with disinformation. It begins by stating that "these procedures are extraordinarily rare, representing a tiny fraction of all abortions performed" 1.0% is not a tiny fraction, and 34 potentially normal infants who could survive outside their mothers, is not an insignificant number. **To state that "when they do occur, they almost always invariably involve circumstances of severe fetal abnormalities incompatible with life, or serious threats to the pregnant woman's health and life" is misleading, as the Bill does not address these infants**.

4. Stating that "one of the many troubling aspects of how this bill has been presented is that the mental health of the pregnant person will no longer be considered relevant rationale for a decision to terminate" raises the question—how is the mental health of a mother considered a medical reason to electively terminate a fetus, that can survive ex-utero? **Which clinical guideline advocates for elective abortion as the treatment of choice for mothers who are acutely suicidal, arguably the most serious form of a mental health illness? The answer is simple, there are none.** The most cited study by abortion advocates is a non-random, non-representative convenience sample that resulted in a 68% refusal to participate, and a 50% attrition over the 5 year follow up[6] the outcomes of which are being used misleadingly to shape abortion policy.

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[4] Auger N, Brousseau É, Ayoub A, Fraser WD. Second-trimester abortion and risk of live birth. Am J Obstet Gynecol. 2024 Jun;230(6):679.e1-679.e9. doi: 10.1016/j.ajog.2023.11.004. Epub 2023 Nov 7. PMID: 37939985.

[5] Why abortion is not healthcare - Pro-life Health Professionals Australia

[6] Reardon DC. A Forensic Investigation and Critique of Suicidal Ideation Reported in a Turnaway Study. Linacre Q. 2024 Oct 30:00243639241281978. doi: 10.1177/00243639241281978. Epub ahead of print. PMID: 39544396; PMCID: PMC11559533.

5. Dr Khot's (RANZCOG President-Elect) subsequent comment is also difficult to comprehend. Stating a mother's mental health "is no less important to the overall well-being and ability to safely carry a pregnancy to term", does not warrant that the infant be electively terminated. "Safely carry" is terminology traditionally used to mean safety for both infant and mother. **If this is the intention, the infant should be delivered alive and admitted to the nursery, as most neonatal intensive care nurseries provide care after 23 weeks**[7]. This rationale can be illustrated by considering a mother with severe post-partum depression or other psychiatric illness after birth, who would be supported to care for her newborn, or if she's unable to, foster care would be arranged until her mental health improved. This is appropriate healthcare.

   However, the difference in the cases Dr Khot is referring to, and this example presented above, is the case of a mother who presents with similar mental health issues whilst pregnant late-term, *and requests a termination*. Current legislation permits the mother to undergo a procedure that aborts that infant, assisted by 2 medical practitioners who agree this is an appropriate course of action. **Passing this Bill will protect this infant, as every effort will be made for them to be delivered alive and admitted to the nursery, preventing an unnecessary death.** Nursery staff are adept at managing clinical scenarios where mothers may be assessed as unfit to take care of their infants for a variety of reasons. This is appropriate healthcare.

6. Stating that terminations at this late stage "already require approval from two medical practitioners who must agree", does not provide any assurances these decisions are made with the infants' survival in mind, hence the need to introduce the Bill. **The fact that there has been an increased number of late terminations of normal fetuses since legislation was liberalised**[8]**, indicates that passing an amendment to close this unethical loophole, would present a rational response towards reducing this undesirable outcome.**

7. Stating that the "current Bill represents another attempt to curtail medical expertise and evidence-based practice", warrants further clarification. What evidence is there that terminating late-term for mental health reasons results in better outcomes? There is evidence however, that terminating late term does result in long term psychological harm for women in at least 1 out of 5 cases[9,10], with a prior psychiatric history a consistent predictor of poorer outcomes[11]. These previous studies are primarily in cases where there is a fetal anomaly. **There is no reported evidence of better outcomes in cases where the infants are normal, hence stating this practice is evidence-based is disinformation.**

8. Dr Heather Waterfall, RANZCOG's SA/NT Committee Chair echoes typical pro-abortion sentiments and likewise fails to recognise what the Bill aims to address.

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[7] Report of the Australian and New Zealand Neonatal Network 2022.pdf

[8] Queensland abortion laws: Late termination | The Australian

[9] Kersting A, Kroker K, Steinhard J, Hoernig-Franz I, Wesselmann U, Luedorff K, Ohrmann P, Arolt V, Suslow T. Psychological impact on women after second and third trimester termination of pregnancy due to fetal anomalies versus women after preterm birth--a 14-month follow up study. Arch Womens Ment Health. 2009 Aug;12(4):193-201. doi: 10.1007/s00737-009-0063-8. Epub 2009 Mar 6. PMID: 19266250.

[10] Korenromp MJ, Christiaens GC, van den Bout J, Mulder EJ, Hunfeld JA, Bilardo CM, Offermans JP, Visser GH. Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional study. Prenat Diagn. 2005 Mar;25(3):253-60. doi: 10.1002/pd.1127. PMID: 15791682.

[11] Dawood Y, de Vries JM, van Leeuwen E, van Eekelen R, de Bakker BS, Boelen PA, Pajkrt E. Psychological sequelae following second-trimester termination of pregnancy: A longitudinal study. Acta Obstet Gynecol Scand. 2024 Sep;103(9):1868-1876. doi: 10.1111/aogs.14848. Epub 2024 Jul 8. PMID: 38978342; PMCID: PMC11324936.

9. The claim that the legislation is ill-conceived is not supported by any of the arguments presented in this statement. The claim that "the current regulatory framework already provides appropriate safeguards" is disproven by **available evidence, that records normal infants are being terminated, at gestations where they can survive outside their mothers**[3]. Infants who if nurtured, can contribute to society and the SA government have a duty to protect.

10. Urging "parliamentarians to trust medical professionals to provide appropriate care", should only come as a result of comprehensively considering the facts presented and making a rational assessment of what's ethically appropriate. **No medical officer should think it is ethical to electively terminate an in-utero infant, at a gestation when the infant can survive apart from their mother, and yet this is precisely what is happening**. Australia has become an outlier in this regard, having removed all legislative protections for these infants[12].

11. Stating that the Bill serves no medical purpose fundamentally demonstrates that the data and the arguments made to introduce this Bill have been ignored, in favour of an extreme ideological position, one that has de-valued the in-utero infant, to the extent that they are not afforded due consideration, even when there is a call for serious concern and it is ethically appropriate to do so—**a position which most medical practitioners within RANZCOG's membership would find questionable.**

12. The last paragraph in the statement's conclusion hypocritically describes exactly what RANZCOG's response to this Bill has demonstrated. By failing to carefully review the data critically and the reasons why the Bill was introduced and what it aims to achieve, **RANZCOG is "prioritising ideology over evidence, politics over patient welfare and rhetoric over medical reality"**.

PHPA respectfully requests RANZCOG review its stance on these matters and consider the ethical dimensions that extend beyond the legislative scope. The association's position should uphold the rich legacy of care and ethical integrity that defines this profession.

The PHPA Executive Team

September 2025

[12] Worldwide Abortion laws