

Mifepristone (RU-486) and limits to abortion

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TO THE EDITOR: As politicians prepare to debate the *Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005*,¹ one question is central: why should mifepristone require special approval from the Minister of Health and Ageing, when all other drugs are simply assessed by the Therapeutic Goods Administration (TGA)? The answer is that abortifacients such as mifepristone are unique in that they are the only drugs designed to end a human life, and therefore their use demands a unique level of ethical assessment and accountability, beyond the scope of the TGA.

The TGA has the vital but limited role "to ensure the quality, safety and efficacy of medicines". These criteria are adequate for assessing most medications, but inadequate for a drug designed to extinguish life.

The TGA in its approval process does not consider ethical criteria.² However, without broader ethical considerations, such as what medical conditions might justify the use of mifepristone, or the moral status of the life to be extinguished, no meaningful assessment of an abortifacient can be made.

Abortion "on demand" (ie, without medical justification) is readily available in Australia, even where, as Judge Fred McGuire stated in a Queensland case: "There is no legal justification for abortion on demand".³ Evidence for the predominantly non-medical justification for abortion was documented in a 1995 survey of women seeking termination of pregnancy in New South Wales.⁴ The most frequently listed contributing factor, given by 60% of the 2249 respondents, was "financial concerns". Younger women were more likely to cite youth, career, single parenthood and changes to lifestyle, while women aged over 30 were more likely to cite completed family and problems in their relationship with their partner.

Because abortion law is under state jurisdiction, the federal government has no stated position on abortion "on demand". Now that it is being asked to authorise a drug for abortion, the government has the

opportunity and responsibility to defend basic standards of law and ethics by limiting mifepristone use to medically essential terminations of pregnancy, excluding abortion for non-medical reasons.

The government should establish, in consultation with medical authorities, valid medical indications for mifepristone, including certain cancers, hormonal diseases, and medically essential termination of pregnancy, and approve the drug for those uses. The criteria could be specified using the existing authority prescription mechanism. This would exclude abortions for which there is no medical indication; for this category, the compelling task for government and the profession is to address the underlying social stresses for which abortion is seen as a solution, reconstructing social supports for women distressed by unplanned pregnancy.

Certainly, setting ethical parameters for the use of mifepristone will not affect the availability "on demand" of surgical abortion, which operates without effective ethical or legal restraint. Yet, even largely symbolic acts can be important. If it is right ethically and medically to set limits on the use of abortifacients such as mifepristone, these limits should be set.

The medical profession should use the debate on mifepristone to reaffirm ethical limits on abortion, upholding our duty of care to both mother and unborn baby. Disappointingly, in the debate so far, leaders of organised medicine have limited discussion of mifepristone to sterile technical matters of safety and efficacy, as if ethical concerns have no bearing on public policy or medical practice.⁵

Much expert advice would be needed concerning authentic medical grounds for the use of mifepristone, and even then the authority prescription system could still be abused. But at least the attempt will have been made to establish valid medical indications for this gravest of medical acts, and the profession will be seen to distance itself from abortion "on demand".

1 Australian Government Attorney-General's Department. Commonwealth of Australia Law. Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005. Available at: <http://www.comlaw.gov.au/ComLaw/Legislation/Bills1.nsf/0/1EBC6A783DF06F5ECA2570D20016C30D?OpenDocument> (accessed Jan 2006).

2 Commonwealth of Australia. Senate Community Affairs Legislation Committee. Inquiry into Therapeutic Goods Amendment (Repeal of Ministerial responsibility for RU486) Bill 2005. Proof Committee Hansard, 15 December 2005. Available at: <http://www.aph.gov.au/hansard/senate/commtee/S8992.pdf> (accessed Jan 2006).

3 McGuire DCJ. *R v. Bayliss & Cullen* (1986) 9 QLR 8 at 45.

4 Adelson PL, Frommer MS, Weisberg E. A survey of women seeking termination of pregnancy in New South Wales. *Med J Aust* 1995; 163: 419-422.

5 Australian Medical Association. AMA supports use of RU486 for termination of pregnancy. Media release, 7 Nov 2005. Available at: <http://www.ama.com.au/web.nsf/doc/WEEN-6HW5DZ> (accessed Jan 2006). □

"GP Psych Opinion": evaluation of a psychiatric consultation service

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TO THE EDITOR: In their letter on "GP Psych Opinion", Wong and Tiller highlighted the poor uptake by general practitioners of a psychiatric consultation service based in a private psychiatric hospital in Melbourne.¹ They compared the results of their service to the similar poor uptake by GPs of the public hospital-based psychiatric consultation service in Brisbane.²

One explanation for this disappointing result may be that most psychiatric illness is chronic, and continuity of care and advice from a consistently available psychiatric colleague is of great importance to GPs — over and above having the patient assessed. This does not seem to have been a strong characteristic of the Melbourne service, given that the assessing psychiatrist was a psychiatric trainee registrar, who is usually either rotating between clinical placements as part of training, or waiting to move on to a more senior position.

GPs' referral practices to specialists are based on a multitude of influences, of which availability is only one. Personal contact, quality of service and continuity of assistance are highly relevant. Perhaps if the Melbourne and Brisbane consultation services can push on and attend to these issues, then utilisation by GPs will increase over time — as this is what happens in more conventional private practice referrals.

1 Wong GK, Tiller WG. "GP Psych Opinion": evaluation of a psychiatric consultation service [letter]. *Med J Aust* 2005; 183: 494.

2 Simpson AE, Emmerson WB, Frost ADJ, Powell JL. "GP Psych Opinion": evaluation of a psychiatric consultation service. *Med J Aust* 2005; 183: 87-90. □