PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY, 23 SEPTEMBER 2013.

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 INQUIRY

Dr CRAIG WHITE AND **Ms CHERIE STEWART**, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WERE RECALLED AND RE-EXAMINED.

CHAIR - Members, we will commence. Craig and Cherie, welcome back. Because you have appeared before us and sworn the oath, there is no need for us to go down that track - we're still in the same environment. I have mentioned this document we sent to you, so we might just work through that, if you like. Do you want to go straight to your copy, and address the questions we have set out in there?

Dr WHITE - Absolutely. I want to thank the committee for putting this together. It was very helpful to see where your particular interest was. Cherie and I have been through it in considerable detail, and there are a couple of items we will need some more information on. I am just letting you know that we haven't stalled because we have got lost or something - it is because we weren't quite clear where the question was going, and we can deal with that.

To go to the first item, about the poisons legislation. There is a question about how it is intended that the Poisons Act will interact with the provision. The short answer to that is: it isn't intended that there is any particular interaction, any more than with any other legislation. The Poisons Act stands alone and it controls the supply and manufacture, administration, and prescribing of all types of poisons, including pharmaceuticals and medicines, in Tasmania. We felt this was fine as it was, and it didn't raise any issues. But if we have missed something we would be happy to talk about is.

CHAIR - You will see from the second dot point we made, that it might be reasonable to include such words as 'the lawful administration' or 'the legal administration' of drugs to facilitate a termination. Is there any need to add such words?

Dr WHITE - I might defer to my legal colleague. I understand the purpose of the question, but would you foresee any potential downside in that, Cherie?

Ms STEWART - The way I look at it, the entire bill is about lawful or unlawful termination. The bill is regulating that matter. I am not quite sure I am clear about the purpose behind seeking to include those words. I guess the definition of termination in that last sentence is drawing a distinction between the performance of the termination and the supply of something that might be used in a termination. So whether that supply is lawful or unlawful is, I guess, irrelevant for the purposes of this bill, because it is regulated under different legislation. I wouldn't mind exploring the thinking behind introducing the terms 'administration' and 'lawful' and 'unlawful'. This definition refers to somebody handing over something that may be used in a termination, but that act, in itself, is not a 'termination', so it doesn't come under this bill.

That action can be a crime under our current criminal framework. Section 135 of the Criminal Code says it is a crime to supply or procure a thing for a person knowing it will be used to procure a termination. The last sentence makes that distinction very clear.

CHAIR - Thanks.

Ms FORREST - This is one of the issues that I raised, particularly from a clinical point of view. With later-term terminations, it is often the midwives who administer the Misoprostol or the Mifepristone, or whichever medications are used. The obstetricians obviously order that medication but they do not always administer it - sometimes they do, but often they do not. I think the midwife needs to be included in the definition as well because midwives are involved, particularly in later-term terminations.

Dr WHITE - So, it is nurse or midwife up the very top. Yes, I get that.

Ms FORREST - Midwives administer the medication and they do it under the Poisons Act. When we talk about using a combination of drugs there are certain requirements for medical practitioners, and nurses, but not midwives have a right to conscientious objection - but that could be fixed. Midwives might administer the drugs, but supply and procurement are different things to administration, in that context.

Dr WHITE - Indeed they are.

Ms FORREST - We are talking about vaginal medications, not oral, so you cannot give it to the woman to take herself.

Dr WHITE - I see exactly where you are coming from. The purpose of this section is to distinguish the act of discontinuing a pregnancy - a termination - from the act of supply or procurement. It was not intended to deal with any other issue.

Ms FORREST - Artificial rupture of the membranes could also come under this section. Midwives often perform that procedure, even in late term termination.

Dr WHITE - That was under 'any other means'. That was meant to be a catch all.

Ms FORREST - Plus surgical intervention - the use of an instrument to do it.

Dr WHITE - A combination of instruments, yes, or using a drug.

Dr GOODWIN - They have some provisions for this in the Victorian act. That also got us thinking about it - whether we need something to cover us.

Dr WHITE - Is that something, Cherie, we should have a further look at?

Ms STEWART - I suppose it might require, at least on our part, some thinking through the practicalities and how it might be approached, from a drafting perspective. I understand that the policy outcome you are after is that midwives are permitted to administer. I wonder if that is currently permitted in our existing framework, which says a medical practitioner has to perform the termination - and that requirement has been replicated in

this bill. It will come down to a matter of fact as to who performed the termination, and I cannot help but think that the administration of the drug would be the performance of the termination.

Ms FORREST - In which case the midwife could not be covered.

Ms STEWART - In which case it is a shift in the policy underlying this bill and the current legislation. If that is the articulation of the policy outcome, we need to address it from a drafting perspective. Obviously the OPC can help to achieve that. I am not quite sure that we need to amend the definition of 'terminate', or if we did, that would be the end of it. We might need to go further. If that is the policy outcome you are after - do you have a view, Craig, on the appropriateness of that? I know there are a lot of studies out there advocating and saying that nurses and midwives should be in a position to be able to -

Dr WHITE - If a midwife is practising within her scope of practice, which includes the ability to access her formulary that is relevant to that practice, then I think this should reflect that. It also recognises the reality, as Ruth explained, that the doctor may well assess the patient, make a treatment decision, document that and it is then up to the nurse to write the orders and then the nurse or midwife, or they together, then carry those orders out. So the actual final event that leads to the termination could be the act of the midwife and we need to capture that. I agree with that; it was certainly an oversight. Thank you.

CHAIR - Are there any further questions on that one, members, anything that needs any further clarification?

Dr WHITE - We are on to minors?

CHAIR - Yes.

Dr WHITE - Consent by minors. The intent was to not create any special considerations around the process of consent beyond that which is required by AHPRA through its code of conduct, which is based on the NHMRC consent guidelines and which is relevant to the next set of questions as well. The usual process to consent in a setting of someone who is under the age of majority is based on a couple of court cases: there was the Gillick case in the UK, which was followed by the High Court of Australia in Marion's case, which established what we call a 'mature minor assessment' and that is where the - I will read from the note - the court said that: 'Parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and this rate of development depends on the individual child.'

In practice usually the cut-off is about 14; below 14-ish you would require a mandate, effectively the parental consent, but between 14 and 18 it depends on the specific child you have in front of you. A 16-year-old who has been living off her wits for the last two years on the streets and out and about is quite different from a girl who gets taken by her mum in the Volvo to Collegiate every day and dropped off and picked up. They were likely to be assessed as a different stage of maturity.

Mr MULDER - It depends what they are exposed to whilst they are in the Volvo, doesn't it, Vanessa?

Dr GOODWIN - Okay, my mother used to have a Volvo and I was [inaudible].

Laughter.

Dr WHITE - Oh, no. All references to people are completely are coincidental.

Mr MULDER - How did I know that?

Dr WHITE - There are well-established principles around the attaining of consent for someone who is under 18. Our assessment was that they were sufficient to deal with the arrangements in this case and that a doctor has to make a considered decision about how much the parents needed to be involved and indeed even what information they give to the parents.

CHAIR - I am just trying to think, members, whether this issue went to some matters raised with us around the guardianship processes. Was that Dr Williams?

Ms FORREST - Michelle Williams the paediatrician?

CHAIR - Yes.

Dr GOODWIN - She did raise it.

Dr WHITE - Part of the reason of not dealing with it in some way in here is so that it didn't interfere with the usual way that consent is obtained, which includes guardianship where it is relevant.

CHAIR - No, I can't think of the detail, Craig. Michelle had indicated some concern about her practical experience with regard to minors and the requirements of the guardianship legislation in terms of the decisions being made by minors, whereas we understand clearly that this bill talks about what is the defined term of 'a woman' in terms of providing consent.

Dr WHITE - Is she saying that the guardianship process was not working in the child's interest?

Dr GOODWIN - I think she thought it was a broad concern around the issue of minors and consent to medical treatment, from memory. This field specifically deals with presumably people with a disability because of the Guardianship and Administration Act amendment but not so much the minors issue.

Ms FORREST - Do you want me to read out Dr Williams's comments for you? There is a little bit of text to it:

> Our next point was, unfortunately, also about definitions and this has been tidied up a little bit as the act has been improved. It was regarding the definition of a woman as a female of any age and a woman's consent is a major part of this. In part 4 of the act we have point 4, that the pregnancy of a woman who is not more than 16 weeks pregnant may be terminated by

> a medical practitioner with the woman's consent. The next part, with the woman's consent, had two medical practitioners for people over 16 weeks of pregnancy.
>
> It's important to us that in that unfortunately we have a lot of very young, teenage pregnancies and also pregnancies amongst women with major mental illness or intellectual disability who are incapable of giving a valid legal consent. We need to be aware that for those people we need appropriate substitute proxy consent. By proxy consent we mean someone who gives consent for that person. It can be a guardian, it can be Child Protection, or it can be an independent advocate appointed by the court.

Then I asked at that point: 'Why doesn't that come under the Guardianship Administration Act currently?' and Dr Williams said:

> The Guardian Administration Act does not cover people under 18, Ruth, at all. We have to apply to Child and Family Services for an order to have the department act as guardian for the child. It's a major hole in the legislation.

I then asked: 'How do we deal with it in regard to any medical procedure?' and Dr Williams said:

> We get a guardian, usually the parent. That is not the Guardianship Act. A parent is considered a guardian again of the child until they have achieved majority or are deemed to be independent under the Gillick case competency. However, when you have someone who isn't Gillick competent - and Gillick competent means someone who has been deemed to be able to make appropriate decisions with a view to the future et cetera - it's important that somebody acts in the child's stead. For some of the children we deal with and I deal with, we have children who are not yet wards of the state, and do not have a responsible guardian who is able to give consent. We need to be aware that we do have a problem with people, particularly under the age of 16, who are not Gillick competent, that we don't have an easy system of appointing an advocate for that person in the decision-making process.

It is page 31 of the transcript if you are looking for it.

Dr WHITE - We will certainly have a look at that. I know Michelle and I certainly value her assessment; I have no reason to doubt any of that. I suppose my observation would be that if there are deficiencies in the consent process, termination legislation may not be the place to try to fix it. It might be better to go back and amend the guardianship [act].

Ms FORREST - It wouldn't only relate to termination of pregnancy, it would relate to any -.

Dr WHITE - No, it would relate to all sorts of things far more common than termination of pregnancy.

Ms FORREST - Even an emergency appendicectomy.

Dr WHITE - Indeed, yes.

CHAIR - Maybe food for thought.

Dr WHITE - Thank you, Ruth, it was very interesting. Moving on, there were further questions to do with consent. The committee would like to discuss the rationale of the removal of informed consent from earlier drafts of the clause. Not through having been involved in earlier drafts but just from talking with people it appears that it was seen as a tautology, it was redundant to have the word 'informed', there was no change or shift in policy, it was just seen as 'consent' is by definition, 'informed' in the context of what we are talking about, and if you draw on the Criminal Code definition of consent, that implies free agreement, and if you look at the medical understanding you do not have consent unless it is informed. It is a key feature of the consenting process. The Medical Board's code of conduct takes you to the National Medical Research Council's guidelines on consent, and all about being informed.

Something that my colleague advised me about is that referring to consent as 'informed consent' is the more common drafting approach, so that was a new fact, from my memory. The only time you move away from using 'consent', for example, in section 164 framework, is when you are trying to give a very different meaning to 'consent'. In section 164(5) of the Forensic Procedures Act, where it means consent after a police officer has made a certain request to provide certain information. We have gone back simply to the term 'consent' because we feel that it covers the need to provide information.

Ms STEWART - It clearly marks the difference between 'informed consent' at the moment. You have given a different meaning to the usual understanding of consent, because it is defined in the 164 framework, and including the referral to counselling.

Dr WHITE - One of the reasons to move to a different way of saying it is to signal that we are not talking about the same thing that 'informed consent' meant in the last version.

Dr GOODWIN - To be clear, what would it be interpreted to mean?

Dr WHITE - Consent?

Dr GOODWIN - In the absence of any definition.

Dr WHITE - By a clinical practitioner, it would mean 'informed consent' - what we would think of as informed consent, just in casual conversation.

Ms FORREST - Because it sits within a health-focussed bill, and that people are responsible under the health regulations.

Dr WHITE - Professional codes.

Ms FORREST - And the professional code, there is no other way that it can be interpreted other than informed consent?

Dr WHITE - I do not believe so, no.

Ms STEWART - The Medical Board is going to signpost to the National Health and Medical Research Council's guidelines, which sets out the information that doctors have to give patients and there is a fairly detailed list of the things that have to be given, and they are all about making sure that the person is informed of alternative options.

Dr WHITE - I have a bit of recall that I sent a link to you, Tom, about the HMIC guidelines on providing information to patients some time back. I can always request that easily. I will make a note and send it to you.

Ms FORREST - That is the one, Craig, the National Medical Research Council, patient information, general guidelines for providing information to patients?

Dr WHITE - Yes.

Dr GOODWIN - There are criminal code provisions also in this which refer to consent.

Ms STEWART - The definition of consent in the criminal code still sits with this framework because it is about free agreement. Any time that there is a free agreement you will not have that consent there for the criminal code. The medical understanding may or may not go a little further than the criminal code. The criminal code specifically provides that it is not free agreement if a person is reasonably mistaken about the nature or the purpose of the act, or if they are unable to understand the nature of the act. That probably draws in with it the element of being informed about what the act is about. Even if that were not the case in the medical context, you have the extra information here.

At least as far as the criminal code goes, it has to be free agreement. From our perspective that still works, and we have the definition already in the criminal code for those, so that will come into play. It means informed in the medical context, so if it is under duress, and do not understand the nature of the act, that is not consent.

Ms FORREST - It says in the principles that information provided in the form and manner which help patients understand the problem and treatment options available which are appropriate to the patient's circumstances, personality, expectations, fears, beliefs, values and cultural background, perhaps you will not give advice and there should be no coercion. The patient should be free to accept or reject the advice. It then goes on with a whole list of things they have to do.

Dr WHITE - It is pretty onerous.

Ms FORREST - That is why it costs so much to get specialists.

Dr GOODWIN - Presumably OPC did not see the need to include a definition? They were quite happy?

Ms STEWART - In that framework where the term is used in the reproductive health act side of things, it is around the four and five, which the consequences for not complying with that is within the medical frameworks so, it draws in all of those understandings.

Dr WHITE - If the committee was looking for reassurance on this, the most delicate way to deal with it would be to put it in the interpretations section, you put 'consent' rather than,

Dr GOODWIN - It is in the clause notes; I suppose that helps.

Ms STEWART - There is a well understood medical understanding of what consent means and that is the meaning that we want to import in to this framework.

CHAIR - Anything further on that matter of consent? Let us go to the next one which relates to section 164 of the criminal code and the different wording with the bill in front of us and particularly given what committee has taken in evidence as to the requirements under codes of practice, there is that broad question as to whether a second practitioner is required at all, given that proper medical process which is undertaken as required by law.

Dr WHITE - To put a perspective around the question of consulting your colleagues, it is not infrequently done for all sorts of reasons. If you were being treated for cancer, you would want your case to be discussed at a multi-screen team meeting and it has been a bit of a difficult thing for some of my colleagues to cope with sometimes to think that they need to take it to a team of nurses and other health professionals and other medical colleagues to discuss a case.

They feel like it is a bit of a front that they have to either justify what they are thinking or to seek advice and fortunately the world has moved on a lot and it is not uncommon that in cases where you in any way feel that there are implications of whatever key you are doing, whether you are going to do some surgery which might be that you are not sure whether it is the best approach or you are doing some other irreversible treatment, that you will consult with a colleague and it is more in the spirit of that, rather than anything else, that there is a level of comfort with some practitioners that they do consult with a colleague.

I think that it would happen whether or not you put it in the legislation. The practice in an area like terminations, where everybody wants to be absolutely above and beyond reapproach, that it would likely continue whether or not it was mandated in the legislation but it does give some level of reassurance to some people who feel that it is something that they need.

CHAIR - On that matter we also raised in that context the qualifications of other medical practitioners, where you are aware that section 1 (64) requires that person to be a specialist in obstetrics or gynaecology and why not that same reference?

Dr WHITE - That was another interesting one that Cherie and I talked about quite a bit and I have talked with others about. The reason, on balance, my preference is' specialises in' is that it does include people who are Fellows of the College of Obstetricians and Gynaecologists, but it would also include someone who is a very experienced medical practitioner who had a diploma of obstetrics, who spent half their time for the last 20 years just doing terminations , they were known to do it safely, they work in family planning, they do not have a fellowship should they be excluded from being the second person.

On balance probably not. You could argue it either way but I think having the flexibility, specialises in, is a valid thing.

CHAIR - From that standpoint then the clause as drafted does not have that requirement but you are suggesting to the committee your personal preference -

Dr WHITE - A medical practitioner who specialises in obstetrics or gynaecology. Someone is going to have to look at that and decide whether they meet the test, whether, for example, my practice is sufficient for me to identify someone who specialises in. I think that in the vast majority of cases, and I am confident certainly in the public sector and I dare say in the private sector, it is going to be a specialist O&G. I am thinking of other scenarios where that may not be essential.

Ms FORREST - We are only talking about post-16 weeks, all of which will be conducted within a hospital setting because of the health risks to the woman. In such a setting at least one of them will be an O&G specialist. I cannot think of a time when you would have a GP with O&G specialty that would be involved.

Dr WHITE - I probably tend to talk to the more flexible forward thinking people sometimes when exploring some of these things. I know that there are a whole range of opinions.

Ms FORREST - I am not saying that both of them need to be but is it not in reality -

Dr WHITE - In reality, in the public setting, one of them will be.

Ms FORREST - In the private setting it would be also, wouldn't it? You are talking about private hospitals here. Surely their own liability would almost determine that there would have to bet?

Dr WHITE - If it is done in a private hospital - I looked at some qualifications for the other providers and as far as one of the providers is concerned, if you said specialist that would not be a problem, from recall.

Ms FORREST - The risk is reducing the number.

Dr WHITE - If it were one of the providers outside of the public sector that would not appear to be an issue. They do list a gynaecologist obstetrician. It reduces to zero any ambiguity.

Ms FORREST - It makes it open to anyone to say that they specialise. After 16 weeks, I cannot think of a situation where one of the doctors involved here would not be a specialist.

Ms STEWART - That is why it is practically neither here nor there when that second requirement is in there because it is likely to be occurring in practice anyway.

Dr WHITE - In terms of being 'practitioner friendly,' everybody understands what that means, while 'specialises in' leaves room for identification.

Ms FORREST - When this was first drafted that was the way it was when it was 24 weeks.

Ms STEWART - The 'specialises in' is how it currently appears in the legislation in the section 160 of the framework.

CHAIR - If there is nothing else, that takes us onto clause 6. We have covered off the two questions raised under clause 5.

Ms FORREST - This came back to the point I raised previously.

CHAIR - Yes. We have covered that reference, the inclusion of midwife.

Ms FORREST - In subclause 4, I believe it should say that a nurse and midwife have a duty to assist, but then you need to define midwife in the interpretation.

Dr WHITE - That is right, and it probably needs a word search to make sure that, where appropriate, if it says, nurse, we consider whether a midwife should be there as well, everywhere it appears.

Ms STEWART - You also need to come back to clauses 4 and 5. If we are saying the underlying policy is now that a midwife can perform a termination, you also need to look at the wording of sections 4 and 5 because that links to a medical practitioner.

CHAIR - The proposition here is assisting in.

Ms FORREST - I was talking about the administration. If it is done lawfully and the doctor has ordered the termination, it is the administration. I don't think the midwife is performing the termination as such at that point, but she is following the orders of the doctor who has ordered that.

Dr WHITE - We are sort of splitting the decision-making from the carrying out and probably we need to have bit of a think about that. I agree with what you are saying.

Ms STEWART - As long as the policy articulation is clear, OPC can help you work through the exact drafting amendments that need to occur to make that happen. I don't have the medical background and Craig may be able to speak more broadly.

Dr WHITE - What Ruth is getting at is absolutely spot on; we wouldn't want to inadvertently create an issue for midwifes through doing this.

Ms FORREST - Particularly with the current case loads of a midwife and things like that where you have a real relationship with a woman and it would be unfortunate to have to bring in a doctor that is completely unknown to her to put in the vaginal medication in what is already a very difficult situation.

CHAIR - Casting back to the start of this conversation with regard to the definition of nurse in our section 3, where Ruth drew our attention to the Victorian act which sets it out quite specifically, did you say, Craig, that there may be a need to revisit that definition of nurse, as set out in our section?

Dr WHITE - No. I think nurse stands as it. But we need to add midwife in that section, don't we?

Ms FORREST - My view is that it needs to be as we have defined nurse in other acts in recent times. Since the passing of the National Health Practitioners Registration Act, we tend to define nurses and midwives as registered under that act.

Ms STEWART - The Acts Interpretation Act has the definition of medical professional, medical practitioner and nurse and that sign-post to the national laws.

Ms FORREST - It does.

Ms STEWART - If that is the policy articulation, OPC can give you guidance on how to get there.

Dr WHITE - We agree with you.

CHAIR - The question at the bottom of that page was already covered by that same conversation which we just had, wasn't it? The bottom of the page under clause 6.

Dr WHITE - Yes. That would be a nurse or midwife has a duty to assist.

Mr VALENTINE - I have one related question that is probably covered under the term 'medical practitioner'. If we are dealing with a circumstance where a woman was unconscious or there is an anaesthetist involved in some way, shape or form, that would be covered as well as the medical practitioner undertaking the termination. An anaesthetist that might be involved would be covered by a medical practitioner in this too, wouldn't it, or is there a need to think about that?

Dr WHITE - It would be a very brave doctor who would say 'I realise that this might save someone's life but I am not going to do it'. I think you would be very brave and close to retirement.

Mr VALENTINE - Whether it is worth thinking of - the only other medical practitioners involved.

Ms FORREST - In a big hospital you find someone who is happy to do it; in small hospitals you do not have a choice.

Dr WHITE - In practise I do not think it will be an issue. If you felt there was a need to change it, it would probably be in the previous clauses -

> A medical practitioner is due to perform a termination in emergency or assist through the provision of anaesthesia and sedation.

You would probably put it in that section rather than the nurse or midwife.

Mr VALENTINE - It is still a medical practitioner though.

Dr WHITE - That is right.

Mr VALENTINE - Either way. There just happens to be two of them involved, so maybe it is covered.

Ms STEWART - It says in 6(3) -

> The duty on the medical practitioner is to perform a termination.

So if you wanted to be doubly certain -

Dr WHITE - Not to do the anaesthetic.

Ms STEWART - To assist, if you like.

Dr WHITE - Professionally, someone is not going to stand in the corner of a room with their arms crossed if there is a life at risk. It does not happen.

CHAIR - Clause 7 - we have a range of questions and they are all on the conscientious objection matter.

Dr WHITE - The first one of those was about the definition of counsellor. I think the first time that we came to talk with the committee there was a discussion with someone who spoke before us, that counsellors are not one of the regulated professions. All psychologists can be counsellors. Psychologists are registered but not all counsellors are psychologists. Anyone can call themselves a counsellor. It was intended to place an obligation on anyone who held themselves up as providing a service which could be construed as counselling. That was the intent of that being so broad.

Ms FORREST - How does that avoid catching the parish priest?

Dr WHITE - It depends on the context of what they were doing. Providing information about pregnancy options advice would bring them under the legislation. If they were counselling around issues of faith or religious beliefs, that would be completely separate. It is not intended in any way to cut across that relationship which has its own special qualities. If a parish priest said, 'I'm going to counsel you about your pregnancy options, terminations' and so on, it brings them under the act.

Ms FORREST - If the woman, having been a member of the parish since she was a little girl and now a woman, and she may be a woman who has four kids and now failed contraceptive - a not uncommon scenario for women to find themselves in, seeking termination. She says to the priest, 'I can't cope with this. You know our circumstances, you've christened all our babies' - the whole story - and he says, 'I really think you shouldn't terminate this pregnancy, we'll find another way'. Is that stepping over the line?

Ms STEWART - It might come down to how the priest is holding himself out because the definition of counsellor means a person who holds himself or herself out as a provider of a counselling service. There is a distinction between, 'Hello, I'm Mr Smith, a counsellor. I've got my shingle out the front, come and talk to me' versus, 'Hello, I'm Priest Smith, come and talk to me about the teaching of this faith'. I am not sure it could be said that

the latter is holding themselves out to provide a counselling service as such. There is counselling that goes on but it is not the general understanding of what counselling is, in the sense of not being a particular faith.

Ms FORREST - It is not a faith counselling as opposed to pregnancy counselling.

Dr GOODWIN - There is that 'or conducts himself or herself in a manner consistent with the provider of a counselling service.'

Ms STEWART - That hinges on the counselling. Have I put my shingle out saying, 'Hello, I am a counsellor come and talk to me about any issue and I will give you unbiased and impartial advice,' or am I hanging my shingle out to say, 'Hello, I am a priest of whatever and come and talk to me about.'

Mrs HISCUTT - Can you put anything in that will protect that group because that group is obviously -

Dr WHITE - That is a good question.

Ms STEWART - It probably comes down to a matter of fact in each individual circumstance rather than being able to use the legislation to tie the bow neatly. It will depend upon the conduct of the person in each individual case.

Mrs HISCUTT - We know what the conduct of 'religious counsellors' will be and that will be to encourage a way to work through it. Generally they do not say to have an abortion or anything like that. Generally they try to work through the birth of a child, and they do four or six years of uni and come out with psychology degrees and all sorts of stuff. You would presume that the ladies who go to see a religious type of person would be looking for guidance rather than a non-specific counselling experience.

Dr WHITE - If I hear that and listen to it carefully, a woman in those set of circumstances will know what the answer is when they sit down and they will be looking for assistance to work through it. I suppose having focused on this in the conversation there is some wording there that could be ambiguous:

> A counsellor means a person who provides a service that involves counselling whether or not for fee or reward.

It is possible that 'a service' can have a couple of different meanings. It could mean the conversation that is had in a 30-minute period or it could mean it is an organised service with shingle and an entry in the Yellow Pages and so on. There might be some value in clarifying what the service refers to.

Mrs HISCUTT - I am sure the Christian lobby group, and that sort, would appreciate something like that.

Dr GOODWIN - There is also the school guidance counsellors.

Dr WHITE - It is not just people from a religious background, there are all sorts of other people in your life that you talk to about things.

Ms STEWART - That group, the school provider, is somebody, from a policy perspective, we would want to see captured because they are going to be holding themselves out as unbiased -

Dr WHITE - Resource to assist someone make a decision that is best for them.

Dr GOODWIN - This is the point about what is the scope of this and who do you want to capture in it and maybe when that question is answered, you can make an assessment as to who is unwittingly captured in it who perhaps was not meant to be. It is not clear to us what the scope of it is meant to be.

Ms STEWART - It is not meant to capture your mum or dad or your best friend.

Dr WHITE - That is black and white.

Ms STEWART - They are not providing any counselling service. If we understand the meaning of counselling to mean helping to guide somebody through a decision, helping them work through their own thinking on the matter and come to their own decision without any judgment or particular bias. If we consider it that way, simply by a matter of interpretation a priest scenario would not be brought into it because they cannot tick the box to say I am providing a counselling service because that is not what they are providing.

Ms FORREST - They are acting as a priest all the time.

Ms STEWART - That is it. For clarity you might feel more comfortable by giving some meaning to that word 'counsellor' that might address some of the concerns that you have. The way I see it is that the priest scenario would not be drawn in on that basis.

Mr MULDER - It seems to me there is a bit of a dilemma. We are telling the doctors we want clarity around them, so we are going to decriminalise this, and then we go to counsellors and people like priests, and might I say a lot of these faith-based counselling pastors and priests hold themselves out as counsellors. They advertise themselves that way.

Dr WHITE - Yes, they can do.

Mr MULDER - Now we are in a really murky area about when and when you aren't. It seems to me that there are two courses to go through; one is that you create the exemptions for religious people, as with the sanctity of the confession, in terms of what a priest can say or what they can't say. The medical profession has it for its consultation, the doctor-patient relationship.

It seems to me that if you want to exclude priests and pastors from being captured by this, maybe you need to either give them a special exemption or get serious about whether you need to put this regulatory framework around about an advisory group, or should these people who hold themselves out to be counselling services in the support area have to declare themselves if they have a conscientious objection to one particular form of counselling? You don't get the woman who unwittingly turns up at a counselling

service thinking she is going to get advice on a full range of pregnancy options when one of those options is off the table due to conscientious objection. This legislation doesn't fix this murky situation.

Dr WHITE - That was a helpful articulation. We are trying to separate the notion of religious or faith counselling or life counselling or whatever it is that you could argue a priest who is a psychologist or not, could hold themselves out to counsel about. If they're holding themselves out to give pregnancy counselling or family planning counselling, I think that is different in the setting of this legislation. It is the people who are seeking to counsel in relation to pregnancy, family planning and so on that we are trying to capture here.

Mrs HISCUTT - Typically a catholic priest's advice is no contraception, no abortion. They will get caught up immediately in this, from what you are saying.

Mr MULDER - It stems from the other requirement of no sex.

Mrs HISCUTT - Based on their faith they will get caught there really quickly. They stand themselves out as guidance for their flock.

Ms STEWART - I see that as something different to holding themselves out to be a counsellor. I think one of the previous witnesses to the committee, Susan Fahey from the Women's Legal Centre had discussed the idea of mandating truth in advertising if you like so that the shingle out the front is really quite clear about what I'm holding myself out to be. If you are articulating that outcome is that women know what they are going to get when they go and visit somebody, that is something that would certainly help achieve that.

Ms FORREST - If it said counsellor means a person who holds himself or herself out as provider of a pregnancy counselling service or conducts himself in a manner consistent with providing a pregnancy counselling service -

Mr MULDER - One of your problems with trying to separate religion as being something different is that only people who aren't adherents to a particular religion see that you can separate life counselling from pregnancy counselling. You actually expressed it a bit earlier on when you said that they are coming here to be counselled about the tenets of the faith rather than pregnancy. From the religious perspective it underpins the counselling, it underpins the moral position and people don't go to a pastor or a priest, generally, to find out what the catechism teaches about Immaculate Conception. They go to a counsellor to find out how the tenets of their faith apply to a particular situation, the life situation they find themselves in. How you would separate being counselled about a moral aspect from the practical -

Dr GOODWIN - It is pastoral care. It is not even about the scriptures or anything like that; they are in a desperate situation and want some support.

Mr MULDER - You can't separate religious counselling from pregnancy counselling that easily.

Mr VALENTINE - That is what Pregnancy Counselling and Support Tasmania was concerned about. They had difficulty with the fact that counsellors are by default considered to be advice givers when in actual fact all they do is help a person think through something. They do not give them advice at the end of it. They were very concerned that this will impact directly on them.

Dr WHITE - To come at this from another perspective that may or may not be helpful, we are trying to make sure that a woman doesn't get caught thinking she is being exposed to all the options with all the implications laid out in an even-handed way, when she is only getting part of the picture. If women know what sort of advice or counselling they are going to get from their priest and they are happy with that, that is fine. We are just trying to protect those who find themselves at risk of being caught.

Mr MULDER - Whilst there was something called Pregnancy Support and one of the options was aborting pregnancy, that is a misnamed service.

Ms FORREST - It's about truth in advertising your service, do you think?

Mr MULDER - Why we are here trying to regulate a profession that has no internal ethos with which to attack it. I think that's where your problem comes in. I think trying to get counsellors in here is probably more pain than it's worth.

Dr WHITE - OPC may think of a better way. At the heart of it we are just trying to make sure women get the range of advice they think they are getting.

Mr MULDER - We are trying to prevent women from being misled, wilfully or otherwise, into obtaining advice from people who have a conscientious objection to one of the options.

Mr VALENTINE - Having information withheld.

Mr MULDER - If that is the policy objective here, I think there is a fair bit of work to do to get the legislation to deliver that policy objective.

Mrs HISCUTT - So you don't see a case where a young lady goes to see her priest who gives her partial guidance on how to go through with a pregnancy, and then a year down the track she says, 'I wish I'd had an abortion', and then comes back on that priest for not providing full pregnancy options? You don't see that happening under this legislation?

Dr WHITE - Who can really say?

Mrs HISCUTT - This is what we need to be able to say.

Dr WHITE - People do and say all sorts of things; they change their mind about all sorts of things, so I can't guarantee that no-one will ever do that.

Mrs HISCUTT - But he is providing a biased opinion.

Dr WHITE - Indeed. If it goes anywhere, it will come down to the facts of the situation: 'What were you going there for? What was the question you asked of the priest? Did the

priest make any effort to understand why you were there and what sorts of things you were thinking about?'

Mrs HISCUTT - So as a lawyer, you reckon that is covered?

Ms STEWART - I do, yes. I don't believe that would come into this, but I am not the one who has to be satisfied. If you are happy that in the policy outcome you can work with OPC to get there. You might look at the truth-in-advertising angle as another way of achieving the outcome. As you say, a woman is aware if she is going to somebody who is not necessarily going to provide entirely unbiased advice.

Ms FORREST - This is in the same section but slightly different issues. One of the things that was raised by both the doctors under subsection (2) and the councils under (3) is that if a woman presents for pregnancy advice, including termination, and they look at a doctor initially, and at what point does the doctor have to refer her? There was some concern that they could not even have a discussion - this is the family doctor that they have been going to since they were a little girl. The doctor knows them well, and as soon as they say 'I am pregnant and I don't think I want to have this baby', or whatever their opening line might be, can the doctor under this clause continue that discussion and say 'How do you know you're pregnant? Let us do a pregnancy test to confirm. How are you feeling about this', rather than say 'I am sorry, I can't discuss termination with you so I can't continue the conversation any further'?

Women front up at the doctor in a distressed state like that and they do not know what they want, a lot of the time, initially.

Dr WHITE - The scenario you describe seems very real and more like the way it would play out. There is no one standing over anyone's shoulder saying that the moment that you become aware, you must do this and three milliseconds is too late. How far an individual practitioner can engage with the kind of helpful discussion you have described - because it is an important relationship - is also going to be a personal choice. There will be some who hold stronger views than others and they may not be prepared to go as far as people who hold a set of views less tightly. So there is a degree of personal choice on the part of the practitioner about whether they see themselves as having conscientious objection and how far that plays out.

Ms FORREST - You could also have the situation where a doctor may have an objection to a termination for no medical indication for example, but the woman has a 14-week blood test, comes back with a high risk of Trisomy 21 for example, and then has the CVS and gets a definitive diagnosis and comes back, even with something like the baby is not going to survive, they may feel in a position to counsel that woman on termination of pregnancy because they may think that sits with their belief system. Does this enable that?

Dr WHITE - I think that includes that. The most commonly discussed scenario is with someone who holds a religious-based belief, faith-based belief, but I do not think this is confined to that. If it is off the agenda for any reason you are obliged to refer someone to another who does not hold -

Ms FORREST - It does not stop that doctor having a medical consultation with the woman up to that point where -

Dr WHITE - No, provided that it is within the boundaries of professional relationship limits.

Ms FORREST - Under their code.

Dr WHITE - If the doctor started ranting and shouting I would expect them to not travel very well with the Medical Board, but the sort of conversation - 'Let us sit down and talk about it. Why do you think you're pregnant, and why do you say you think it would be hard? What options have you thought about?' and so on. That sounds perfectly reasonable. Then you reach a point where you say 'You seem to feel it necessary to explore this option further, I don't think I will be able to provide that type of care for you and here is some information about where you can go for that'.

Ms STEWART - Equally, I do not think the Medical Board would look kindly on a doctor who asked a woman to undergo a series of tests, for example, an ultrasound, and a number of, - it would depend on the fact about what occurred in that continued period, and was there an effort to dissuade, if you like.

Dr WHITE - Steer her away, get her over the 16 weeks by stringing it out a bit. I think that would -

Ms FORREST - It is better not delaying access, that is what -

Ms STEWART - Yes, exactly.

Ms FORREST - The other example I use is of a woman who has had the test - maybe she is at-risk - and comes back with an unfortunate outcome from those tests, and then the discussion is had again because at that time she might not even be considering termination. The first visit she may not be, she is expecting a healthy baby.

Dr WHITE - Yes, things can change. She might go home and tell her partner, 'I'm pregnant again,' who says, 'I'm out of here.' It can change just like that. It needs to be a sufficiently robust set of words that allows proper appropriate professional interaction. Women need to know what they are dealing with and if options are going to be limited, they need to know that.

Mr VALENTINE - How realistic is it that someone is going to be able to be prosecuted under it when it comes down to 'I said-they said' in a counselling situation, for instance.

Dr WHITE - You always have those dilemmas. Courts seem to work through them. I cannot say; you have to trust the process don't you?

CHAIR - I am going to the document put out by the Victorian AMA and this is their template, the conscientious objection template. It may have been based on legal advice and if so it is probably the risk averse nature of legally trained people. If it becomes clear that a patient you are seeing is wanting help with a termination, you must stop the consultation at that point. If that template is transported to Tasmania because of our similar wording, all of the things which we have been discussing, the moment -

Ms FORREST - Wanting help 'with' is the wording, though. Wanting help 'with' a termination is the difference.

CHAIR - It might be, we do not know what they intended by all of this, that is the trouble. Then if the courts at some stage, when they are addressing a complaint about a counsellor, might go to what happens with the medical boards. They might say, 'What is the comparison here?'. The medical boards say that you have to cease -

Dr WHITE - That is the AMA rather than the medical board. The AMA is sort of a politco-advocacy industrial body. That is advice to doctors and I personally did hear it the way that Ruth had it, that it is a woman who comes in and says 'How do I get a termination? I have decided. I am firm in my commitment and beliefs, and don't even think about trying to talk me out of it.'. That is different from the woman who comes in and says 'I think I'm pregnant but I don't know how I'm going to cope.' I think they are different scenarios. If you were someone who had an objection to termination and a woman came in and said 'How do I get a termination?' and thumped the table, you would go down that black and white path.

CHAIR - That is more particularly the case because of our deficiency of pregnancy options advice. It seems to me, and from the discussion we have had previously the committee might have felt this as well, there is some concern or some misunderstanding out there as to the fact that even if they are seeking pregnancy options advice, which includes continuing or terminating, people seem to have thought that the moment somebody comes and you have a conscientious objection, you cannot have any conversation. That is not the intention at all and neither is it the wording.

Dr WHITE - And a further misunderstanding you have implied is that people confuse pregnancy options advice. They tend to go straight to termination and it is not that, it is family planning. For example, it is about how these are all the options and let us work with you about the pros and cons of each of them and work out which is the appropriate one.

CHAIR - In fact both of those circumstances for applying conscientious objection are very broad in terms of how far you take the conversation until you maybe get to where a person says categorically that they want help with an abortion.

Any more on that matter?

We will come to the notion of 'refer', as it applies in the medical sense, and then we will come to 'prescribed services' and some other matters to do with that. Can we go to the next dot point, Craig, which addresses the matter of 'refer'?

Dr WHITE - I know there has been a bit of discussion about this over time. It may not be the perfect word, but it was seen to be the most useful and helpful one. The medical board's code of conduct distinguishes between three types of involvement of others in the care of the patient. It distinguishes between 'delegation', which is the doctor asking another provider to provide care on the doctor's behalf, whilst they retain overall responsibility for the patient's care. For example, a specialist in the hospital delegating day to day care to the more junior doctors. There is 'handover', which involves

transferring all responsibility to another health care professional, such as would happen between doctors when they finish a shift, or a patient leaves a practice and they go to another practice - you would expect a handover at that transition point. The third category is to 'refer', which is defined as sending a patient to obtain opinion or treatment from another health care professional. It usually involves the transfer, in part, of responsibility for the patient's care, usually for a defined time and for a particular purpose.

That's on page 9 of the code. It is the one that seems to fit the circumstances.

Mr VALENTINE - It may simply be providing information, as opposed to a written referral.

Dr WHITE - The writing of a referral is, as much as anything, a requirement of the Health Insurance Commission, so that Medicare benefits are payable for reimbursement. That's not an issue we're trying to deal with in here. We are saying if there is an aspect of care you're unable, for whatever reason, to provide - your skills don't extend that far, your hands have gotten too shaky, whatever the reason - but you have a patient who would benefit from something you can't provide, then you would tell them where they could get that service. It is a relatively low threshold for someone to get over, particularly when you're not sending someone to a 'termination' clinic, where all they do is talk about terminations - where they greet you with, 'Hi, you're here for your termination'. There are no services like that. They're all about, 'What are your options?'. I feel, on balance, that it's an appropriate thing to do.

Ms FORREST - To clarify that point, you don't see a specialist without a written referral, because they want to send you the bill. That's the Medicare and health insurance requirement - for the funding to be provided.

Dr WHITE - In that particular situation.

Ms FORREST - Yes. But, generally we are talking about a GP in this situation, and to refer to another GP doesn't require written referral.

Dr WHITE - Or to the Family Planning Clinic. If you are sending someone to a clinic at the Royal Hobart, you'd usually provide some basic information.

Ms FORREST - So they can get in the door and be seen?

Dr WHITE - You'd give them the name of the clinic and a phone number.

Ms FORREST - Yes, that is right - so they know where to go. When you look again at 4.3 in the medical code - delegation, referral and hand over - delegation and hand over clearly indicate that you are giving responsibility for the care of a particular woman to somebody else and absolving yourself. Sorry, with delegation you retain the overall responsibility for the patient's care.

Dr WHITE - Hand over means you give it all away - they are no longer your patient.

Ms FORREST - Which they do not want to do, because they are still the patient's GP. Delegation means that you are still responsible for the patient's care, and they do not

want to do that because they have a conscientious objection. But referral involves sending a patient to obtain an opinion or treatment from another doctor, and it is only transferring part of the responsibility, for a defined time.

Dr WHITE - It is quite circumscribed.

Ms FORREST - It is not a written referral in the medical sense, to get funding for the specialist appointment?

Dr WHITE - That is a requirement of HIC, if that is relevant to the particular circumstances. We are not seeing that as essential. The concern was that women were pointed in the right direction. No more than that.

Ms FORREST - Do we have any other questions on this one, Paul?

CHAIR - We have a number of other points, but if we stay with 'refer' for the moment. Or have we covered that?

Ms FORREST - This is not in the list of questions, but it was raised by someone on the committee. If a woman seeks termination of pregnancy options advice, there was some concern that the woman should be pregnant at the time. For example, you might be my GP, and I am deciding whether I am going to have a family. I might come to you, Craig, to get some advice about options if I get pregnant and decide it is not the right time, or there is an abnormality, or whatever. If I am seeking pregnancy options advice, but I am not pregnant yet, would there be a need for a referral at that point? If the woman just wanted to talk about the doctor's views on termination, for example?

Ms STEWART - Is that seeking pregnancy options advice, though?

Dr WHITE - It could be argued that way. This is about giving women options. If, at that point, the doctor said he could not talk to you about terminations, but provided a leaflet describing the services that are available, it is up you, the woman, whether you take advantage of that.

Ms FORREST - Pregnant or otherwise?

Dr WHITE - Pregnant or otherwise - but everybody's needs have then been taken care of, without compromise to anyone.

Dr GOODWIN - In relation to this 'must refer the woman to another medical practitioner' issue, we have had a bit of discussion on this committee about referral, and whether it just means providing information about family planning - where you can access family planning services. But this is fairly prescriptive, because it talks about having to refer to another medical practitioner so, I am just wondering about that.

Ms STEWART - As it is written, the referral would need to name the medical practitioner.

Dr WHITE - It could just say 'Medical Practitioner, Family Planning Tasmania'.

Ms STEWART - It says they have to refer them to 'another medical practitioner'.

Dr WHITE - But not a named medical practitioner.

Dr GOODWIN - That's cutting hairs.

Ms FORREST - If you are putting 'or service' though, it gives you the option. If you put in 'or prescribed service' after that, it would deal with that issue.

Dr GOODWIN - So, you would be happy with that?

Ms STEWART - That achieves the outcome we are after, certainly.

Dr WHITE - That would certainly work and remove any ambiguity.

CHAIR - You would be well aware that the Victorian legislation says, 'in the same regulated health profession' - does that help at all? That they have categorised it?

Ms STEWART - I think that comes about as a result of their drafting approach. I do not know that there is necessarily anything significant in that. The difference there is that a counsellor is not a registered health practitioner. Because we are dealing with counselling we have had to take a different drafting approach - the language being used there.

CHAIR - I thought we were still on the referral to the health within subclause (2).

Ms STEWART - Are you saying that Victoria uses a different language, they use registered health practitioner?

CHAIR - No. They don't cover counsellors at all so you have to refer to another registered health practitioner in the same regulated health profession.

Ms STEWART - That effectively is the outcome we achieved by saying doctors refer to doctors and counsellors refer to counsellors. There is the like for like referral.

Dr WHITE - Except they seem not to have dealt with non-registered counsellors.

Ms STEWART - Victoria doesn't regulate counsellors -

Dr WHITE - That's right.

Ms STEWART - in the referral obligations so they haven't needed to go there. They have had a different policy outcome.

Mr MULDER - Which I think comes to the point of whether we want them there or not. The amount of issues and problems that we are getting around this whole issue and how I think it is virtually impossible to step through them. That is a finding for the committee.

CHAIR - If we cut it off on the refer in the medical sense. Maybe some who have appeared before the committee are jumping at shadows in terms of this notion of 'refer'. It would be interesting down the track because any discipline as that particular clause will be

administered by the boards - you would hope they would seek some proper guidance about interpretation.

Dr WHITE - The boards according to professional standards.

Ms STEWART - And you have essentially got the guidance about what they would do in a Vic doc article because that article was about analysing a case that had come before in a Victorian context where they talked about what does 'refer' mean and how do we interpret it.

Mr VALENTINE - Can I overcome this problem? Couldn't it simply be that a doctor hands the patient a pamphlet produced by perhaps Health and Human Services or the state which has a full list of services provided on it.

Ms STEWART - That would tick the box for 'refer'.

Mr VALENTINE - Wouldn't that tick the box?

Ms STEWART - Absolutely.

Dr WHITE - A little squeak from Heaven's corner is that the doctor doesn't even need to physically hand it to them. They need to make sure the woman gets the information. So I would be a bit reluctant to say the doctor has to hand them the leaflet.

Mr VALENTINE - What I am trying to say is that any doctor with a conscientious objection is then not needing to even say to the woman, 'You go there', which to them would be a breach of their conscientious objection right.

Ms STEWART - Exactly.

Mr VALENTINE - To simply hand a pamphlet which gives all the different services and what they do to the person and, 'You choose'.

Ms STEWART - In fact the doctor could avoid that altogether by having a sign in the waiting room that says, 'I do not give advice about pregnancy options counselling. I don't advise on terminations'. It is something that MA Vic??? talked about as saying, 'Consider it a conflict of interest' and the first thing to do there is to try to avoid it.

Dr WHITE - Avoid it where possible.

Mr VALENTINE - Except someone raised an issue about that very thing, the notes in the surgery. The person who goes in, not knowing that that surgery or that doctor has an issue, is then forced to go to the reception and say, 'I want advice on termination' and they are then forced to disclose why they are there, which is not something that people might want to do.

Dr WHITE - I think people can be more creative than that and say, 'I forgot to put money in the parking money, I'm off'. There are all sorts of options to them.

Ms STEWART - Even that sign could say, 'Contact family planning, here's the phone number'.

Mr VALENTINE - I guess it can. My question really is whether the state has a part to play in this by providing an information pamphlet in that circumstance to overcome this problem that doctors with conscientious objections have. What would you comment about that?

Dr WHITE - Under the new construct, would that be something that THOs would do, would it be population health? You're not sure? I think there would be someone who would be keen to make the information available, so I think generally yes, just exactly who that would be I'm not quite sure. That would need to be worked through once we knew what was on the table as far as the legislation goes.

Ms STEWART - That's it, it might depend if it were left as it was and a named practitioner effectively had to be named, I imagine that somebody like Family Planning or Women's Legal Centre would develop these over time.

Ms FORREST - Keeping them current.

Dr WHITE - That is always the problem.

Ms STEWART - The second angle is, if you go down the path of prescribed service then you have always got your regulations which would need to name who was the prescribed service. There is your list in fact and it would be the responsibility of the department to insure that list was kept up to date, and it would need to be developed in consultation with those services that are open to list this there.

Mr VALENTINE - Is that workable?

Ms STEWART - It should be. A prescribed service angle, definitely, if that's the path you seek to go down, that's the way that it would work. We have a regulation-making head of power in the legislation already so by using the word 'prescribed service', the word 'prescribed' means prescribed in regulation so you bring about the need to develop the regulations and obviously that would sit with the department to develop those. As Greg is alluding to, once we know the parameters of the bill, the department will finalise an implementation plan which will necessarily involve education materials in that.

Dr GOODWIN - Family Planning is an obvious one; what could be some others? Women's Health Centre, The Link and those sorts of services?

Ms STEWART - Yes, they are the three that come to mind immediately.

Dr WHITE - You would probably maintain a website source rather than hard copy. Hard copies might be business cards with the website address on it just to try to keep it current.

Mr VALENTINE - So there's no real cost involved.

Dr WHITE - There's always a cost.

Mr VALENTINE - In terms of having them make sure that there aren't out-of-date leaflets out there.

Ms FORREST - The Victorian legislation requires a medical practitioner to declare to the woman that they have a conscious objection. Why was that not included?

Dr WHITE - We'll probably both have a go at this.

Ms STEWART - It was a deliberate decision not to put it in. Two grounds really; one was looking at it from the doctor's perspective. It would force the doctor by law to disclose their personal view, which they may not feel comfortable doing. The second perspective is looking at it from the benefit that gives to the woman. We didn't think it was entirely necessary that we legislate for the doctor telling the woman - I can imagine a scenario where a woman might be feeling vulnerable already and to have the doctor say, 'I'm sorry, I completely disagree with your belief system and I hold a different one' - it doesn't seem to be something that is necessary from the clinical perspective or indeed to advance the pathway of the woman accessing further advice, counselling or treatment.

Technical problem.

CHAIR - We will suspend for a moment.

Dr WHITE - We were talking about the conscious omission of a conscientious objection.

Ms STEWART - The point that I was making was that we didn't think it was necessary to legislate that the inform aspect occur. There is nothing stopping a woman asking and a doctor disclosing that. But it was about, 'Does it really need to be in legislation and what purpose would it serve?'.

CHAIR - Any others on that matter of inconsistency with the Victorian? We have talked about the prescribed service and the possibility of a pamphlet and so on, haven't we? Is there any more that needs to covered there? We are under the access zones and unauthorised recording. Specifically, that has been put to the committee and we wanted to clear our mind on that as to the media covering a protest and thereby recording - whether that had been contemplated in the drafting of the bill in terms of some protection.

Dr WHITE - Like security cameras outside the premises.

Mrs HISCUTT - Before you start, I was going to say, would that include security cameras?

Dr WHITE - Security cameras would probably constitute authorised recording. The unauthorised recording is a different category and the simple position is that the media can share any information with consent. We would be very uncomfortable if the media were showing images of women coming or going from a centre; all they need to do is to get consent. That was our assessment of that.

Mrs HISCUTT - Are you saying that it is normal practice for the media not to take images and film of women coming and going?

Dr WHITE - It is not the taking of it; it is what they do with it that is the offence.

Mrs HISCUTT - Okay, put it on television.

Dr WHITE - What is the exact wording? Recording and distribution. It is a point of view really; it is coming back to how do you best protect the person. Published or distribute. To me that means they can record but they need to be very careful what they do with it.

Ms FORREST - They can pixelate faces and things like that.

CHAIR - There was a suggestion under the prohibited behaviour paragraph (d), that 'unauthorised' could be inserted to read 'an unauthorised recording'.

Ms STEWART - They would then have to give a meaning to 'unauthorised -

Dr WHITE - Authorised by whom? If you editor sent you down, is that authorised?

Ms STEWART - The third angle is the law enforcement angle. There is an exception in the police offences act at section 13 (d) that if you were seeking to put the matter beyond doubt it might be able to be transferred over. I am paraphrasing terribly here but it essentially says that if a recording takes place by a law enforcement officer in the reasonable conduct of their activities then that is not taken to be an offence under the section. So, something similar to that could be brought across if you wanted to put the matter beyond doubt.

Dr GOODWIN - Going back to the security camera issue, how is that protected?

Ms STEWART - That would probably be seen as an implied consent, if you are entering the building.

Dr GOODWIN - Assuming the security cameras are visible.

Ms STEWART - If they are not, I do not know whether in this day and age it is pretty rare to walk down the street and not get captured by one. If you were looking to put the matter beyond doubt and make sure that it is clear, I do not believe it is necessary. But that is just the way that I am looking at it; so if you are looking at pulling across something similar to 13 (d) in the police offences act, you might be able to explore it.

Mr MULDER - One of the issues you have got there if you are trying to cut out the idea of a video camera is that law enforcements moving this way. Quite often cameras are mounted in the cars; they are actually recording everything. In other words, you are saying the police car cannot drive past these places. The other thing is the static cameras that are not actually manned by law enforcement officers. Local councils actually manage them but it is what becomes of the footage. It is the purpose for which the video footage is being used and perhaps that is a better way of tackling it rather than trying to stop and prescribe the recording of it.

Ms STEWART - You might be able to distinguish between the recording of it in the security purposes.

Mr MULDER - And to the use of which it is made.

Ms STEWART - Keep it as an offence to distribute without the person's consent.

Mr MULDER - Or for non-law enforcement purposes.

Mrs HISCUTT - It does say there in section (d) -

Mr MULDER - The distribution rather than the tape capture.

Mrs HISCUTT - It does say it there in section (d); I reckon you are on to it there: use to produce.

Mr MULDER - Sorry, that was not a contribution; that was side comment. That is why I did not get your permission.

CHAIR - Are members clear, then? Okay, then we go to infringement notices under clause 11.

Ms FORREST - Before we go there, Mr Chairman, there is one thing we mentioned last meeting which did not find its way onto here - in clause 10 under 'proceedings', talking about 'proceedings may only be instituted by a police officer' or head of the department, depending on who we are talking about, which offence. I was a bit concerned - 'the proceedings for an offence under this part must be instituted within 12 months of the date' - when in most other areas of limitation it is three years. We think of a woman, post-clinic, who experienced some issue, she may not be in a position to institute that action within 12 months, bearing in mind she may decide against a termination, proceed with the pregnancy, all those kinds of things. I think 12 months is too short, and would be there any reason why -

Dr WHITE - Has post-natal depression, cannot make decisions clearly. There is no logic to it.

Ms STEWART - I have no objection to it being three years.

Dr WHITE - If we could simply reference the prevailing statute of limitations.

Ms STEWART - I think that might vary, according to different offences, so it pays to have it.

CHAIR - Clause (11), the infringement procedures. The question revolves around when it might be envisaged, when such infringement notices would be used, given this is a different process than proceedings for offences.

Dr WHITE - You would hope very rarely. It seems to have become standard drafting practice to include a provision for infringement notices in primary legislation. Giving effect to that would require making a regulation that permits the issuing of infringement notices. It is hard to say how many there are, because we do not know what the final shake of the legislation looks like, but the issue that inevitably would give everyone

reassurance, is that they would have to come back through parliament and be tabled, before they became part of the regulations. That is the downstream issue for consideration.

CHAIR - The bigger question was whether there was anything sitting in the minds of those who put this together.

Dr WHITE - From my perspective, no, and I am not aware of anyone rushing around saying, let us order ten thousand infringement notices to use in the first year.

Ms STEWART - If the bill was passed in its current form there are only four offences in it, because we do not issue infringement notices for crimes under the criminal code. You have your counsellor failing to refer a person engaging in prohibited behaviour in an access zone, publishing or distributing the recording, or failing to provide a name and address to a police officer. It would not be inappropriate for all of those to appear in regulations, allowing the issuing of an infringement notice. Bearing in mind, that does not necessarily mean an infringement notice will issue, but it is with the discretion of the enforcement officer to issue one, if it is at the lower end of the spectrum of offending. If somebody were a persistent offender, a decision might be to take the matter through the courts rather than deal with it via an on-the-spot fine. All regulations need to be tabled before the parliament, who can disallow, so there are checks and balances there.

CHAIR - Anything further?

Mr MULDER - Infringement notices are introduced for high volume offences, so you did not have magistrates dealing with repeat conduct. Why did we move down this path? Can you imagine it not being highly contentious, the first time someone got an infringement notice under this legislation, for what amounts to deliberately breaching it? Why would we have an infringement notice provision at all, unless we worked out, later on, that this was happening three times a week, and did not want to clog up the courts. What is the policy logic behind having infringement notices for such contentious issues?

Ms STEWART - I suppose that the contentiousness of the issues might be a matter of perspective, but as I understand it, the issuing of infringement notices is also a less costly way of moving forward with an enforcement action, rather than commencing proceedings in court. The other thing to bear in mind is that a person can argue against an infringement notice and fight against it. The Monetary Penalties Enforcement Act regulates it and once you have paid it, you are effectively saying yes, I admit to this offence. If you decide to fight it, you can go down that path. It does not essentially shut off the option of it.

Mr MULDER - I appreciate that. Here is an offence, you can issue an infringement notice for it. It sends the message that this is not a higher scale of offending. It is usually reserved for almost inadvertent stuff, rather than deliberate stuff.

Dr GOODWIN - With this protest provision, it could vary from people standing 120 metres away chanting, to people full on harassing and recording, and interfering. You might want to build in a bit of flexibility where you could use an infringement notice.

Mr MULDER - Thanks for clarifying that, I am happy with that.

Dr GOODWIN - We could use an infringement notice for something that was at the minor end of the scale, as compared to something really serious where you might want to arrest someone.

CHAIR - Go to the matter of the new section 178(e) in the criminal code and specifically whether it is consent, under the criminal code, notwithstanding that the clause notes address the matter for the bill, but the question has been raised, because this is a new section of the criminal code, the notion of consent will be as set out in the criminal code. The question is, whether there might be a need for clarification. We might have gone there earlier Cherie, when you gave your explanation about consent and how it applies in the criminal code.

Ms STEWART - If you will take that meaning section 2(a) definition of consent, would be incorporated into this.

CHAIR - Which is, very broad.

Ms STEWART - Yes, free agreement. The criminal code goes on to say, 'here is when it is not free agreement'. So it offers quite a bit of guidance.

CHAIR - The final one, is the capturing and reporting of instances.

Mrs HISCUTT - I missed an earlier question, would I be able to go back to one earlier question?

CHAIR - South Australia and Western Australia provide data, and whether we can go there - I did mention to the committee at one stage that back in 2001, the South Australian, fairly robust data, was discussed in the Legislative Council debate at the time. The feeling was then that Tasmania ought to be capturing some data on terminations, because South Australian stuff is pretty good.

Dr WHITE - Data is always attractive when you want to have a rational debate about things. I do not know how many times someone says, 'I wish we had the data on this'. We are a long way from having perfect data. In an ideal world, I think not a problem. In the circumstances we are in at the moment, I wonder about whether the value of having the data outweighs the difficulties in collecting it, and whether in an environment where we are trying to make the procedure more normal - in a clinical setting - it will cause anxiety in women to know that their data will be reported.

Dr GOODWIN - They are not identified of course.

Dr WHITE - Indeed, but not everyone is reassured by that. De-identification is a lot harder in Tasmania than it is in even in South Australia, where the population of Adelaide alone is a lot bigger than the whole of Tassie. In theory, it would be great to have the data, but I see it as potentially complex. I am not sure that we are able to legislate getting data from interstate, because our legislation would not have jurisdiction on reporting of interstate procedures. You cannot ask women as they come off the plane, 'Did you have a termination while you were outside Tasmania?'. I wonder how useful it would be, given the dynamics of the way women in Tasmania access terminations, which includes

a lot of them, we believe, going outside Tasmania. I should not say 'a lot' because we do not know, but I think it is more likely to change, with more of them doing it here, if they do not feel it is being reported centrally. This might be something that comes up in the review of the legislation on terminations.

Mrs HISCUTT - I think your logic is a bit flawed. There are a lot of diseases and problems that are reported, that patients would wish no one else knows about.

Ms FORREST - They are contagious ones, though.

Mrs HISCUTT - This is pretty contagious. You're producing another being.

Dr WHITE - It is pretty sensitive and it inhibits people accessing treatment. It is a problem. I have never looked at it in Tasmania but I am aware, because of my training in Victoria, that is the reason you need to have the special clinic in the heart of Melbourne for sexually transmitted infections, where you only ever known as a number so there is no risk of identification.

Dr GOODWIN - This issue was raised with us by Dr Did you read her evidence on this? One of the concerns she raised was that we do not really have a good handle on the incidence of foetal abnormalities before 20 weeks. Most post-20 weeks terminations would be done in the public system and there would be a record of them, but not for the pre-20 weeks. There is a feeling that the incidence of foetal abnormalities may, in fact, be increasing but that is only anecdotal - we do not have that data. I completely understand their concern with that significant gap in our data. How difficult would it be, given that they are already doing it in South Australia, and Western Australia? It seems to be reasonably straight forward.

Dr WHITE - The foetal abnormalities question would probably be better answered by a carefully constructed research approach, rather than legislated reporting of a clinical practice, because I am not even sure you would even know. You do not know, for example, of the abnormalities that happen in the setting of spontaneous abortion. You do not really know, even if you measure this, how many abnormalities are happening. It may be that there are no more, but for nutritional reasons women are able to carry them longer than in a less well-nourished society. It is a bit problematic to even draw conclusions from that information.

Ms FORREST - We do not know how many spontaneous abortions are related to abnormality, as opposed to other reasons why they occurred.

Dr WHITE - Absolutely, there are so many unknowns. It is taking us more into the area of research and I wonder how much value you would really get from the data. And, what sort of abnormalities are we talking about - are you going to send every DNA sample off for DNA analysis?

Dr GOODWIN - I do not think the other jurisdictions go to that extent. I cannot remember which one it is - whether it is WA or South Australia - but they just record the reason for the termination, which can be foetal abnormality, or other reasons.

Ms STEWART - But you will still have a gap in the data unless you force all women who have a termination to undergo further screening or testing to determine if there is a foetal abnormality. It may not be known, and the woman may be seeking a termination for reasons other than foetal abnormality, particularly in early gestation.

Dr WHITE - Or it may be a mix of reasons.

Dr GOODWIN - Yes, but I think they only record the reason why they seek the termination, rather than making them go through extra tests to determine whether -

Ms STEWART - So you're still going to have that gap, because there will still be the category where we don't know.

Dr GOODWIN - Potentially, yes.

Ms STEWART - And I think there may be more - at least in South Australia, there are more terminations performed in public hospitals, so they have greater access to the information.

Dr GOODWIN - The other one - most of them are performed in the private system.

Ms STEWART - In Western Australia.

Dr GOODWIN - I think so, yes. I believe so.

Ms STEWART - I'm not sure.

Dr WHITE - So just to be clear, we're not really enthusiastic about that one. We can see more problems than solutions with it. I think Michael Pervan might be coming to talk to you, and he has an interesting view on data - he is our data man.

CHAIR - Leonie, back to the point that you were -

Mrs HISCUTT - Sorry to take you back. Clause 5 (2) in Part 2 says:

> In assessing the risk referred to in subsection (1), the medical practitioners must have regard to the woman's current and future physical, psychological, economic, social circumstances.

I ask the question before: Why wouldn't you lift it straight out of the criminal code and just say the doctor can decide, for whatever reasons he deems necessary? I was told that was very prescriptive. Then someone else said you should add 'severe foetal abnormality'. It seems that there is always going to be someone who can think of something else that should be in this legislation. We are taking it out of the criminal code and putting it into the medical code, so why wouldn't you let the medicos decide and lift the words straight out of the criminal code?

Dr WHITE - And have the broadest possible range that is relevant in those particular circumstances.

Mrs HISCUTT - Whatever the doctor sees as being relevant, yes.

Dr WHITE - I know Cherie has given it a lot of consideration, so I will leave that to you, Cherie.

Ms STEWART - That provision sets the minimum that has to be taken into account. There's nothing stopping a doctor from taking other matters into account, but it's quite clear - here is the list of factors that have to be taken into account.

Mrs HISCUTT - But wouldn't a doctor normally consider everything that seems to be for the benefit of his patient, without having to refer to a list?

Ms STEWART - Because there has been a history of lack of understanding of our current framework, this makes it very clear which factors have to be taken into account. The current wording is - and I will grab the criminal code so I am quoting exactly:

> ... the medical practitioners may take into account any matter which they consider to be relevant.

This legislation sets the standard and says, 'This is what you must have regard to'. If there are other things a medical practitioner wishes to consider, there's nothing in here that stops them from doing that, but this sets the minimum. It also provides clarity from the woman's perspective - about what she can expect to be asked, going through this process. These are the factors that are taken into account.

Mrs HISCUTT - It was also raised that it was too prescriptive.

Dr WHITE - The other thing you raised was the question of foetal abnormality being included.

Mrs HISCUTT - That was something that somebody else thought of, and that's always going to happen.

Dr WHITE - The reason we didn't go down that path was because it fundamentally shifts the test from being about the woman, to setting up a bit of competition with the baby, with the foetus, about foetal abnormality. It was not seen as a useful addition in terms of decision making.

Ms FORREST - The Victorian Law Reform Commission made some comments about that as well - that it was a bit fraught in the disability area.

Dr WHITE - Well, I think it becomes fraught when you consider what abnormality, how much abnormality, at what stage -

Mrs HISCUTT - No, I wasn't suggesting you add it. I noted that when you start including prescriptives -

Dr WHITE - It's meant to be prescriptive as a baseline and you can go as far as you want but here are the minimum things. It is a purely technical assessment of whether someone will survive the anaesthetic. In a sort of narrow minded medical way, you have to

understand all of the woman's circumstances, including, but not limited to, these four areas. That was the intent of the framing of it, so it was a bio, psycho, social, contemporary approach.

Ms STEWART - Each of the factors listed there are either named up in the Victorian legislation or form part of case law in New South Wales by the then acting chief justice Kirby, so there is a precedent for them being used.

Ms FORREST - In the medical code as well. Most of them are in the medical codes, or RANZCOG guidelines.

Mrs HISCUTT - They are already there.

Ms FORREST - Craig, there was one issue of survival around viability, there was some questions asked about 'up to 24 weeks' when the bill was originally brought in, then babies surviving and people saying, at what point. Do you have any comments around viability? There has been some work done through the UK House of Commons committee that looked at this. There is good information in the UK report.

Dr WHITE - Yes, there is. Where Tasmania chooses the line is as much about our starting point as where we might end up in five or ten years time. Sixteen weeks, you would have to talk to the person putting the legislation forward. There was something the judgment formed about - at what point are people comfortable? I think that included some consultation with some of the clinical people who felt that at 16 weeks there was less debate about looking for reassurance of your colleagues that this was the appropriate course of action than it would be if it was moved up to a later point. You could make it at a later stage and that does not stop people from taking a two doctor approach, as happens in all sorts of areas of clinical practice. I do not think there is anything from my point of view that argues it either way.

Mr VALENTINE - You have fuller information though, don't you?

Dr WHITE - You do. On the other side of it, some people may feel uncomfortable leaving it that long. In practice in Tasmania for the foreseeable future, if there was a woman up to 16 weeks, the chances are they would get a second view from a colleague and discuss the case.

Ms STEWART - I suppose the issue of viability in itself is quite complex because what does viability mean and what happens if we end up at the point where any gestation of foetus could be removed and put into an artificial womb. Is that viability? There are some dangers in basing the gestational period -

Dr GOODWIN - We are not there yet, are we?

Ms STEWART - It is something that when you read some of the literature around it,

Dr GOODWIN - We could put it inside men's bodies for a while.

Mrs HISCUTT - Does a death certificate have to be issued at 20 weeks? Does there have to be a process where there is a burial, or some sort of legal disposal?

Ms FORREST - When it gets to 20 weeks, 500 grams, but I would have to check.

Ms STEWART - There are some complex issues around basing the line on viability and the committee heard that some people support having no gestational period in the legislation. That is an option that would achieve the outcomes that we are after. If you are going for the consent based model throughout, as the ACT has. If we are going to base our legislation around viability, the UK House of Commons Science and Technology Committee did a thorough investigation into the science around viability and landed on the 24-week period. I think in 1990 it was at 28 weeks and they did another report at that time and reduced it to 24 weeks but I think the most recent one was 2007 where they landed on 24 weeks.

Ms FORREST - Because survivability below that was negligible, and it's viability without complication.

Dr WHITE - Without severe -

Ms FORREST - Severe disability, yes.

CHAIR - Thanks very much, Craig and Cherie.

THE WITNESSES WITHDREW.