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First, Do No Harm – The Forgotten Ethic

Mark Cutrupi –Pro-life Health Professionals Australia (PHPA) – Executive Member

As healthcare professionals, our practice is underpinned by a code of ethics. The Hippocratic Oath: "First, Do No Harm" is the basic underpinning of modern medicine. In the current climate of healthcare, it seems our professional bodies are forgetting our commitment to this code, especially with respect to our vow to non-maleficence. We are seeing this deviation from an ethical practice of medicine more and more in the sphere of reproductive "healthcare", and I would like to focus eventually with specificity on medical abortions.

What is medical abortion?

Medical abortion is a form of abortion that is sold as a less invasive, safer and more "humane" form of abortion. In Australia, women have access to this form of abortion up to 63 days (9 weeks) gestation.[1] It is prescribed by a doctor and the medication (mifepristone plus misoprostol) that is taken to facilitate the abortion is accessed through a pharmacy. The medication causes uterine contractions to occur, which expel the baby from the womb. It is common to hear this process trivialised by being described as just a "bleed" or the passing of "fetal tissue" or a "clump of cells" – The intent in doing so, is to strip all the humanity from the act, in an attempt to make a gravely inhumane process appear to be humane. It mustn't be forgotten however, that what is inside the mother is a growing human, who, at 5 weeks already has a heartbeat and a developing brain, and by 9 weeks already has visible limbs that are forming.[2] Moreover, women often have the impression that this form of abortion, given that it is done "earlier" and simply involves taking tablets (self-administered) is without its risks – I will soon show that this is not true.

The changing culture of healthcare

The risks both *psychological* and *physical* associated with medical abortion are serious and are not described enough to the women who are seeking it by the relevant health practitioners – both doctors and pharmacists. This in itself, apart from the obvious failure in abortion being aberrantly defined as "healthcare", is a grave *failure* of the most fundamental role of the health professional – *Do No Harm*.

A symptom of this failure is the changing culture of healthcare and demands for it to be a buffet of "services" that patients simply select and access at their own discretion – medical abortion falls into this smorgasbord of medical "services" that are possible and therefore because it is possible, the healthcare system deems it a healthcare "right", just because it is possible. Falling into this trap of opening up the immensity of possible medical technologies to everyone and anyone increases the opportunity for atrocities against human dignity being committed, as is clear also in the realms of IVF and voluntary assisted dying. As we accept more technologies in medicine, we also risk falsely quantifying what we view as "freedom" by the range of options available to us, and thus if it is available *"I should have a right to it because it is MY freedom and healthcare is a human right!"* – lines similar to this are often jammed down our throats, and they represent a wider social disease that has infected healthcare and slithered its way into the minds of its custodians.

To clarify, autonomy of decision making in healthcare is not a bad thing, in fact it is a good thing – we are fortunate we can get second or third opinions on matters relating to our health and we are fortunate in a lot of situations we can choose who our healthcare providers are. It however becomes problematic when autonomy is weaponised and sought with entitlement. Moreover, autonomy without being equipped with accurate knowledge is *blind discretion*. It must be understood, that as health professionals, we are not called to simply provide what the patient *wants* just because it is available and they want it, we are instead called to offer them what they *need* based on our expertise, and to educate them in full. And we are certainly not called to skim over or paint a more pleasant view of risk just to fit whatever we believe the patient wants to hear – we need to be impartial and use the evidence.

Healthcare is not a buffet

We are often bombarded with the non-sense phrase *"my body my choice"*, and this has infiltrated the healthcare profession specifically in the realm of reproductive "health". To demonstrate the senselessness of such a statement, take this example: a drug-user addicted to opioids manipulates a doctor into prescribing him oxycodone for a pain condition that he made up. This person is questioned by the pharmacist and is discovered to have lied to the doctor to obtain the prescription to fuel his addiction. What would be the appropriate response by the pharmacist under his oath to do no harm – say to the drug user *"your body your choice, here you go have the oxycodone, it's what you want."* OR *"you are addicted to prescription opioids, I want to offer to help you through this difficult part of your life, what you need is help from an addiction specialist, would you like me to refer you to an addiction clinic?"* I challenge anyone to argue against the former being an obvious case of grave negligence and the latter being an example of good healthcare. Sadly, what is also obvious is that the offering of medical abortion looks all too similar to the former, and, through the lens of the rhetoric used by those who advocate bodily "choice", the latter would typically be characterised as stripping "freedom" from the patient. Why is it that the healthcare system makes abortion an exception to grave negligence? We must not forget what healthcare is – *healthcare is the facilitation by health professionals of the treatment or prevention of disease or illness with the objective of restoring or improving the health of people.* Pregnancy is not an illness or disease, therefore destroying the life of an unborn child to end a pregnancy, at any stage, is not justifiable healthcare, especially when doing so also has detrimental effects on the mother. It is a violation of the code of ethics that holds the health system together.

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Furthermore, I would like to comment on the senselessness of the notion of "reproductive healthcare". In every situation that a woman seeks an abortion, one thing that has certainly already taken place, is reproduction. In the womb of the mother, there is already present a unique human life with DNA that is distinct from every human being in all of history and in time to come. It is clear then, what the healthcare system means by "reproductive healthcare" is actually *post*-reproductive healthcare. They want to be able to kill what has already been reproduced. In every situation of abortion, reproduction has already occurred – the opportunity is missed. The abortion is being sought after for the very reason that reproduction *has* occurred. Rather perniciously and deceitfully, a "post-reproductive death warrant" is now fantastically redefined as "reproductive healthcare", and as long as it is on the healthcare buffet menu, why shouldn't we have a right to it? And if it is post-reproductive care that we are truly after, why not terminate the life of a human who was reproduced 5 years ago?

Restrictions to medical abortion access lifted

Lets now focus on a serious example of the implications of this concerning change in the culture of healthcare – the Therapeutic Goods Administration's (TGA) recent lifting of restrictions on prescribers and pharmacists in being able to prescribe and dispense MS-2 Step (Mifepristone and Misoprostol) for use in medical abortion. Before August 2023, doctors and pharmacists required additional certification and registration with the MS-2 Step program and were required to undertake mandatory training in order to prescribe or supply MS-2 Step.[3]

Prior to the change[3]:

- 1 in 10 doctors could prescribe MS-2 Step and;
- 3 in 10 pharmacists could dispense it.

Now, *all* pharmacies are able to stock and dispense the medication and *any* medical practitioner or nurse practitioner, will be able to prescribe MS-2 Step in the course of their practice. The TGA says this decision "will assist in addressing important access issues for patients who require this medication"[4] – setting aside the obvious misuse of the word "require", it appears however, no added work was made towards importantly addressing the requisite improved access to *information* about the risks to women of this medication – in fact, healthcare providers are now less equipped and less trained to provide this medication than ever before as a result of this change. A most concerning and predictable flow-on effect of this, will be that women seeking medical abortion will not be counselled and informed adequately of the harms of abortion in general, as the predominant body of health professionals providing medical abortions are no longer specially trained to do so. There is just cause for concern in this area when we look at the rising uptake of medical abortions in Australia. Speaking now in 2026, it is even more alarming given the newest published U.S study we now have from the Ethics and Public Policy Center (EPPC), the largest known study of the abortion pill, which identified that 1 in 10 women had a serious adverse event within 30 days of taking the abortion pill, and more than 1 in 10 women had to seek emergency or follow-up care due to serious complications.[19]

With that all in mind, we as Australians should be sorrowful when we view the trend of the uptake of the abortion pill in this country:

The number of prescriptions for mifepristone/misoprostol for medical abortion increased from 3220 in 2014–2015 to 20,741 in 2017–2018[5] – this was while restrictions on prescribing and supply were in place!

If we now look at the total prescriptions for MS-2 Step processed under the Pharmaceutical Benefits Scheme for the 2024–2025 period, this number has now increased to 51,261 (not including unsubsidised prescriptions).[20]

Expanded access has predictably seen these figures skyrocket. As a result, many more women have, and many more will continue to be impacted by the horrors of abortion and it's after-effects, both physical and psychological. Murdering an innocent child in the womb is now as easy as obtaining a prescription for amoxicillin from a pharmacy. This has paradoxically occurred with the support of a healthcare system that has vowed to "Do No Harm".

So then what are the risks that are not being openly spoken about when it comes to medical abortions?

- Retained fetal or placental tissue or incomplete abortion – this occurs more commonly with medical abortions compared to surgical abortions, and if it occurs, requires an invasive surgical vacuum aspiration.[6]
- The overall incidence of adverse events was 4 times higher in medical versus surgical abortion in a follow-up study of >40,000 women who had an abortion up to 63 days gestation.[7]
  - haemorrhage was 4 times higher
  - incomplete abortion was 7 times higher
- Uterine infection – which is most implicated in abortion when there is retained fetal/placental tissue.[8]
  - In rarer circumstances, fatal septic shock may occur after medical abortion with mifepristone/misoprostol.[9]
- Although mifepristone/misoprostol is prescribed by a doctor and supplied at a pharmacy, the taking of the medication itself is unsupervised and is self-administered by the woman, outside of a clinical environment. Concerns about the medication being taken improperly, women putting off taking it after having second thoughts, but then taking it anyway, potentially after 63 days gestation, and even diverting it to other women must be discussed. Unsupervised use of medical abortion pills is associated with an increased risk of serious complications that require further medical intervention such as:[10]
  - incomplete abortion
  - failed abortion
  - haemorrhage leading to anaemia and requiring blood transfusion
  - septic abortion

A cohort brainwashed

With the TGA's lifting of restrictions on abortion access in 2023, pharmacists and doctors have undoubtedly now more so bought into the propaganda that abortion is safe and good. Why would the common healthcare professional betray the zeitgeist of their profession, when they have spent years and years entrenching themselves in that very system that got them to where they are?

As a result, the harms of abortion will continue to be hidden, either maliciously or under the false pre-tense of standing for a "good", sold under deceitful terms. These harms are not restricted to:

- Psychological trauma and post-traumatic stress
  - rates of mental health disorders in women who had undergone an abortion were approximately 30% higher[11]

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  - Abortion can function as a traumatic stressor with the potential of causing Post-Traumatic Stress Disorder (PTSD) and Post-Traumatic Stress Symptoms (PTSS)[12, 13]
  - 40% of women who had underwent an abortion experienced one or more PTSD symptoms in a US study involving >800 women[14]
- Suicidality[15]
  - In the year following abortion, women were 3 times more likely to commit suicide than the general population, and nearly 6 times more likely to commit suicide than women who gave birth
  - women who aborted had a 154% higher risk of death from suicide compared to giving birth
- Impacts on future pregnancies
  - induced abortion may be a risk factor for ectopic pregnancy for women with no previous ectopic pregnancy[16]
- Breast cancer – The link between abortion and breast cancer risk is debated, however, a meta-analysis of the link between abortion and breast cancer risk was conducted in chinese women, which found among these women:[17]
  - Induced abortions is significantly associated with an increased risk of breast cancer
  - Breast cancer risk increases as the number of induced abortions increase

Women seeking abortion are already vulnerable![18]

- Past traumatic experiences including past sexual violence are common in women who are seeking abortion
- Pre-existing PTSS are present in 23% of women requesting an abortion

These women need to be supported, not have their trauma fuelled even more so. An undertrained group of health professionals delivering medical abortion as a healthcare solution is far from the answer.

We must listen to the stories of those affected

Are the health professionals listening to the stories of women who *have* had abortions, who live with grief about their decision? Would their decision have been different if they were better informed? What about the fathers who grieve for their aborted children? When did they get a say? Abortion isn't just a women's issue, it is a human issue. Those brave enough to speak about their experiences can be found many places online, here are a couple:

RIGHT TO KNOW:

https://righttoknow.au/

H3Helpline:

https://h3helpline.org/help-after-abortion/abortion-stories/

Choice at all costs?

The growing trend of healthcare violating its fundamental ethic in order to accommodate the perverted ideal of "choice", by defining the *wants* of the patient as healthcare *needs*, simply because advancements in technology allow it, is a growing disease of the healthcare profession. We should accept medical technologies only if they preserve the dignity of the human person and are compatible with the main ethic that allows us to put our trust in our healthcare system – Do No Harm. Healthcare "services" that use death and destruction as a means of facilitating the *wants* of the patient, such as medical abortion, are a product of this disease, and the custodians of our health system – the professionals and experts that make it up, in whom we place our trust – need to be open and honest about its truths and risks if they are to uphold integrity in their practice, such that this disease in healthcare may be healed. We need pro-life pharmacists, nurses and doctors to continue to fight back and stand firm, with the belt of truth buckled around their waist.

Mark Cutrupi
Pro-life Health Professionals Australia (PHPA) – Executive Member

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South Australian Hon Sarah Game MLC's pro-life victory

We congratulate Hon Sarah Game MLC other courageous MPs, Right to Life South Australia and outstanding activist Dr Joanna Howe who worked tirelessly in South Australia to overcome a massive hurdle in the fight to protect unborn life .

The Termination of Pregnancy (Restrictions on Terminations after 24 Weeks and 6 Days) Amendment Bill 2026 – to protect the life of unborn babies after 25 weeks gestation - was introduced by MP Hon Sarah Game MLC and passed the Legislative Council of the SA Parliament (17 June 2026) – 10 votes to 9.

Coinciding with the Legislative Council debate a rally was held on the steps of Parliament House in Adelaide. An enthusiastic group of pro-lifers braved the rain and blustery conditions to support the pro-life parliamentarians and greeted news of the Legislative Council win with rousing cheers.

Later that evening, after the passage of the bill in the Council Labor rushed the bill into debate in the House of Assembly. Ultimately the bill did not pass the lower house – both houses are required for the bill to become law. It was defeated 36:9.

The good news is the South Australian election in March 2026 saw the composition of the Legislative Council change with the election of 3 One Nation South Australia candidates - all 3 voted for the bill.

It is pleasing Premier of South Australia **Peter Malinauskas MP and Leader of the Opposition Ashton Hurn MP (Lib)** voted in favour of the bill in the House of Assembly. Mr Malinauskas voted in favour of decriminalising abortion in 2021 while Ms Hurn was not in government at that time.

South Australia's Termination of Pregnancy Act 2021 legalising abortion to birth was passed on 19 February 2021. Abortion is legal up to 22 weeks and 6 days without restriction. Late-term abortions are legal after 22 weeks 6 days with approval from two doctors, if the continuation of pregnancy would involve "significant risk of injury to the physical or mental health" of the woman.

The SA government's Annual Report for the Year 2023 from the South Australian Abortion Reporting Committee reports 4,905 abortions in South Australia in 2023, compared with 4,851 in 2022. Forty seven (47) late term abortions were performed after 22 weeks and 6 days gestation. Of these, 37 babies (nearly 80%) were aborted for reason of physical or mental health of the mother. Ten babies were aborted for fetal abnormality. There were no late term abortions reported to save the life of the mother.

Dr Joanna Howe, Professor of Law and Director of Australia Life said during the campaign ""Since the enactment of abortion up to birth in July 2022, there have been 105 babies killed through late-term abortion. These poor babies have been injected with potassium chloride in the heart and delivered intentionally stillborn. This is not healthcare. It's murder and it has no place in a just and humane society."

Dr Melissa Lai, Senior Neonatologist (newborn medical specialist) and President of Pro-life Health Professionals Australia said "At 25 weeks' gestation, for a normally developed baby, resuscitation and intensive care support is offered as standard care, with average survival over 82% across all tertiary nurseries in the Australian and New Zealand Neonatal Network," she said. "There is, in fact, no medical reason to terminate these infants in-utero by feticide, in order to save a mother's life."

Over the past two years, with successive attempts to pass pro-life bills in South Australia Right to Life Australia has campaigned and asked supporters to write to your representatives and attend the rallies held on the steps of Parliament. We thank you for your commitment - your work to protect life has been fruitful.

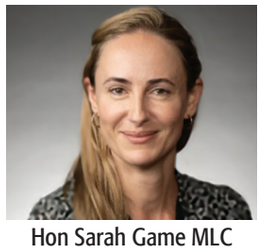
HOW YOUR SOUTH AUSTRALIAN MPS VOTED:

LEGISLATIVE COUNCIL VOTE:

AYES (10)
Bernardi, C.
Centofanti, N.J.
Game, S.L. (teller)
Girolamo, H.M.
Hewett, R.J.
Hood, B.R.
Hood, D.G.E.
Ngo, T.T.
Quaremba, C.L.
Scriven, C.M.

NOES (9)
Bourke, E.S.
El Dannawi, M.
Gumbys, H.J.
Hanson, J.E.
Hunter, I.K.
Maher, K.J.
Selwood, M. (teller)
Simms, R.A.
Wortley, R.P.

PAIRS
Henderson, L.A.
Lensink, J.M.A.


Hon Sarah Game MLC

HOUSE OF ASSEMBLY VOTE:

AYES (9)
Brown, M.E.
Hurn, A.M.
Koutsantonis, A.
Malinauskas, P.B.
Paton, D.
Roylance, R.J.
Telfer, S.J.
Thomas, C. (teller)
Virgo, J.W.

NOES (36)
Agness, J.P.
Andrews, S.E.
Batty, J.A.
Ben, L.R
Bettison, Z.L.
Bolkus, A.C.
Boyer, B.I.
Brock, G.G.
Champion, N.D.
Clancy, N.P.
Fatchen, T.A.
Fulbrook, J.P.
Hildyard, K.A. (teller)
Hood, L.P.
Hughes, E.J.
Hutchesson, C.L.
Marozzi, M.J.
Mitton, J.A.
Nicholson, L.H.
O'Hanlon, C.C.
Pearce, R.K.
Picton, C.J.
Priest, T.M.
Rich, C.C.
Roberts, J.L.
Rolls, A.J.
Savvas, O.M.
Schultz, M.J.
Shaw, E.R.
Spencer, M.R.
Stinson, J.M.
Szakacs, J.K.
Teague, J.B.
Thompson, E.L.
Whetstone, T.J.
Wilkins, D.G.

Child Under the Age of 12 Euthanased in the Netherlands

On Monday, 22nd June 2026, the government of the Netherlands confirmed for the first time ever the death of a patient under the age of 12 through deliberate, life-ending action taken by medical professionals. Reporting to the parliament, Minister Sophie Hermans officially confirmed the decision of euthanasia made for a patient between the ages of 1 and 12, in the Dutch government's 2025 annual report on purposeful medical terminations of human life.

The decision by the Dutch medical system to end the life of a patient under the age of 12, which marks the first known case of such occurrence since the fall of Nazi Germany in 1945, was legally permitted through the 2024 changes to the model under which euthanasia procedures function in the Netherlands, which made it no longer a criminal offence for parents and registered doctors to cause premature death through medical means in terminally ill patients between the ages of 1 and 12.

According to the official English website of the Government of the Netherlands, in certain situations, [the doctor may decide, together with the parents, to terminate the child's life. This decision is always made in consultation with the parents and, if possible, also with the child.]

In light of the unprecedented governmental approval for the life-ending procedure in a patient under the age of 12, proponents of euthanasia were quick to voice their apparent justification for the decision to purposefully end the life of the patient, portraying euthanasia as a choice of compassion and necessary to stop suffering in terminally ill patients.

Such supporters of deliberate terminations of human life often use emotive and charged language, and draw on anecdotes in an attempt to convince others to agree with their viewpoints. However, they often fail to do comprehensive research into the topic and rarely possess a full understanding of the medical procedures in ending the lives of terminally ill patients.

While uninformed activists proclaim euthanasia as a means of painless, dignified death, their logic does not take into account how artificially induced death works in reality. Different opinions are present within the medical community, but regardless of the type of lethal drug used to induce premature death in terminally ill patients, it can never be guaranteed that deaths through chemical injection will be painless or dignified. It is for the same reason that in the United States, opposition to the implementation of the death penalty through lethal injection is growing more and more prevalent, with widespread demand to end lethal injection as a lawful practice, even for perpetrators of heinous crimes, due to the suffering and lack of dignity involved in the medical process.

The fact that many supporters of death penalty reform push for the unconditional end of all lethal injections as a means of induced death, instead of pushing different drugs to administer the death penalty, is because no drug known to scientists can guarantee a painless and dignified death, whether in lethal injection, or euthanasia. Much less than eliminating suffering and the loss of dignity as supporters of euthanasia would claim, the inducing of premature death through lethal chemicals may be the source of grave suffering and loss of dignity in the final moments of a terminally ill patient's life.

The truth of the matter is, the only reliable way to ensure the comfort and dignity of a patient at the end of life is to invest in palliative care designed to eliminate pain and discomfort, and to make patients feel respected and cared for in the final chapter of their lives.

However, the ugly truth is that as providing quality palliative care cost more funding and effort than simply prematurely ending the lives of terminally ill patients through euthanasia, self-interested and entitled policymakers and managers of healthcare systems will do everything they can to avoid responsibility, with the help of activists ignorant of the facts.

With the precedent set by the government of the Netherlands in allowing doctors and parents to make decisions to end the lives of patients without valid consent, unless if supporters of human life and dignity do something, more and more child abuse and elder abuse will be perpetrated by impatient caregivers of terminally ill patients through pressure and deception which could not be easily monitored or reported.

Let us all remember that we can, and will, make our contribution by exposing, and eliminating the deliberate ending of human life.

"Born Alive and Left to Die" Book your screening of the film NOW!

Right to Life Australia commends Australian Christian Lobby for the production of the film "Born Alive Left to Die" exposing the devastating reality of babies born alive after abortions and left to die. In 2012 Right to Life Australia hosted Jill Stanek, registered nurse from Illinois, USA as keynote speaker for our conference held in Melbourne. In her presentation she gave testimony of her discovery of a baby with Down Syndrome born alive after an abortion, left to die without medical care and how she cared for him until he passed away.

During her testimony at the Born Alive Abortion Survivors Protection Act Hearing, U. S. Senate Judiciary Committee on 11 February 2020 Jill Stanek said:

> *"One night, a nursing co-worker was transporting a baby who had been aborted because he had Down syndrome to our soiled utility room to die – because that's where survivors were taken. I could not bear the thought of this suffering child dying alone, so I rocked him for the 45 minutes that he lived. He was 21 to 22 weeks old, weighed about 1/2 pound, and was about the size of my hand. He was too weak to move very much, expending all his energy attempting to breathe. Toward the end he was so quiet I couldn't tell if he was still alive unless I held him up to the light to see if his heart was still beating through his chest wall.*
>
> *After he was pronounced dead, I folded his little arms across his chest, wrapped him in a tiny shroud, and carried him to the hospital morgue where we took all our dead patients. Christ Hospital readily admitted babies there survived abortions. A spokesman told the Chicago Sun-Times (article submitted with testimony) "between 10 percent and 20 percent" of aborted babies "survive for short periods." From what I observed, it was not uncommon for a live aborted baby to linger for an hour or two or even longer. One abortion survivor I was aware of lived for almost eight hours."*

The ACL documentary reveals a truth many Australians have never been told - that defenceless babies born alive after failed abortions are denied care and left to die.

To host a screening of the video for your friends, church or other group please contact www.acl.org.au

STOP PRESS:

French National Assembly Votes to Legalise Assisted Suicide and Euthanasia

Constitutional Council will assess compliance with the Constitution

On 15 July 2026 French National Assembly MPs voted for a bill **to legalise assisted suicide and euthanasia** by 291 votes to 244. The legislation was rejected by the French Senate three times previously. Prime Minister Sébastien Lecornu will now refer the bill to the Constitutional Council . Of many concerns is the absence of a conscience clause allowing healthcare facilities to refuse to provide euthanasia on their premises.

If legalised, assisted suicide and euthanasia would be permitted for adults with a "serious and incurable" life-threatening illness "in an advanced or terminal stage" with physical or psychological suffering that is "unbearable" or resistant to treatment.

The French president Emmanuel Macron openly supported the vote. In translation, he said on X: "In 2022, I made a commitment to pave this path with the French people," and "…this commitment has been fulfilled."

Immediate opposition was expressed by the Catholic Bishops' Conference of France (CEF) who said "By choosing to legalize euthanasia and assisted suicide, the members of parliament have enshrined in French law the possibility of causing death. This choice breaks with the long tradition of care, whose vocation is to alleviate suffering and accompany each person to the natural end of their life". "Our relationship to vulnerability, old age, disability, and illness will change. The poorest are likely to be the first to pay the price: not wanting to be a burden on their children or grandchildren, elderly people in precarious situations may feel pressured to die".

Vatican News reports the French Bishops' Conference insist they are not giving up. In their view, the matter is not over, as several significant legal avenues remain open.

A Case to Oppose Legalisation of Telehealth Carriage Service Consultations for Assisted Suicide and Euthanasia

Both assisted suicide and euthanasia are now legal in all Australia's states and the ACT with a bill to follow suit expected to be introduced into the Northern Territory this year. The federal government has not yet made legislative amendments to exempt doctors from the ban on telehealth consultations for assisted suicide and euthanasia.

In November 2023, Justice Wendy Abraham of the Federal Court of Australia ruled assisted suicide and euthanasia – euphemistically "Voluntary Assisted Dying" – fits the definition of "suicide" under the Commonwealth Criminal Code. Justice Abraham ruled the word "suicide" in the federal code covers the intentional ending of a person's life.

Because of this ruling it remains illegal under Commonwealth law to use a "carriage service" (phone, video, email or internet) to counsel or discuss assisted suicide or euthanasia (metaphorically called "VAD") as this violates prohibitions against inciting suicide. Doctors face criminal prosecution for discussing assisted suicide and euthanasia ("VAD") over telehealth platforms like phones or email.

There have been many attempts to overturn this restriction including the tabling of private members' bills. In March 2025, the Australian Medical Association media release called on the government to amend the Criminal Code.

It is essential those concerned with the protection of the lives of patients oppose all moves by the federal government to legislate to permit doctors to use telehealth consultations for voluntary assisted dying and euthanasia.

The offence of using a Carriage Service for suicide related material

It is an offence to use a carriage service for suicide-related material, as contained in section 474.29A of the *Criminal Code* 1995 (Cth) and is punishable by a maximum fine of 1,000 penalty units.

Arguments against Telehealth Consultations for euthanasia and assisted dying:

- As a matter of principle, the policy of our federal government is in opposition to suicide. The Australian government has had a National Suicide Prevention Strategy NSPS including plans, programmes and research to help prevent suicide and reduce its impact.
- For our federal parliament to vote to abrogate the present ban on the use of Carriage Services to facilitate or counsel for suicide would be in direct opposition to the NSPS.
- Telehealth consultations touching on voluntary assisted dying and euthanasia would be the most serious and decisive step in the lives of patients. Any consultations between patients and their physicians which involve patients requesting access to voluntary assisted dying must, of necessity, be treated with seriousness because it involves ***"life and death"*** decisions.
- For our society to allow ***"life and death"*** consultations to take place by telephone or by video diminishes the principle of the inherent dignity and value of human life. As a society we must not countenance such a devaluation of life.
- The prospect of telehealth consultations allowing access to assisted suicide is a dramatic step down a perilous path if physicians were authorised to prescribe death-on-demand without seeing patients in person.

Continued on page 7

- Even face to face consultations between patients and physicians are often unsatisfactory for the care and welfare of the patient, due to patients' problems with open communication.
- In the case of consultations for "VAD" patients may find it more difficult to verbalise their underlying thoughts. Patients are often experiencing undiagnosed depression. There may be a complex interplay of factors relating to their physical and mental health. These factors may affect their judgement and capacity to deal with issues and decisions facing them. Such factors are also impacted by mental illness.
- Such situations require great skills on the part of physicians. However, , they are unlikely to be able to draw on those skills within the context of a telehealth consultation.The unnatural situation caused by a remote consultation, even via video, cannot resolve such grave issues for the benefit of patients.

VAD has been legalised in all six states and is already practised in three states. There is a profound possibility that Australians will grow accustomed to the deliberate ending of the lives of patients and come to accept VAD as routine medical practice.

Given this new atmosphere, the introduction of Telehealth Carriage Service consultations for assisted suicide would likely be viewed by Australians as just an inevitable next step.

We need to alert legislators to this likelihood - that medical practitioners are authorised to approve assisted suicide for patients and prescribe fatal dosages of medications for patients to commit doctor assisted suicide – all without the medical practitioner ever seeing the patient in person.

Serious questions arise regards physicians who engage in telehealth consultations. Statistics available from Annual Reports on the operation of voluntary assisted dying in Victoria show that a limited number of medical practitioners are responsible for the majority of voluntary assisted deaths .

Victorian statistics reflect British Columbia, where a limited number of physicians perform the vast number of MAiD deaths. Dr Ellen Wiebe, one of Canada's most outspoken euthanasia doctors, operates a euthanasia clinic in Vancouver disclosed that she has killed 400 people by MAiD (Medical Assistance in Dying).[1]

In Victoria, certain medical practitioners are known 'facilitators' of VAD. Their reputations have spread by word of mouth and by referrals from other medical practitioners.

Were legislation passed permitting telehealth consultations for VAD, an undesirable consequence would be the further concentration and increase of VAD procedures performed by a limited number of "specialist" medical practitioners, reflecting the situation in British Columbia.

The language of the legislation

Language referring to **"specialty consultations"** (assisted suicide requires consultations) or end-of-life care (the assisted suicide lobby defines assisted suicide as **"end-of-life care"**) requires clear definition, to prevent its use for assisted suicide.

Imprecise language within the legislation may enable assisted suicide doctors to perform assisted suicide assessments and prescribe lethal drugs, without meeting or physically assessing the person.

Assisted suicide is not health care.

Assisted suicide does not treat or cure a disease or condition - it causes death. The main goal of assisted suicide lobby is to normalise assisted suicide by redefining it as **end-of-life** care and **to expand the availability of assisted suicide by telehealth consultations.** Assisted suicide by telehealth achieves the second goal. Telehealth may also lead to out-of-state assisted suicide deaths in Australia.

Medical error is a leading cause of death globally.

Research by the University of New South Wales[2] estimates as many as 18,000 people die every year in Australia because of medical error.

Assisted suicide by telehealth may exacerbate the problem of misdiagnosis and the unfortunate death of misdiagnosed patients.

It is highly doubtful there would be adequate safeguards from exploitation, such as **elder abuse**, which is rampant in Australia today, yet is difficult to detect. This would be particularly relevant in telehealth consultations because the abused patient would find it difficult to convey any abuse. Abusers may well be surreptitiously close to patients, unknown and undetected by the medical practitioner conducting the consultation. Face-to-face consultations however, can reveal potential abuse.

The possibility of patients being led to impulsive requests for VAD.

The pressures, tensions and atmosphere of audio or video consultations, to which patients may be unaccustomed could lead to impulsive decision making . With some states already allowing physicians to raise the option of VAD, vulnerable patients will be exposed to greater risks of making impulsive decisions and asking for VAD.

Eugene Ahern (updated 2026).

[1] https://thelifeinstitute.net/news/2023/canadian-doctor-boasts-of-euthanising-patients-as-concerns-rise-over-canadas-maid-law

[2] https://www.unsw.edu.au/law-justice/our-research/impact/australia-has-an-ethical-and-an-economic-obligation-to-reform-medical-negligence
Further reading: Kristen Hanson, 14 July 2020, The Washington Times – When Telemedicine can be dangerous, even deadly. https://www.washingtontimes.com/news/2020/jul/14/when-telemedicine-can-be-dangerous-even-deadly/

Man Euthanased in Ontario After Consult Outside Coffee Shop

A physician from London, Ontario (Canada) was investigated and suspended for conducting a MAiD (Medical Aid in Dying) assessment outside a Tim Horton's coffee shop.

In June 2023 Ontario doctor Dr. James MacLean met a 45-year-old patient suffering from Crohn's disease and depression. The doctor then performed his assessment of the patient's eligibility for euthanasia. The doctor then drove him to an industrial funeral preparation facility and euthanased him. The man's family were not told and could not even say goodbye.

The Catholic Herald stated an investigation was launched into MacLean following two public complaints relating to two cases involving Canada's euthanasia and assisted suicide regime, known as Medical Assistance in Dying (MAiD). In addition to the above case, in the second case MacLean failed to administer the full euthanasia drugs. He declared the patient dead, only for the man to start breathing again after MacLean left the home. Dr. MacLean was reprimanded and required to submit to **six months of clinical supervision** due to failures to adhere to protocols and procedures but permitted to continue providing MAiD. Details are reported on Sky News[1] and the Catholic Herald.[2]

Note: An excellent interview is available online - Dr. Ramona Coelho, a family physician and former member of Ontario's MAID death review committee was interviewed on Radio CBC London[3]. Dr Coelho stated "What is striking is not only the seriousness of the concerns identified in these cases, but the limited regulatory response".

[1] https://www.skynews.com.au/world-news/global-affairs/doctor-euthanises-man-45-with-crohns-disease-and-depression-after-evaluating-him-outside-tim-hortons-coffeehouse-chain/news-story/0f5363c5260503098f53effb97b9e10a

[2] https://thecatholicherald.com/article/doctor-assessed-man-for-euthanasia-outside-doughnut-shop

[3] https://www.cbc.ca/listen/live-radio/1-158-london-morning/clip/16217943-does-maid-need-stronger-regulations

Assisted Suicide Bill Re-Introduced In UK

In England and Wales, a new attempt to legalise assisted dying was signalled in June 2026. The bill which mirrors Kim Leadbeater's failed *[Terminally Ill Adults (End of Life) Bill* would allow terminally ill adults with less than six months to live to request medical assistance to end their lives

Lauren Edwards Labour MP for Rochester and Strood announced she will reintroduce the failed bill to the parliament as a private member's bill.

The UK Christian Medical Fellowship said things have changed significantly since the bill was first tabled in late 2024. They reported that in response to concerns by the House of Lords, Lord Falconer - the bill's sponsor - proposed more than seventy amendments.

On 29 November 2025 MPs voted 330:275 to give Kim Leadbeater's bill a second reading. It was then examined by a Committee, amended and debated at report stage. On 20 June 2026 MPs voted 314:291 to pass the bill to the House of Lords. There was a reduced majority of 23 when it was passed to the House of Lords.

The bill was extensively scrutinised in the House of Lords, revealing all the dangers of legalising assisted suicide and failed to pass as peers ran out of time to conclude debate before the end of the parliamentary session in April 2026.

On 11 September 2026 the bill will have its Second Reading vote in the House of Commons. If passed at Second Reading, it may dominate the remainder of the parliamentary session and longer. There is a concern the Parliament Acts could be used to force this Bill into law. Under the Parliament Acts, legislation can be forced onto the statute book without the consent of the House of Lords only if the same bill has been passed by the House of Commons in two successive parliamentary sessions.[1]

The Christian Medical Association – an organisation of 4,000 doctors, 500 medical and nursing students, and 450 nurses and midwives reported several MPs who voted for assisted suicide have publicly said they would oppose using the Parliament Acts. They stated "This is a private member's bill addressing profound questions of life, death, and medical practice. It should not be forced through Parliament without both Houses retaining and exercising their full roles in revising and safeguarding."[2]

The introduction of the bill has been criticised by other Labour MPs with concern about timing on such a controversial issue after the resignation of the UK Prime Minister Sir Keir Starmer on 22 June 2026 Right to Life UK reported The Royal College of Physicians, Hospice UK, Sue Ryder charity, the British Association of Social Workers and the British Geriatrics Society have all reiterated their serious concerns with the re-introduction of an assisted suicide bill.

Alithea Williams, SPUC's Public Policy Manager, said:

"It's incredibly disappointing that this MP is choosing to bring back this dangerous and divisive bill. That Ms Edwards is taking forward an identical bill – that not a single royal college, medical body or disability organisation could support – shows the extreme arrogance of the assisted suicide lobby. Instead of addressing any of the myriad concerns raised, they are opting to try to steamroller it through." [3]

References:

1. https://www.hansardsociety.org.uk/publications/briefings/assisted-dying-bill-parliament-act
2. https://www.cmf.org.uk/the-assisted-suicide-bill-returns-now-is-the-time-to-kill-this-bill/
3. https://righttolife.org.uk/news/press-release-mps-who-supported-assisted-suicide-bill-now-oppose-it-being-forced-through-via-the-parliament-acts-suggesting-bill-likely-to-fail-if-it-comes-back

Alert For All Northern Territorians

The Northern Territory (NT) government has introduced an assisted suicide and euthanasia bill into the Parliament on 23/7/2026.

Right to Life Australia provided an extensive submission to the government's Legal and Constitutional Affairs Committee Inquiry opposing the introduction of the legislation. The Inquiry Report supported the introduction of assisted suicide and euthanasia legislation.

There has been a long history of the battle to protect the vulnerable in the Northern Territory. In 1995 the Northern Territory became first place in the world to legalise assisted suicide and euthanasia under the *Rights of the Terminally Ill Act 1995*.

Federal MP Kevin Andrews' *Euthanasia Laws Act 1997* amended the self-government acts of the territories and prohibited territorial governments from legalising assisted suicide and euthanasia. The Federal Parliament then passed the Restoring Territory Rights Bill 2022 paving the way to allow the Northern Territory government and the A.C.T (which has already legalised euthanasia) to legalise assisted suicide and euthanasia.

There are 25 Members of the Legislative Assembly, each representing a single electoral division. We ask all supporters in the NT to contact your representatives and oppose legislation to allow assisted suicide and euthanasia. https://parliament.nt.gov.au/member

Archiving Right To Life Australia's History

Our volunteer Anne is working on classifying our archives. She has a long history with Right to Life Australia, initially volunteering her services at the Brunswick Road office! Anne enjoyed a long career and now volunteers for many agencies including the Sports Museum (being a keen Essendon football supporter). After loss of our archives in 2022 we started to gather our legacy documents together again. The cataloguing of our archives is critical in recording the history of the movement. Thank you Anne for your dedication to this vital role.