PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY 19 AUGUST 2013

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 INQUIRY

Dr CRAIG WHITE, CHIEF MEDICAL OFFICER, AND **Ms CHERIE STEWART**, LEGAL POLICY OFFICER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WERE RECALLED AND RE-EXAMINED, AND **Dr SUSAN KERRIE DIAMOND**, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Welcome back, Craig and Cherie. Susan, I assume you are familiar with committee proceedings of the parliament where you are protected by parliamentary privilege while at this committee hearing but outside there is no protection, so we suggest caution when speaking with the media or make comment because you do not have the protection of parliamentary privilege.

We have asked you two others back because of lack of time last time. In commencing proceedings, Craig, is there anything that you or either of your colleagues wants to cover first?

Dr WHITE - Thank you for having us back. I asked Dr Diamond to join us because she is the deputy secretary of Children, Youth and Family Services at the moment. I was aware that there was some discussion last time about adoption and I thought it was worth supporting the committee by bringing along the best person we have to talk about what is known about the process of adoption in terms of effects on individuals and so on. There was some sense I had that you if you didn't want to carry pregnancy to birth and keep the child yourself that you just go through to term, have the baby and give it up and everything is fine. Unfortunately it is not such a rosy picture for everyone involved in that so I suppose I was trying to help the committee understand what the alternatives are for women who find themselves with an unwanted pregnancy which is going to be a problem for them or if they're carrying a severely disabled child. I thought that was a useful counterpoint.

Dr DIAMOND - If you don't mind, I would like to read a bit because it will keep me on track. The first point I would like to make is that there has been an enormous decline in adoption over the last 40 to 50 years and that points to the fact that women's first choice as an alternative to an unwanted pregnancy is clearly contraception, termination or, these days, to raise the child themselves. When you look at the numbers of children who are currently being adopted locally, placing a child for adoption is not the preferred alternative for women in managing unwanted pregnancies or when they give birth to unwanted children. There are certainly issues related to the raising of unwanted children and placing children for adoption. Specifically, there are unique issues around every woman's circumstance and her decision about whether to terminate a pregnancy or not and it is important that the woman has the opportunity to consider and explore options, particularly when one of the alternatives to termination is that the child is born into

circumstances which are far from ideal. These days, women do choose to raise their own babies when the pregnancy might have been unwanted and they don't necessarily find that easy.

There is evidence that both unintended and unwanted childbearing can have negative health, social and psychological consequences, and there is evidence of children at two years of age who are born as a result of unplanned pregnancies having significantly lower cognitive functions than children born as a result of intended pregnancies. The data in relation to the research is dated because the issue of unwanted children and large numbers of children being placed for adoption was really an issue of the 1960s to 1990s, so the research in relation to that is largely informed by that period. Research informing the consequences of adoption certainly relates largely to the 1980s and 1990s when adoption was common enough and the response locally to unwanted pregnancies was that it warranted research. These days in Tasmania we are down to very few children being placed for adoption locally and research about the consequences of adoption is not high on the agenda.

There are studies that have compared children born to women who were twice denied an abortion as opposed to women who had not requested termination, and the studies have found that there are less positive outcomes for the children born as a result of unwanted pregnancy who remain with their birth mothers throughout childhood. We know today that the babies of single mothers are overrepresented in the child protection statistics, possibly as a result of those mums being most likely to live in vulnerable circumstances and coming from a low socioeconomic demographic. There are risks to children there.

For women themselves, there was a study done in Western Australia by Winkler and van Keppel in 1984 which looked at the traumatic consequences for women who had placed their children for adoption and found they suffered profound and long-term grief, feelings of guilt and shame and often there were identity issues that occurred for themselves and the children. The evidence was that mothers who felt the relinquishment of their children had been entirely their own decision tended to fare better psychologically than those who felt they had had little choice in the matter. The trauma of separation continued to haunt mothers to varying degrees throughout their life. Clearly, the recent federal and state governments' apologies to those who felt they had been forced into adoption was indicative of the fact that that grief and trauma was recognised.

Dr WHITE - We are happy to continue the dialogue that was unfolding at the last encounter.

Ms FORREST - I have a few questions that need a bit more clarity. I would like to go to parts of the bill. We touched on some of these areas last time but I think we need a bit more clarity around a couple of areas, particularly under the interpretation section.

We had some discussion with other witnesses around the interpretation of 'terminate' - to discontinue a pregnancy so that it does not progress to birth by (a), (b) or (c) in the bill in clause 3. I was concerned about the words 'to birth' and the suggestion was we could take it out and it wouldn't have any impact but since our last hearings particularly, I was thinking that any pregnancy that is brought to an end other than by going into labour spontaneously is terminating a pregnancy. Looking at an elective caesarean, I thought of a situation where a mother may have a breach baby which can be delivered vaginally and

she didn't want to have a caesarean but felt she was coerced into it, perhaps, and the usual range of complications may have occurred - post-natal depression, infection or whatever. Looking at this legislation she may think, 'I didn't have the approval of two doctors. My termination occurred after 16 weeks, two doctors should have approved my termination of pregnancy' - and even induction of labour for medical indications. How do we avoid those being somehow caught up in this? Do we need 'to birth' in there to differentiate these?

Dr WHITE - You're right to point out that that is an entirely unintended outcome of the proposed legislation. It wasn't in any way intended to capture the scenario you explained; even without the complications it is not intended to capture an induced birth or a birth by caesarean section. I know a fair amount of thought went into the selection of the term 'to birth', where it was intended in context to refer to a delivery by means such as caesarean section or vaginal delivery. Cherie may be in a position to flesh that out a little more.

Ms STEWART - You have summarised that quite well because when the consultation version of the bill was put out originally those words were not in there, and it was subsequently raised that that very scenario you are suggesting may possibly be drawn in. As a matter of statutory interpretation, I think a court would be unlikely to follow that, simply because when we looked further at how the word is used throughout the legislation, and particularly in clause 5 of the bill that applies to terminations after 16 weeks, that framework doesn't sit well when you try to apply it to a delivery that wasn't an intended termination - a live birth, effectively.

Having said that, I think the words 'to birth' are useful because they help to distinguish between an intended termination versus the ending of a pregnancy that is intended to deliver a live birth. For that reason we would support them continuing, and I think that those words coupled with the statutory interpretation around clause 5 would be enough for a court to say this bill doesn't apply to a caesarean or vaginal delivery, it is about an intended termination.

Ms FORREST - I have talked to some obstetricians as well about this to get some advice - went back to the old stomping ground - and when you read it at first glance they say, 'That's ridiculous, of course every pregnancy ends in a birth of some sort', even a miscarriage, and for some women it is important that is seen as a birth to them, so do we lose anything by taking that out?

Dr WHITE - I understand what you are trying to do because the last thing that we want to do with this is to perpetuate further confusion about the status of any sort of clinical activity. Cherie, do you want to talk to that a bit more?

Ms STEWART - Yes. If we lost the words I don't believe it would be fatal to the bill in that I don't think it would draw in the examples we're trying not to draw in. I do think that having those words there helps in making it clear that we're not about drawing them in because it is about discontinuing a pregnancy so that it does not progress to birth. The aim is to capture those that are intended not to progress to birth, so that is where a termination -

Dr WHITE - I suppose what we're debating is the difference between a legal mind and a clinical mind, so legally when you sit with Cherie and hear that explanation it all makes perfect sense, but when you're out in the clinical world it's possible that saying something does not progress and deleting to birth still makes the point more reassuringly perhaps.

Ms FORREST - Several doctors said they don't look at the legal side of it because they don't care about that but I said I do need to care about that now. The point here is that we don't have a definition of 'birth' and I thought about putting in 'live birth' but sometimes babies with encephaly are born alive so they're a live birth but they are simply not going to live, so how would a court then interpret this? Cherie made the point that a court would look at this and not apply it to an elective caesarean, for example, but how would they apply to exclude it without a definition of birth?

Ms STEWART - The usual step for a court is if there is no definition in the legislation itself that can inform that the next step would be to consider the ordinary use of the term 'birth'. If we look at the Macquarie Dictionary its definition of birth refers to independent being or life so you are effectively then drawing in that line or difference, if you like, between an intended live birth versus not.

Dr WHITE - I suppose the other factor that a court is likely to take into account is the intent of the legislation, which is to provide an updated framework to consider terminations, so they will be focused more on the definition of 'termination' as leading to a different end point that the birthing end point, so if you do a caesarean section or a vaginal delivery there is a different intention from the Reproductive Health Bill that we are discussing; that is a different outcome than is intended from the process described in here. I suppose that is the other way that a court may differentiate.

Ms FORREST - Michael Stokes raised a concern about the risk of homicide with a child that is born alive. It is known that encephalics are often born alive but will die soon afterwards and there is no expectation that there will be an attempt to resuscitate that child, but if there was a termination that had occurred past 24 weeks, let's say, because before that we know that resuscitation is usually futile and not attempted generally. There would be an expectation that unless there was a gross foetal abnormality that was not consistent with ongoing life, or quality life - or whatever decision has been made by the parents prior to the induction of the labour - then there would be an expectation that a child other than in those categories would be resuscitated, otherwise there could be a risk.

Dr WHITE - Which is an existing risk.

Ms FORREST - Yes.

Dr WHITE - In that very rare scenario, clinicians would take every effort to avoid putting the mother, the parents, themselves through the productive delivery. It is difficult, as you know, in legislation to deal with every possible scenario, and that is a rare possibility under current legislation - and this one hasn't sought to deal specifically with that particular scenario.

Ms FORREST - So effectively it wouldn't change?

Dr WHITE - My understanding is that it is exactly the same as under the current.

Ms STEWART - Where Mr Stokes says that the termination ends in a live birth, it falls outside the scope of the bill.

Dr WHITE - Yes, you move into a different legislative jurisdiction.

Ms STEWART - Yes, that's in fact the very intention. We are not intending to alter the law about what happens if there is a live birth. That will remain and is not changed by this bill.

Ms FORREST - That is a matter of opinion, I guess; most of us thought that was the right thing to do.

You probably heard the evidence from others about some of the medical staff - obstetricians, particularly - wanting to include gross foetal abnormality as an indication for a termination. I read through the Victorian Law Reform Commission's report which comments quite extensively on this in that effectively it means you are discriminating against babies, foetus, whatever, with significant abnormalities. Their suggestion was that you should perhaps link the impact of having a baby with such significant abnormalities with the mental wellbeing of the mother, rather than naming it up specifically. Does the department have a view on this? I was informed of an incident where a death certificate was prepared for a baby born with gross abnormalities, and that was the reason given. There was some concern about it becoming a coroner's case unless it was linked to maternal mental wellbeing.

Ms STEWART - I have read those same comments in the Victorian Law Reform Commission's report and you do encounter difficulties if you name it up as a separate category over and above, or as distinct from the impact on, the physical and mental health of the woman. That is the current test being proposed in the bill. I say that because, as the Victorian Law Reform Commission noted, it hasn't been something that has been put up for consultation and it is likely to draw criticism from the disability sector. It seems to me there could be an inference if it is named up in legislation that that is something that women ought to be considering. I am not sure there has been evidence presented that for a woman who has had a diagnosis of a severe foetal abnormality that there is not an impact on her mental health. If there is an argument coming forward that there is no linking and that is the need for it, certainly that is not something that I'm aware of.

The other aspect is that if you start to introduce language like 'severe abnormality' or any other similar terms that in itself opens up a discretion and quandary about what does that mean and who gives meaning to that? Is it what the woman considers to meet that meaning? Is it what the doctors do? Do you try to define it in law? Where does the line stop?

Ms FORREST - For some women, a cleft lip can be very distressing and considered a gross malformation, whereas it is completely correctable. When the baby is born, it is an unfortunate thing to see. How do we deal with this? Then you could have it right through to the ones that are not compatible with life, where it doesn't seem to be the challenge.

Dr WHITE - Taking a clinical perspective on this, it is difficult to put words in that are useful in every setting - such as 'gross abnormality' - because there will be times where it's black and white - like anencephaly, where I don't think anyone is going to debate it - but at some point back from that it becomes moderate, and is your moderate the same as my moderate, or is my moderate your gross? There are difficulties. To me it is one of the factors that is part of the consideration with the woman and her capabilities, capacity, social and psychological circumstances that you need to look at in that context.

Ms FORREST - Would the word 'lethal' make any difference in there? Trisomy 21 is generally not lethal; trisomy 18 is; some of those are not detected until after 16 weeks, probably a significant number. This is a very vexed area.

Dr WHITE - My understanding of the way it was proposed is that those discussions could still take place, and if it was assessed by the woman as what she wanted within the framework, then it could lead to a termination.

Ms FORREST - Through her mental health impact?

Dr WHITE - Yes.

Ms FORREST - Some of the obstetricians are saying they think they are being disingenuous by putting a termination for an anencephalic baby down as a maternal mental ill-health. I tend to agree, but how do you do it otherwise?

Mr MULDER - The issue is the desire of the mother to care for the child with that, so it's not necessarily the mental health of the mother that is the concern. It's the willingness of the mother to provide the level of care that such a child would require.

Ms STEWART - And perhaps capacity as well, not just a matter of willing.

Mr MULDER - Yes. Maybe that's a way through that minefield. It's not her mental or physical health that is at issue here; it's the fact of her capacity or willingness.

Dr WHITE - Some women can find it very distressing to be carrying something other than a baby that will have a happy outcome birth. I believe there is still a link back. They are not tossing a coin; they are making a reasoned, personally focussed decision about if it is okay for them. That is ultimately a call that the Council will wish to make but, from our point of view, we weren't seeking to add a further definition around the nature of the foetus. It was being framed up around the circumstances of the woman.

Ms FORREST - Similarly, I put it to you that if we took out the two-doctor test after 16 weeks, it would remove the problem anyway - or pushed it out to 24 weeks, where it was originally, that would remove a lot of those concerns and problems.

Dr WHITE - We have no objection to that.

Mr VALENTINE - It gives time for the mother to think it through and get advice.

Dr WHITE - Yes, get the information and talk to people.

Ms STEWART - The other point, as you touched on, Craig, is that it would be a departure from what we have currently and what we put up for public consultation because it is a recognition of the law, as you say, of the focus being on the foetus over the woman, which is a shift from what we have now and a shift from human rights approaches.

CHAIR - From a medical, clinical point of view - and Ruth mentioned the matter of a fatal abnormality - what are those circumstances such that the child has very little chance to survive past a few days and therefore why would it not then be reasonable to consider aborting before birth? What clinical circumstances are there which would render the child so likely to survive post-birth?

Dr WHITE - It is not a vast range but there is a range of usually congenital abnormalities where the development of the embryo and foetus lead to some kind of problem that is incompatible with life, such as the example that was mentioned of the brain failing to form and no matter what you do it is not going to be compatible with life. It is dealing with a congenital abnormality.

CHAIR - If you try to define what gross foetal abnormality is, could you not go down that path of very little likelihood of surviving after birth and therefore the mother might prefer a termination before the birth? I would have thought there would be all sorts of traumatic circumstances associated with that.

Dr WHITE - Indeed. Yes is the short answer. I suppose the point that Cherie and I were really going to is that we weren't speaking in the consultation to consult beyond factors relating to the woman in seeking the termination, and if there is a way of expressing that I think it would, in terms of issues for the woman, be consistent with the way the legislation is framed up. If there is a further test or definition which goes to one of the factors being nothing to do with the woman but all about the foetus, that is additional circumstance we didn't consult on. That may or may not be a problem, but it starts to introduce something that wasn't contemplated in the original legislation, not that there was any intention to do anything other than support a choice for termination in accord with the procedure set out, but based around issues linked back to the woman as opposed to the nature of the foetus. It is more about the change to the way it is framed up.

Ms STEWART - Adding another criterion, you would need to look at how then the provision would be interpreted as a whole. Does it mean that if you are naming up abnormality, however you want to describe it, that that can't link back to the mental or physical health of the woman and, therefore, what happens to a woman if she does not meet that second criterion? Can she still come within the first lot, the impact on her physical and mental health if she does not fall in the wherever you draw that gross abnormality or however you describe it? If that was something you were contemplating it would need to be looked up from that statutory interpretation angle as well as the clinical angle.

CHAIR - Unless we give some certainty or guidelines, if you like, aren't we through this wording perpetuating the concern that we seem to understand doctors currently have for them to perform an abortion? That is the message I have been getting.

Dr WHITE - I hear what you're saying and commend you for having the conversations. All I am saying is that the framing of it needs to be given some thought. I don't have any

problem with it. It's just that it would need to be framed in appropriate manner so it didn't have any unintended consequences. As I sit here, I don't have any to throw on the table but if you were going to add that further perspective, the two ways of doing that I see are to frame it back in the same manner as other things have been framed to relate it back to the health of the woman and I think that's in the flow of what is already on the table. The alternative is to add another perspective, which is where there are no implications for the woman other than she is carrying a child with gross abnormalities and can seek a termination in that circumstance. If the Council wished to deal with that in the legislation that would have my support.

Ms STEWART - The other thing to consider also is once you have that first criterion there that relates to the foetus, where does that end? Do we, in future, end up with more lists being added there? At the moment the bill is consistent with our existing laws which grant rights to the foetus after birth. If we are naming up, as you're saying we're linking back to the foetus, so where does that line end and what comes next after that once we start elevating that to legislation? Is it a protection, is it a right and what does that flow on to?

Ms FORREST - Does that conflict with some of the human rights conventions?

Ms STEWART - Certainly. Even our own criminal legislation is quite clear. The protection of the Criminal Code comes in at the point where a child has been born and, as I understand it, that is consistent also with human rights approaches.

CHAIR - Ruth mentioned that if we were to remove the second doctor component, the problem would be overcome. How is that so, because you said yes to that proposition?

Ms STEWART - You then end up with a consent-based framework and how it plays out will occur in the medical, clinical setting rather than the legislation imposing the criteria. As a matter of practice, we understand that quite often in terminations occurring at later gestations, 24 weeks and above, a clinician often feels more comfortable having those conversations with another clinician, so often in practice that very thing is occurring. You then have the question about whether we need to elevate this to be at act level or are we okay for clinical settings operating.

CHAIR - How does it change whether you have one doctor or two, particularly clinically?

Ms FORREST - My point was slightly different than that. It was taking out the requirement to prevent greater risk of injury to the physical and mental health of the mother and then it opened it up to not to have to prove that to allow a termination for a foetal abnormality because it is a consent-based framework.

Dr WHITE - Up to the time cut-off. If you increase the time cut-off, it can be done by consent rather than meeting the tests that apply after the cut-off.

Ms FORREST - Yes. That is what I was suggesting, or pushing that to 24 weeks, but then there is a different expectation of a baby surviving at that stage.

Mrs HISCUTT - Further to that same theme, if you start naming up problems that would justify an abortion, does that then leave open the fact that if you don't fall into that

criteria there could be a reason to not? A doctor might look at it and say, 'That baby has no gross abnormalities, therefore it is not a justification to have an abortion, which will lead to other social, economic or mental problems'.

Could it be creating more problems than you are trying to solve if you were to introduce something like that?

Dr WHITE - That would probably be a question for the lawyers, in terms of how you draft it to avoid those. For me, that sort of pathway could start to take you down - if you are starting to legislate around the foetal health status, does it start you thinking whether you should accelerate birth if the mother is an alcohol user to avoid foetal alcohol syndrome? There is, for my mind as I sit here and reflect on it, a thin-edge-of-the-wedge argument about it but I'm sure that parliamentary drafters and lawyers are capable of framing it up in a way that it doesn't take you down the wrong path, if it's felt that that's an improvement to the way the legislation is put and it's more reassuring to the clinical community.

Mr MULDER - But doesn't it also get into the fact that you could list this but there are mild forms of it that wouldn't be a problem and then there are major forms that would be a problem? Then you get into another list of defining the seriousness of that particular thing - I think that's the quagmire that you get into because it's not a case of you either have it or you haven't, it's a case of you have it to a certain degree.

Where do we now draw the line in amongst that murky mess in each of these conditions that you name up? I think that's the difficulty.

Dr GOODWIN - I do understand the concern which was raised with us last time. This is a fact. It does occur that there are babies or foetuses with severe abnormalities so I feel that it should be clear in the legislation and that it's covered. This is a fairly grey definition of physical, psychological, economic and social circumstances - why not be upfront about it? I do have some empathy with their position.

Mr MULDER - I would support that because I can't see a difficulty with saying, '... having to define the condition or its severity'. That's something you leave to the clinical judgment of the clinician, in consultation with the mother. Why can't we leave it as 'severe abnormality'?

Ms FORREST - On that, and again this might be a question that you might be able to answer, Craig, but having listened to the discussion here and the comments you have made, in section 5(2),

> 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 and social circumstances.

Maybe it's something to add after 'psychological', or anywhere in there perhaps, about the likely outcome of the foetus. I don't know but it just adds another consideration to be put in making that determination about the mother's mental and physical health. Number (2) sits under (1) -

Dr WHITE - I hear what you are saying. Another way of saying that might be 'and other implications of the current pregnancy continuing'. That then doesn't have the pitfall of seeking to redefine it in terms of the foetus's condition directly.

Ms FORREST - What they need to be able to prepare is a death certificate that enables them to state clearly why they did it. It also helps with the perinatal data collection. If we are going to have statistics to understand the reality of the number of terminations, the reasons for them and the outcomes of the women, if you want to do some research in the future, if you can't clearly articulate on the death certificate why this was done, it makes it difficult. As Vanessa was alluding to, it's important to provide that somehow. I think if a doctor is doing a termination, predominantly because the baby has anencephaly, they should be able to write that and not be questioned and not have Pathology say, 'This is a coroner's case, I'm sorry'.

Dr WHITE - That's a fair comment.

CHAIR - Any further questions?

Mr MULDER - I have an issue about early-term abortions that I want to cover. We heard from Professor Lim that the Royal or the public health system or at least the southern Tasmanian health organisation, as far as he was aware, was conducting abortions for severe abnormality in late term but that they weren't conducting the early-term abortions and they weren't available in the public health system, at least in the southern health system and I believe it's the same for the north and north-west, on the basis that he had six doctors, two of whom were conscientious objectors and the other four would do them if they were asked and to quote him he said, 'They had not been asked or directed to provide that service by the commissioners'. By that I take it he means the health organisation hasn't actually delivered that as a service the southern health organisation is delivering. So that leaves it to the private sector to perform those abortions and that then leaves us with the difficulty of people in remote locations far away from these clinics having to travel to Melbourne. I'm just wondering why the health bureaucracy hasn't picked this point up if it's so important and put that to a list of services to be provided by the health organisations.

Dr WHITE - I think the best answer to that at this stage is that the commissioning process is only just over 12 months old and it's not yet mature to a degree that it can get down to the level of every single procedure and possibility. It's a very big change for the health system to deal with and there will be increasing layers of detail and complexity added over time. It's a reasonable question but in these circumstances we haven't specified every little detail.

Mr MULDER - Going back then to the situation that pertained prior to the health organisations legislation coming in, why was there never any push within the public health system to allow the public health system to perform these procedures?

Dr WHITE - I think that's a question for others rather than me sitting here as chief medical officer. My own experience at the Royal Hobart Hospital was that there was a different profile of conscientious objection and concern, so things have obviously moved on and it's really a question for others.

Mr MULDER - Who do you suggest I ask?

Dr WHITE - It's a good question.

Mr MULDER - If I can't ask the chief medical officer, who should I be asking?

Dr WHITE - I'm not involved in the commissioning activities. Michael Pervan is the commissioner and he would certainly be able to tell you what their thinking is and how they are going to deal with that over time. Up to the point of commissioning happening, organisations were funded on an input basis and the actual procedures depended on what was on their waiting lists, they were determined by who was referred into clinics and so on, so it's a part of the whole clinical system.

Dr GOODWIN - Craig, in terms of the process, are you able to give us a bit of an idea of what the process would be to get these early terminations as part of the service agreement? What is the process for that happen, is it a ministerial direction or does it come from the hospital? How do we get it on the agenda?

Dr WHITE - I can describe it in very general terms because I'm personally not in charge of that area but I can give a general understanding of it. The intention is that it's based on the health needs of the region and Tasmania as a whole with regard to the amount of resources that are available and what can be safely provided locally and where we have the work force. Then it becomes a bit of a numbers game about how much you do with regard to waiting lists, modelled emergency department presentations and so on. To get more detail than that it would be worth having Michael address you.

Ms FORREST - There has been some concern that the Police Offences Act should be sufficient and the requirements could stop people with surveillance cameras being used in the clinic vicinity. I am sure that has been looked at by the department in developing the legislation. Can you explain why that act is not adequate and what impact it would have on that sort of activity in the area?

Ms STEWART - The Police Offences Act is not considered to cover the range of activities that occur outside clinics in Tasmania. It is correct to say that there are not often large numbers of people outside the Tasmanian clinics; there are small numbers. These small numbers are not required to obtain a permit under the Police Offences Act. Section 49AB of that act says 'a person must not organise or conduct any of the following activities without a permit if it is held on a public street'. It covers fund-raising drives, road cycle events, and a demonstration or a procession. These are defined within that act. They draw in with them the idea of large numbers of people. Unless there is a large number of people you are not required to have a permit under the Police Offences Act, so we do have a gap there. From a drafting perspective, the task is then how best to cover that gap. Your options are to signpost bits of the Police Offences Act that may apply under the nuisance provisions. It was my feeling that it was better to name prohibited behaviour and define that in the one area so that it is quite clear in the bill what behaviour is captured under that definition, rather than it be by a piecemeal basis.

Dr WHITE - And it was context-specific.

Ms STEWART - That is right.

Dr WHITE - While the Police Offences Act applies to everything, the intention in raising it here was that it applied only to the locations of terminations.

Mrs HISCUTT - You are trying to cover one or two people that stand out the front and harass and intimidate; is that the intent?

Ms STEWART - To cover all, whether small numbers or large numbers.

Mrs HISCUTT - So **t**he Police Offences Act would cover the large.

Ms STEWART - The demonstration or procession.

Mrs HISCUTT - So if you have individuals or up to five people, let us say, they are not covered under the permit system.

Ms STEWART - It doesn't t appear to be.

Mrs HISCUTT - They would be covered, in your opinion, under harassment. You are not allowed to go out there and swear at people in the street; that is against the law.

Mr MULDER - There is a specific section of the Police Offences Act which says 'jostle, insult or annoy.' I think that sort of behaviour -

Mrs HISCUTT - That would cover that already?

Mr MULDER - It would.

Mrs HISCUTT - Why do you think it is not covered already?

Ms STEWART - The thing that has been pointed out to us also is that sometimes that can actually be looked at from the perspective of the public as a whole, as opposed to the perspective of the woman. It is something we accept, that one person has the ability to make another feel uncomfortable or upset or impose stigma; it does not in fact require a number of people to do that. The intention of the access zone provisions are to have it in one particular area. We have no doubt it covers it.

The other thing about the Police Offences Act is that it doesn't establish a zone; there is no area that is established. The bill creates the area and clearly defines the behaviour that falls within it, and it adopts the penalties that we feel are proportionate to the offence, instead of drawing in those ones that might be appearing in the Police Offences Act.

Mrs HISCUTT - How do OH&S rules come into that, because the clinic is a workplace, and being on a workplace, if you are in the hallway it is the same thing as in the forestry industry. If you are protesting in a certain area, you are already out of line. Can you see that applying here?

Ms STEWART - I do not believe that the police have the power to arrest somebody for standing on the street, holding up a sign or handing out pamphlets.

Mrs HISCUTT - Even if you find it intimidating or insulting?

Ms STEWART - No. That is why we have gone down the path of the access provisions. We want to make it abundantly clear. It is quite distinguishable from forestry protests where we have seen that police have the power to come in act. We have been told that complaints have been made in relation to the protesting that is occurring outside the clinics in Tasmania and that they have not been moved on. That cannot be stopped.

Dr WHITE - They have not been to date.

Ms STEWART - So we still see them in clear view of the clinic.

Mrs HISCUTT - Is it a big problem? Is it happening a lot?

Ms STEWART - Is it happening in Tasmania and I can attest to seeing two gentlemen standing outside the clinic holding up signs and frames. I am sure that when you talk to other support organisations that deal with women's experiences that this would be coming through that as well.

Ms FORREST - With regard to the concerns that were raised about referral requirements for conscientious objection, we had a number of discussions with witnesses about referring to another medical practitioner or service because it seems that would make it easier in some locations as well as more practical and reasonable. Looking at how you ensure that the service is an appropriate one, is it just giving the contact details and those things of the service? The same with the counselling people; they are required to send them to another counsellor, but sometimes another service may be able to provide the counselling and it is not just a counselling service. It could be a women's health service, for example. There were some concerns around that. Is that a reasonable thing from your perspective, that you could include that without diminishing the intent?

Ms STEWART - I do not believe that adding the word 'service' in there is a problem at all. If you can give it meaning so that we make sure it is about women accessing the right kind of service that is something that would not change the intent of the underlying policy goal of that section. If you took the approach of taking something like a prescribed service, you could then prescribe the services in regulations, so that if names changed over time, for example, it would be a relatively easy matter to amend the regulations and they could be taken before the parliament.

This leads me to an article that appeared in the Victorian AMA publication called *Vicdoc*. That article was commenting on a decision of the Medical Board's Performance and Professional Standards Panel in January of this year. That was in the context of Victoria's legislation, which uses the word 'refer'. It does not say 'effective referral'. It just says, 'Refer the woman to another registered health practitioner'. That article noted that a doctor had failed to refer and that behaviour was considered to be unprofessional conduct. In reaching the decision, 'The panel considered the law and the doctor's conduct in the context of the reasonable expectations of the community and the practitioner's professional colleagues within the contemporary environment'. It concluded that the word 'refer' under the legislation requires that, at minimum, a practitioner send or direct a patient seeking an abortion to another practitioner who does

not have a conscientious objection to abortion, or otherwise facilitate access to such a practitioner. In the panel's view this duty will be discharged if the doctor provides the patient with the name of a non-objecting medical practitioner or health service such as an established family planning centre or an appropriate reaccredited abortion clinic.

That article is also useful because AMA Victoria is saying to its members essentially. and I read again:

> Our advice is to consider your conscientious objection a conflict of interest. As with other conflicts of interest, the conflict should be avoided where possible and made known if necessary. To avoid the conflict, signs placed in your waiting room or on your website stating that you are not available for advice or assistance with terminations of pregnancy should serve to ensure you are not confronted with a dilemma. If it becomes clear that a patient you are seeing is wanting help with a termination, stop the consultation at that point and advise you have a conflict and then you can refer the patient on to a family planning clinic.
>
> Doctors who are troubled by this should remember that at the family planing clinic the patient will be discussing her pregnancy with another doctor and regardless of her intentions from the outset, it is not a certainty that she will proceed with a termination. If you refer her as soon as you become aware that she may be considering a termination; that is, you refrain from any further discussion, you are in fact referring her to family planning for advice on her pregnancy and there may still therefore not be a termination as a result for all sorts of intervening reasons.

Ms FORREST - Are you able to table that, Doctor?

Ms STEWART - Yes, we can. I have some copies and I can email it, if it is appropriate.

Dr GOODWIN - On that point, from what I can gather from what you have just read, it would be sufficient to just hand the patient a flyer with the details of family planning; that's what I picked up from that.

Dr WHITE - Yes, that is providing information.

Ms STEWART - The main goal really is so that the woman does not walk away not knowing where to go next so that her access is not impeded.

Dr WHITE - To continue in the same vein, you could have on your sign, 'I don't want to see patients to talk about terminations. If you are intending to do that, I suggest you go and have a look at the family planning website.'.

Ms FORREST - Or there may be another doctor in the practice who will do it.

Dr WHITE - Absolutely. It is not meant to be onerous on the doctor, but it is also important that the responsibility of the doctor to look after their patient is discharged.

Mr VALENTINE - Do you see that flyer as something the department might be committed to produce and update on a regular basis?

Dr WHITE - We could have a think about that. There may be others who are better placed than us.

Ms STEWART - I imagine it will generate itself over time, if you like; that over time doctors' names will become known if they go down the path of referring to another doctor, so I imagine someone like Family Planning will probably in any event be doing something like that.

Ms FORREST - It would make it much easier with the prescribed services as you suggested would be the case.

Dr WHITE - I think some sort of qualifier such as was put into that by Cherie would be useful to make sure that we don't set it up so they could refer her to Jim's Mowing because it's a service - we want her to go to an appropriate service.

CHAIR - The committee can certainly get its mind around that as an issue. We will draw this part of our hearing to a conclusion. Thanks very much.

THE WITNESSES WITHDREW.

PUBLIC

Ms JUDY HEBBLETHWAITE, PRESIDENT, **Ms KIMBRA BOYER,** VICE PRESIDENT, **Ms MARIANNE WYRSH,** YOUTH HEALTH FUND COORDINATIOR, **Mr DAVID PEREZ,** CHIEF EXECUTICE OFFICER, THE LINK, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome, everyone. You are probably familiar with the circumstances of a parliamentary committee and the fact you are protected by parliamentary privilege while here, so nothing you say can be challenged by anybody anywhere. If you choose to make comment to anybody outside this committee as to the proceedings, they may be actionable against you but that is for you to consider and be cautious about.

Ms HEBBLETHWAITE - I would like to open with a statement on behalf of the board to indicate that we support an approach that ensures Tasmanian women have the right to understand and access a full range of reproductive health options available to women in other jurisdictions in Australia. The board welcomes legislation that will ensure women and doctors in Tasmania are no longer threatened with criminal sanctions for terminating a pregnancy and where women are able to access unbiased advice when confronted with an unexpected pregnancy. We believe the proposed changes outline an ethical framework for the termination of a pregnancy that will improve reproductive health, particularly for young Tasmanian women.

I would also like to request that when Marianne and David provide their evidence it could be considered in camera due to the nature of some of the evidence around the cases of the young women who access the services of The Link.

CHAIR - The committee would need to consider the notion of taking evidence in camera and we would be happy to do that, but it may not be necessary to mention names.

Ms HEBBLETHWAITE - It won't be names that we mention, it may be that the circumstances would identify them or the health practitioners they might have interacted with.

CHAIR - Let's proceed for the moment and we can come back to that towards the end of this presentation. We would have some questions based on your submission anyway, so is there any generic type of evidence?

Ms BOYER - We are really clarifying that our board is very diverse and has a significant level of experience across a range of health and education issues. We unanimously support this particular legislation and have four underpinning reasons for that. I think you just heard from the previous witnesses that the issue of the failure of the public health system to provide access to women to terminations of pregnancy is a major issue and has been well before the formation of the state health organisations. I used to work in the health system and it's been an issue for quite a long time. It started with an issue of conscientious objection but it has become almost in the area of cost-cutting. It is regarded as a superfluous service.

Our strong view is that the change in the legislation will further enable the health system to provide access to abortions or termination and appropriate counselling and clinical

support that surrounds those, which at the moment is not available. I think we are the only jurisdiction in Australia where it isn't available and we think that is not appropriate. That means that when terminations are undertaken in Tasmania, or when our service sends young women to the mainland for terminations, the issue of quality, particularly clinical quality, is not necessarily justifiable or not being able to appropriately follow through. We are very confident in our counselling service, and the counselling service that our team provides, but that counselling service isn't available to all women and we very much fear that some women who access abortions interstate don't have the necessary counselling, follow-up and support.

Even more serious is the appropriate clinical follow-up and support. If they have had a very adverse clinical experience here and have gone to the mainland or to another clinic, then being able in their normal health system to follow up in terms of appropriate quality and clinical support is a major issue. So we think there is quality of health issue. That quality of service is something we take for granted in our health system. I thought that the Victorian AMA comment was very important as part of that process.

The third thing is that there is a significant issue of equity here. Women with access to information, support and resources can in the current legal situation obtain abortions. For some of the people Marianne and David are going to be talking to you about, this is not possible. For young rural women there are obviously some issues. It is even more of a hassle, and the clinical follow-up after a termination interstate is an issue.

The Link Youth Health Service has been providing support through a program called Innovative Health Services for Homeless Youth for women across the state, but again that can only be provided to women who are 24 and under, so there are women in very parlous situations who are over 24 that we can't help. That is something that breaks our heart.

They are the general issues we believe the legislation must address. While it still remains part of the Criminal Code we very much feel it enables those people who don't want to do abortions and those people who don't want to face up to the fact that they have conflicts of interest, and deal with them as conflicts of interest, are able to have what they see as the system on their side rather than on the side of the individual clients. We speak for the young clients we serve, and those who we can't serve because they are a little older. We speak for women who never go into this situation lightly but deserve all the support they can to make the best informed decision they can.

Mr VALENTINE - My question is in regard to the 16-week limitation. Do you have any thoughts on that limitation as to whether it is adequate or inadequate?

Ms BOYER - In terms of general principle our view would be that if we had a properly functioning service or system whereby there was early intervention, then the 16-week issue wouldn't become the issue that it is. We have stories of where clinics have been deferred or delayed and where clinics have been happening fortnightly, and in that fortnightly delay you can move into the 16 weeks totally by accident or by cancellation or by a whole lot of other things, which is entirely inappropriate. We would not want to get tied up on the 16 weeks; we would be looking at a system that flows appropriately and where women have appropriate interventions as early as possible.

Ms FORREST - You have alluded to the history of the change with the public system not providing them, but are you able to give us some more information about what actually happened - the conscientious objection that happened?

Ms BOYER - It happened in different places in different parts of the state at different times, but we became aware through the Innovative Health Services that there was a gradual build-up of people coming to seek funds from that program for terminations. As we dealt deeper into the system - this was very early on in my time on the board and just after I had left the health system - we became aware that it was because particular people in particular settings were doing it. For example in those early stages there was a practitioner on the north-west coast who was still performing terminations in the North West Regional Hospital and people were going there from the south and the north to access those. At some stage there were people in the north who were doing it and not in the south. It seemed to start from the south and it seemed to start from a particular issue. I don't know whether you remember a young medical graduate. That was certainly when it became publicly aware, but we have been seeing a growing number.

Ms WYRSH - That's what sparked that situation. I can say that with the Youth Health Fund, as it now referred to, before the major expense and request financially on the fund was around counselling, particularly in the north-west. Some 80 per cent of the budget was used on that. Then they introduced the Better Mental Health Plan. That has worked brilliantly, so there is less impact on the funds. So lots of decisions, whether legislation or program-based and introduced by the commonwealth, can affect the cost to the funds, so it changes.

With regard to the fund, because it is a youth health fund, with a lot of people in puberty and early adulthood, a lot of it is about sexual health. There are a lot of things changing - their brain, hormones and things like that - so a lot of the requests coming to the Youth Health Fund are around sexual and reproductive health. When that became public there was a fear. We have heard of practitioners saying as a reason that, in front of a young woman and her boyfriend - and her boyfriend's mother was also there - basically he wasn't going to go ahead with the procedure because he didn't want to get his pants sued off. It seems that when it became public that it is the Criminal Code it frightened a lot of practitioners. They thought, 'I don't want to be in that position that I might be sued because it is under the Criminal Code'.

Ms FORREST - Are you aware of the action the medical graduate took and what he did?

Mr MULDER - I think from memory he complained to the police and the police interviewed the doctor. It went absolutely no further than the one-off interview, and as a result of that an entire medical profession have irrationally been spooked.

Ms BOYER - You are a very brave man to say that about the profession. It certainly was a major issue of concern. The fact it was in the Criminal Code and that police were involved was a major issue. I think it also related to a lack of leadership within the Royal Hobart Hospital at the time, but it was something from which the public health system has not yet recovered and our belief is that this legislation will help it recover. It will enable appropriate ministerial directions and other things.

Dr GOODWIN - You did mention the cost-cutting aspect of it as well. Do you think it evolved into that or is it an accumulative impact - that we are unsure about the law, plus there will be a cost to providing that service?

Ms BOYER - I won't answer it directly but I do think that there is an issue about it. Because the money from the Youth Health Fund is a quantum amount and because we were overspending and cost-shifted within the organisation, we were paying for terminations out of other parts of The Link budget which we shouldn't have been using. We went to successive ministers to complain about the situation and our argument was that the state and the state hospital system should fund it because we were actually providing funding and access to services that in every other state was provided through the public health system. In each of those cases we have had our budget topped up to enable that to occur.

Ms HEBBLETHWAITE - The fund itself should be used for a variety of other purposes, like oral care, dental care, a whole range of other matters.

Mr PEREZ - What we are finding is that it happens every year, that the impost that the paying for termination has on the fund, pretty well takes money away from a whole lot of other things. We need something that should be provided by the public system.

Dr GOODWIN - Can you tell us how much the fund is?

Mr PEREZ - The overall funding for the Youth Health Fund is around $120 000 but that includes a whole lot of other things that the fund does including wages and a whole lot of things. Roughly every year, we have had to top up by at least $30 000 specifically for assisting young women with terminations.

Dr GOODWIN - How much do you think is being spent a year on terminations?

Ms WYRSH - We have a breakdown back from 2009, where on average, that year, it was $57 500 and then in 2010-11, $59 400; in 2011-12, $58 000 and then this last year, I haven't got the total figures yet but it's around the $50 000 mark. What's included in those costs, particularly as we are working with the younger age group, for example, if they have to go to Melbourne for a procedure, every single case that I have been involved with is different. I don't work one-to-one with clients. I am just the person who does the money stuff and hopefully makes the worker and the young person, when they are working with practitioners, it smooths out that process. I talk money. Since Marie Stopes have taken over the Croydon Day Surgery, that amount has significantly increased and it depends on the gestation.

The procedure, if they are going to Melbourne, it's at least $1 300 and then as each week goes by it goes up and up, to potentially $5 000, $6 000, $7 000 just for the procedure. They don't have in-hospital care there any more. Whoever goes to that clinic, whether some of the procedures are in a day or it could be two or three days, they then have to go and stay at a local hotel, where there is 24-hour access to ring a nurse, should something happen. The fund looks at each individual woman, depending on age and maturity. We will pay for a support person to go with them. We would never just say, you are off the support. It's a huge -

Ms FORREST - Do you fund two people to go?

Ms WYRSH - Yes. Quite often a parent has gone with a daughter. We are not silly. It's not like you take a friend and 'Oh, a free trip to Melbourne'. It's someone who is a support person that goes with them so there is their air fare as well plus -

Mr PEREZ - Yes, but where possible they might contribute as well.

Ms WYRSH - It's always us, 'Can you contribute?' and if they can but sometimes they can't, there is nothing. You could have instances where both parents are on a disability pension and their daughter was - this was a procedure that happened in Tasmania actually - saying she thought she actually wanted to go through with the pregnancy, so it's not always decided once they have come to The Link. As soon as a young person comes into The Link and discusses they are pregnant, 'I don't know what to do' or 'I have been to see so-and-so doctor and they have said I have to make a decision now because I'm this many weeks and if I don't make it now I won't be able to have it', we will always say, 'You have time. You need to be sure about this decision that you are making. You may have to go to Melbourne if you decide to go ahead with this. We can help you with that. What we are wanting here and now is that you are sure of the decisions that you are about to make'.

With this particular woman, we paid for her to go to see a specialist psychologist to discuss the pros and cons of going ahead with a pregnancy or to terminate so that she had actually thought through all of that. The result of that particular case was, after seeing the psychologist and really thinking about it because she had more time, and it was her decision and not her parents saying 'You can't have this child', she decided that the correct decision, for her at that point in time and her whole situation, was to have that termination so that went ahead in Tasmania.

I can give you hundreds of cases and they are all very different. It really depends on the person, the family, their support. Other women will come in and maybe they've had one or two children and they are very clear from the start that 'I cannot go ahead with having another child'. In some cases it's not that they have not been considering what might happen if one has intercourse and what sort of contraception they can go with but sometimes they are allergic. I have had a woman tell me she has tried all of the pills, the condoms, Implanon - she is one of the unlucky women who are allergic or have really bad reactions to those forms of contraception and that's why she became pregnant. She had already had a child and had this pregnancy on the way so we always try to assist in supporting them and she said she would have an IUD but only under a general anaesthetic because I think she had - and I don't need to know the whole story - it's like 'I'm listening to you, what your situation is like now', and sometimes they are in tears, they are panicking, they are really stressed. For her that scenario worked out well. She was able to have the procedure in Tasmania and she was able to have the Mirena but The Link Youth Health Service supported her. She had no money so we supported her in making sure she could get in with the relevant practitioner, she would get a script for the Mirena and she was then able to be referred to that clinic in Hobart in a timely fashion because they are only there once a fortnight.

At the one in Moonah they are only there once a fortnight. They are fly-in, fly-out practitioners so if something happens - flights are delayed, there is a death in the family, sometimes people need to have annual leave, you don't want to get burnt out - the clinics

will be closed so there is a whole range of reasons why it's much harder for young women to get in and access, if that's the decision they have to make, an early-termination of pregnancy. There are so many barriers in the way that lead to the more likely scenario being a later-term termination.

Ms BOYER - It goes back to your original question that if the system was improved at the front end -

Mr VALENTINE - You wouldn't be dealing with the end.

Mr PEREZ - Even if one of the clinics is not open, a delay of a fortnight could be crucial. If we had a decriminalised system where access was more equitable across the board, we would not see some of the later-term terminations.

Mrs HISCUTT - Last financial year, did you say it was $52 000 or $57 000?

Ms WYRSH - The 2012-13 financial year or the one before?

Mrs HISCUTT - How many women does that fund?

Ms BOYER - We can provide you with the table of figures, but we would appreciate them being kept confidential.

Mrs HISCUTT - A ballpark figure would do - is it 10 or 100 women?

CHAIR - I think in the context of what Kim just indicated, they are prepared to give us the information but it is sensitive, so on that basis we would treat that as in camera.

Ms BOYER - Simply as an indication, this is young women of a particular age group who are particularly financially disadvantaged. This is not the be-all and end-all of the figures, these are only the figures of the service we provide - and there are lots of others.

Mr MULDER - I just worry about the need for confidentiality surrounding such global non-identifying data.

Ms BOYER - Can I explain why?

Mr MULDER - If there's only two, I can understand, but if there are 20, 50 or 150 -

Ms BOYER - We are keen for it not to be widely publicly known that our service is subsidised by government to provide terminations.

Mr PEREZ - It is an issue, too, around some of the figures and because of the nature of Tasmania. If you look at those figures from the north-west, for example, we know there is only one practitioner in the north-west doing terminations, so although the data is not identified it is very easy to make a connection between the data and the individual.

CHAIR - We might be going into the area of your request for in camera evidence.

Dr GOODWIN - Would it be possible to break that down into the mainland terminations and the local ones?

Ms BOYER - Yes.

Mrs HISCUTT - The people who work for you, your frontline workers - psychologists and counsellors - can you tell me how many you have that are contact people and what qualifications do you require of them?

Mr PEREZ - The first person a young woman would see would be a youth health worker, of which there are five, and they are minimal diploma level. The Link youth health service is also the lead agency for Headspace Hobart which employs GPs and psychologists.

Evidence taken in camera.

CHAIR - We will go back into public session.

Ms FORREST - From some of the discussions we have had about the provision of termination of pregnancy services and the history, some might argue that having termination of pregnancy services in a regular gynaecology ward may not be the most appropriate location but a separate clinic setting may be more appropriate to give the counselling and support. We're talking more about publicly-funded access to terminations as opposed to providing terminations necessarily at the Royal Hobart Hospital, the LGH and the North West Regional Hospital, for example. Is that what you are saying?

Ms BOYER - In the distant past when they were provided in the public system they were provided in the gynaecology wards but in particular sessions, which enabled people who had conscientious objections not to be part of those sessions, and that seemed to be quite good. I'm not a specialist at organising clinical services but my view would be that you would let those providers determine which would be the best quality, best accessible, best type of service that could be provided from both the client's perspective particularly but also the clinician's perspective.

Ms FORREST - You have theatre staff, anaesthetic nurses - a termination doesn't happen with just one person present.

Ms BOYER - Absolutely not, and the follow-up becomes crucial. It isn't just the period of the termination, it is the pre and the post that are very important.

Ms FORREST - So for people who have a conscientious objection that extends to all those areas, so maybe publicly-funded terminations outside a hospital may be another option that should be a part of the considerations?

Ms BOYER - Indeed.

Mrs HISCUTT - Dealing with young people, as you do, do you find there is a lack of information on contraception amongst this group? Do you think sex education could be improved in schools?

Mr PEREZ - There's not one fix to this. Sex education can certainly be improved. I believe there are some really good moves currently happening within the department and the national curriculum. We mustn't forget that contraception fails; there is no single contraceptive company that would say theirs is 100 per cent effective. We can do a lot better with education that looks at relationships and consent and being in a headspace where you can have sex with someone rather than because you want to.

Mrs HISCUTT - Do you think there is a degree of ignorance amongst younger people?

Mr PEREZ - Less than what we perceive. With people we see at The Link, often there has been a failure of a contraceptive, generally condoms. Occasionally they might have been having sex when they weren't prepared at a party, so we're dealing with adolescent behaviour which tends to be risk-taking anyway. Even with the knowledge there is still the potential that can happen but I believe the level of sexual education we currently have in schools is inadequate, although there are definite moves in improving that.

Mrs HISCUTT - So you would be aware of a report that came out recently - 169 pages - from Uniting Care?

Mr PEREZ - I am aware it exists but I haven't had the chance to read the report in detail.

Mrs HISCUTT - I was interested in your opinion because that report says the understanding of contraception is very minimal.

Ms FORREST - On the north-west coast particularly.

Mr PEREZ - I think it's a fairly small sample.

Ms BOYER - It is a tiny sample of approximately 50 kids, so I don't think you can make a judgment on that.

Mrs HISCUTT - In the bill it talks about fines for counsellors who don't refer on. Would you like to give your opinion on that part of the bill?

Mr PEREZ - It is a part of the bill that we support and very important. If we have a client come in and we are providing advice, be it clinical or psychological, if it is something that we can't deal with because we don't have the expertise or someone has a personal objection, it is really important for the continuity of care that that person has access to the right information. Otherwise what you are saying as a clinician is I am not going to tell you the full truth. I think a person has the right to all the information so they can make a decision.

Dr GOODWIN - You mentioned the ectopic pregnancy example where the Royal was not prepared to perform a termination in that situation. Are there any other examples where you would think it would be fairly straightforward that a termination would be warranted where people have come to you and said, 'The Royal won't help me'?

Ms WYRSH - That's the only one I'm aware of. I guess the main stories that we hear from people and particularly from the Royal is that 'you have to hurry up, you've only got this amount of time'. That is more common. The ectopic pregnancy is the only one I've

heard of and I don't know why that happened, although she is a particularly difficult young person so maybe they just didn't want to work with her.

Ms FORREST - This is an obstetric emergency, though; you've got to be in theatre within hours, generally.

Mr MULDER - I think in fairness we're getting one side of the story from someone -

Ms WYRSH - Yes, and it's only one case.

Mr MULDER - who is difficult to handle, and no-one's ever gone to the Royal and said, 'What did she tell you?'.

Dr GOODWIN - I am just trying to get a feel as to whether there was a general pattern.

Ms WYRSH - No.

Mr PEREZ - I think because the current legislation doesn't support an approach that is through the health system, whether it is delivered by the health system or contracted, there is no real quality across the current clinical system for termination. The stories can vary far and wide and it can change. Currently in the north-west, for example, there is not much of an issue because the practioner would inform them, but it only probably takes that person to move out for it to then become an issue.

Dr GOODWIN - Or retire.

Mr PEREZ - Yes. We currently have a system and I strongly believe that parties, because of the fear - you can run the case that no-one is going to be prosecuted but they can be, and if no-one has then what is it doing in the Criminal Code anyway? I don't think it allows for an homogenous system of care that has strong quality control.

Dr GOODWIN - In terms of the services you provide, would you be the major provider of youth health services in the state or would there be others who might be providing similar assistance?

Mr PEREZ - We would be the main one in the south. The Youth Health Fund is run a bit like a brokerage so we have the funding to run the fund but there are people from other agencies that we don't directly employ who spend it for us.

Ms WYRSH - A central criterion for them is that they work with that age group on a daily basis and have one-to-one contact so that when they're talking to a young person it's in a confidential setting. The idea of the fund means that hopefully it doesn't matter how isolated a young person is or where they're living, they have reasonable access to the Youth Health Fund. We have work from Dover to Flinders Island.

CHAIR - Thanks very much; we appreciate your evidence.

THE WITNESSES WITHDREW.

PUBLIC

Ms MARILYN BEAUMONT, CHAIRPERSON, AUSTRALIAN WOMEN'S HEALTH NETWORK, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Marilyn, welcome to the committee. Have you appeared before a parliamentary committee previously?

Ms BEAUMONT - I have.

CHAIR - So you are familiar with the protection of parliamentary privilege which is afforded you?

Ms BEAUMONT - I am.

CHAIR - Thanks for your written submission. There will be no doubt some questions flowing from that which you have provided but we extend to you the opportunity to speak to it if you wish.

Ms BEAUMONT - Thank you. I will take up that opportunity. In representing the Australian Women's Health Network, it is an organisation that has a vast membership of organisations and individuals across Australia and that includes within Tasmania. Our submission comes from the national board which has representation from Tasmania on it. It draws from evidence based very much on our most recent publication which I have here today, which is on women's sexual and reproductive health. All of the knowledge and evidence that is currently available has been brought together in that. I touch on that later in my submission.

In addition to that, my submission is informed by my past and current work within health service provision and health policy and legislation and so on. I have been working as a nurse since I was 17 and have come through direct clinical work into a representational role within the Australian Nursing Federation, and held various positions there between 1987 and 1995. That included representing nurses in areas where they were exercising a conscientious objection to certain procedures that they didn't believe should be given to a patient or undertaken by a patient. I have been involved in counselling nurses around things like that.

In my position as CEO of Women's Health Victoria during the period 1995-2009 I was very much involved in the advocacy around removal of abortion from the Victorian Crimes Act, and also as a member of Victorian health service boards and I was on Melbourne Health Board for three consecutive terms over nine years. Most recently, I am into my fourth year on the Northern Health Board and I am currently the Chair of that board. I can see and understand the services which are offered within public sector acute health service providers. Northern Health sits in an area of extraordinary growth in the growth corridors of Melbourne and quite a big pocket of marginalised, disadvantaged and quite diverse communities. I bring all of that to my submission and I really welcome the opportunity to address what I think is a really important piece of legislation for the health of women in Tasmania.

The position that the Australian Women's Health Network takes is that removal of abortion from the state criminal codes is a classic case of parliamentarians catching up with the people. I think that the majority of people support removal of abortion from the Crimes Act when they understand that it's actually in a crimes act. Most of them don't understand that and don't think that and when they do they think and say, 'Why is that the case?'

All of the evidence suggests that removal of abortion from the Crimes Act reflects what a vast majority of voters would want done. On the one hand they say, 'Remove it from the Crimes Act' but they also say, 'We want to have fewer abortions'. The two things are not inconsistent in that decriminalisation and being in favour of fewer abortions are two quite important issues for discussion in our community.

Fewer abortions is not tied to access to termination of pregnancy; it's tied to a better sexual and reproductive health education process. Removing abortion from the Crimes Act merely codifies what is current clinical practice and does not result in either more or less abortions. What causes abortion is overwhelmingly unwanted pregnancy, and what causes unwanted pregnancy is disempowered women coerced into sex or as a result of violence, or poor or non-existent contraception. There are many examples of women already having had a number of children when contraception fails and they find themselves pregnant. They don't find themselves pregnant because of no action on their part. They find themselves pregnant because they have been involved with a man and they have had sex and the contraception has failed. So the connection between the reliable contraception and men taking more responsibility for contraception we think lies within the need for better sexual health and reproductive education.

Our position on decriminalisation is part of a more comprehensive agenda for action to promote women's sexual and reproductive health and I'm happy to discuss that further.

The other thing I'd like to touch on is the issue of stigma and shame. There are many examples in history of what seem to us today to be very common social and health issues that are being kept secret or have been kept secret in the past. Examples include pregnancy out of wedlock, rape, cancer, mental illness, sexually transmitted infections, to name a few. We are not very far past the time when to say you had cancer was a thing of great shame; you would be surprised by that but that is the case. And attached to these being kept secret is stigma and shame, even casting out. Stigma is a mark of disgrace that sets a person apart and stigma brings experience and feelings of shame, blame, hopelessness, distress and reluctance to seek or accept necessary help.

For health professionals, because of their work in a particular field such as pregnancy termination services, stigma means that they themselves are seen as corrupt, evil and so on. Health professionals can also be contributing to a patient experiencing stigma and shame by the way in which the service is provided. We think the conscientious objection clauses in this legislation are important in addressing that occurrence. Individuals and organisations who oppose action to make access to abortion safe and legal invariably base their campaigns on predictions and vilify and threaten anyone being public in their support for decriminalisation.

I have personally experienced that. When we first became involved in advocacy to seek to remove termination from the Crimes Act, a number of very well-respected

parliamentarians said, 'Marilyn, why would you expose yourself to such threats and vilification?', and I said, 'Why wouldn't you face them and do something about this? It's time.'. It was certainly the experience in Victoria between 2003-08 and I would understand it is the experience in Tasmania as well.

Such statements as decriminalisation will lead to abortion on demand and more abortions are clearly wrong. This has not been the case in Victoria or the ACT following decriminalisation, despite abusive and threatening pamphlets within electorates of supportive MPs and hate mail to their electorate offices. Women's health advocates were also being exposed to this hate mail and Women's Health Victoria had to implement quite extensive processes to keep our staff safe and secure because of the hate mail. That shouldn't be the case in a democracy when we are having what I think is a very important discussion about an issue of such importance to women's health.

The fear this action is intended to generate is part of silencing and maintaining stigma and shame, and we should name it for what it is. We all have a role in creating a healthy community that supports social inclusion and reduces discrimination. Ways to help include talking openly about our experiences and encouraging those who are in representative positions to be involved in an open and informed discussion. I remember saying to many of the parliamentarians after the Victorian legislation I felt very proud to be part of such an extraordinary debate in such a healthy democracy. There were views expressed on all sides of the spectrum, and that should be happening within our country.

Removing abortion from the Crimes Act and making laws which give parameters for the provision of abortion within the health sector does not lead to more or less abortions. Maintaining abortion in the Crimes Act would maximise the pain and shame women experience in doing so. Some would say the current law is fine but we say they are wrong, as the current statutes only work when they're not enforced. Removal of abortion from the Criminal Code is an important step in bringing the laws up to date with contemporary thinking and contributes to our moving beyond stigma and shame through threat of criminal prosecution.

Doctors who provide abortions should not be treated like criminals. Making it illegal to beset, harass, intimidate, interfere, threaten or impede a person within a radius of 150 metres from premises at which terminations are provided also makes a significant contribution to moving beyond stigma and shame for service providers, women and their families and those supportive people who go with them to access termination services.

Equity in access to termination of pregnancy services is a pressing issue. Financial status, geographical location and the legal context all bear upon readily available services being accessed in Tasmania. Decriminalisation is an important step towards exposing and understanding what these access issues are about. Community and health service provider education about implementation of the new legislation continues beyond the point in time when the new legislation is enacted, and we continue to do that in Victoria.

I will turn briefly to the issue of patient and consumer-focused care, patient rights and conscientious objection. There has been a lot of work done over many years, most recently with the Australian Charter of Healthcare Rights developed by the Australian Commission on Quality and Safety in Healthcare. In July 2008, all Australian health ministers endorsed the charter as the Australian Charter of Healthcare Rights for use

across the country. The charter applies to all health settings anywhere in Australia, including public hospitals, private hospitals, general practice and other community environments. It allows patients, consumers, families, carers and service providers to have a common understanding about the rights of people receiving heath care.

There are two areas I have drawn attention to in my submission and they are respect and communication. The charter outlines respect as care provided that shows respect to me and my cultural beliefs, values and personal characteristics. Communication outlines that I receive open, timely and appropriate communication about my health care in a way that I can understand. It talks about the right to be informed about services, treatment, options and costs in a clear and open way. Patient- and consumer-centred care is something which has become much more central to health service accreditation standards and is certainly one of those in the new accreditation standards that all healthcare services must meet. I am very much involved in that work at Northern Health.

The charter of patient and consumer care identify the rights of health service users and gives reasons why health professionals do not have the right to impose their personal views, whether moral, religious or ethical on their patients. Conscientious objection is the notion that a healthcare provider can abstain from offering certain types of medical care which he or she does not personally agree with. The right for health professionals to be able to exercise that is entirely appropriate and operates across a range of areas. There must be boundaries between professional obligations and personal morality. Can personal morality override professional duty when it comes to patient care? I think that has been an active discussion within all my years in health service provision and in representing nurses as the development of new diagnostics or new interventions continues, it is a very important and active discussion.

The Royal College of Nursing statement on conscientious objection I have outlined, but it does talk about the need to respond as appropriate to social and legal policy initiatives to ensure that provisions are made to protect nurses claiming conscientious objector status in the case of what are considered to be morally controversial practices. These can include abortion, euthanasia or dying with dignity, organ transplantation and so on. We will continue to have a discussion about these things probably forever.

The approach can be found across all health professional bodies and clearly supports the clarity in your bill in clause 6, the duty to treat, and also the obligations on medical practitioners in clause 7. This took me to the AMA's position in Victoria in 2007 where the president of AMA Victoria put out a press release which talked about doctors' views regarding abortion being as diverse as the rest of the community. He said that AMA Victoria would welcome legislation which provides that legal certainty for doctors, rather than relying on a 38-year-old common law ruling.

I think the new Tasmanian legislation deals with this issue very well. The meaning of 'refer' was something which was talked about at length in Victoria and arising from the Victorian AMA's consideration of that, they put out a statement which talked about doctors troubled by the obligation to refer should remember that with a referral to a family planning clinic, the woman will be discussing her pregnancy and her options with another doctor who can provide her with all of the information and advice available. It is not a certainty that she will proceed to termination. During the course of the work to remove abortion from the Crimes Act we had a lot of media [reports] around what the

impact of it would be. I brought some of those things with me where Archbishop Denis Hart talked about the abortion bill being a real threat and that Catholic hospitals may close wards if the law is passed, that doctors would leave the state and whether they would continue to provide services until they saw what came out of the passage of the bill. They were talking about leaving the state or retiring, that nurses would quit, that they would not be coerced into providing abortion and so on. None of those things came to anything.

What I think we have to understand is that this is some of the noise that happens around what I think is a really important debate. To understand what the impact of that is if this legislation is passed, and I would say when this legislation is passed, is that none of this ever comes to any fruition, and it hasn't in Victoria.

Four years after the act coming into effect in Victoria there have been no examples of any of this impact on service delivery happening. The AMA in Victoria post the passing of the legislation put out a fact sheet and template. We were involved in making a request that they assist us with that. Women's Health Victoria was told of a situation where a young woman goes to a GP and the GP says to her in a very shaming and judgmental way, 'I don't provide abortions and neither should you be having one', the woman said, 'I'm just exploring my options'. So the template that was produced outlines for doctors how to exercise their conscientious objection. It's on the AMA's website. It allows what I think is important, making transparent and visible what the views are of a provider, and we think that should be the case of all health service providers where the public sector, private sector, Catholic hospital or otherwise - and in our Sexual and Reproductive Health position paper we say that anybody who is providing counselling or pregnancy options, and they advertise their services as pregnancy options, they should be making it transparent whether or not they have a view about termination of pregnancy because a woman needs to know that. Catholic hospitals should be the same in terms of their services, including the intervention for somebody who has been sexually assaulted or needing contraception after giving birth, and so on. The full range of services should be available and if they are not, make it transparent that your services are limited in some way.

The other thing I would like to touch on very briefly is my role on health boards. One of the things that taking abortion out of the Crimes Act does is to put the legislation in a report that health boards should get on how the health service is being compliant with legislation which impacts on its services. It enables us to have a conversation about: do we provide termination of pregnancy in this health service? What does the population health data tell us about what the population needs are? If we don't provide it, should we? If we don't provide it, who do we refer to? What sort of service delivery interface do we have? If we don't provide it, on most counts we should be. I think it was the case most recently in Bendigo, where one medical practitioner was basically hounded out of town by protesters who came every time they were providing a service and there was some difficulty in continuing that service delivery system with no leadership coming from the health service executive or board. It is incumbent upon us to be saying there are a full range of services which should be provided and we should have practitioners available to us who provide those services. We should promote the fact that we provide them and make sure we provide them with some continuity.

That is the scope of the submission we make and I am happy to go into more detail and answer any questions.

Mr VALENTINE - Is the issue of coercion a major issue in your experience and do we need to somehow cover that?

Ms BEAUMONT - Coercion being through protesters - ?

Mr VALENTINE - No, the partner of the woman who is seeking the service. In your experience, do you see that as a big issue?

Ms BEAUMONT - If the woman were in an environment of supported decision-making and that were something which was in play, that would be something that should be brought to light during the process of decision-making. Supporting the woman through the decision-making is key. Yes, there are situations of violence leading to pregnancy, often the situation of violence being experienced by the woman for the first time in a relationship and falling pregnant for the first time. That is quite a big area but I don't think there is significant evidence that women are being coerced into having abortions. If we have a service system which supports women's informed decision-making and it comes to light, it can be dealt with and dealt with effectively so that it is clear it's the woman's decision.

Mr VALENTINE - With regard to conscientious objection, if the doctor has a conscientious objection, rather than referring her to another service, he hands an established information pamphlet to the woman, do you see that as sufficient?

Ms BEAUMONT - The AMA take that point and say if a doctor has a conscientious objection they should have clearly stated in their waiting rooms the fact they do and that there is a way the woman can get information and that further information can be found at your local family planning clinic. They could also have the Better Health Channel website on a notice which can be made visible in their waiting rooms. The woman can say, 'There's no point going in there and I won't be having to pay the money to be told what I can find out somewhere else'.

Mr VALENTINE - Without doing that, do you see that a doctor who passes on an information pamphlet to the woman is perhaps a way of overcoming some of the conscientious objection problems that exist?

Ms BEAUMONT - I don't even think you need the amount of information you might put into an information pamphlet to be available. The doctor should not really be in a position of expressing a view at all. If they have a conscientious objection, they don't need to enter into any provision of information. This talks about the doctor's personal beliefs, he or she is not able to offer you advice or assistance regarding termination of pregnancy, including abortion, in case people aren't clear about the language. If you require advice or assistance regarding termination of pregnancy, please ask for an appointment with doctor *x*, who might also be in the practice, or refer to the local family planning clinic and the detail is in here, or further information can be found at the Better Health Channel at www.betterhealth.vic.gov.au. On there is comprehensive information, and it is kept up to date, about where you can go for various aspects.

Mr VALENTINE - The last question was in respect to the 16-week limit. Do you see any issues with that limit?

Ms BEAUMONT - I think any limit is going to always be the point of a lot of discussion. I think there are so many different personal circumstances that women find themselves in that the ideal is to have support through decision-making about continuing with a pregnancy or not as early as possible. That is the ideal. I think that as we move into more and more refined diagnostics around foetal abnormality, the issue at which point in number of weeks you can have certain access to termination or not is always going to be problematic. If we are going to use diagnostic techniques then we have to be prepared to make decisions based on the findings, or we don't use any diagnostics at all.

Mr VALENTINE - Because that might be 18 or 20 weeks, mightn't it?

Ms BEAUMONT - That is exactly right. The longer into the pregnancy the more accurate the diagnostics can be, and that is now. So as diagnostics become even more refined and we can use diagnostics for a fuller range of foetal abnormalities, it is a continuing discussion, so I think any number of weeks is problematic.

Ms FORREST - A detailed scan or diagnostic scan is usually around 18 weeks. If we left this change of process requiring two doctors - it does not change the access as such; it just changes the processes around it - do we run the risk of pushing that diagnostic test back being done a bit earlier so that we can fit into the 16 weeks, where it can contentious, particularly with issues like fatal lethal abnormality and that sort of thing?

Ms BEAUMONT - I think we do. As I said, the diagnostics are much more accurate the longer into the gestation period we are. I think women are under pressure to have these diagnostics done, so if you said, 'I don't want to have any at all', you would be under pressure to have the diagnostics.

Ms FORREST - More from the paediatricians than from the obstetricians.

Ms BEAUMONT - From paediatricians. I find it quite a difficult area, and the need to have panels in place and various processes. There will always be the opportunity to have that because it is good practice. We shouldn't have to be mandating and compelling, because I think good practise arises in decision-making anyway.

Ms FORREST - On the other side of the same coin, perhaps, certainly beyond 16 weeks, and probably beyond 14 weeks, there is always going to be an obstetrician or gynaecologist involved in that decision-making because it is not a simple procedure beyond that point.

Ms BEAUMONT - I think that is right.

Ms FORREST - You could potentially argue that at least there is going to be a gynaecologist involved and possibly the referring GP. It originally it came in at 24 weeks to change the process. After that point of about 24 weeks generally a baby born after that has a fair chance of survival, but further on obviously the better, so bringing it back to 16 weeks sort of muddies the waters a bit.

Ms BEAUMONT - I think that is right. I think the Victorian Law Reform Commission canvassed this extensively when we had a report from them, including the issue of foetal viability and when that is and in what circumstances, and what massive technological interventions have to be brought to bear, or what outcome potentially with some difficulties and disabilities for a birth at a very early point versus terminating the pregnancy if foetal abnormality is diagnosed. I believe setting an arbitrary point of weeks is going to always be difficult.

Ms FORREST - If it pushes out to 24 weeks, a doctor wouldn't have to link it to the mother's mental health necessarily. If there is a gross foetal abnormality, it can purely be for that reason.

Ms BEAUMONT - That's right.

Ms FORREST - We are getting into the foetal abnormality issue. From discussion with the obstetricians concerned you are clearly terminating a pregnancy for the major reason that the baby has some lethal abnormality. It would no doubt have an impact on the mother's mental health and wellbeing, for some more than others, in carrying a baby with such deformity to term. They are concerned that if they just put that on the death certificate, currently it could become a coroner's case because they don't link it directly to the mother's mental health under the current legislation and the proposed legislation. There was a suggestion that if you keep the two-doctor test, whether it is 16 weeks or another time, according to the legislation that in a woman's current and future physical, psychological, economic and social circumstances it was suggested you could also include other implications of the pregnancy continuing, which would capture those things. Would that be a useful addition?

Ms BEAUMONT - Trying to find words that might fill what can be a wide range of quite difficult circumstances. The issue of lethal foetal abnormality and whether or not it is best for the woman's mental health for that to be terminated is, I think, a very difficult decision. She should be supported in the number of weeks she is pregnant; she should have the time she needs. Our health system should be skilled and experienced in supporting women in those decision-making processes. The idea of foetal abnormality and what is acceptable as a disability to some people is different with others. We had extensive discussion with the Victorian Women with Disabilities network during the period of the Victorian law reform process and they came down very strongly on the side of it being the woman's decision because her circumstances and the circumstances she finds herself in are what should prevail. I believe there are situations where that can happen along a spectrum. Sixteen weeks is very early and there is a lot of pressure.

Mrs HISCUTT - What would be wrong with lifting all those words out of the current bill - 'the current and future physical, psychological, economic and social circumstances' - and replacing them with 'medical practitioners may take account of anything which they consider pertinent', or words to that effect?

Ms BEAUMONT - It is difficult to vary legislation on the run. I am not an expert, but the more words you add the more difficult it is in its interpretation.

Mrs HISCUTT - Do you reckon this could better simplified by saying all things that the doctor and yourself deem to be taken into account?

Ms BEAUMONT - Trying to find words which take into account all circumstances is always difficult. The simpler the wording is and putting in place processes which bring expertise to bear which don't have to be enumerated in legislation, is good practice. Trying to add words to bring all the circumstances into account always makes it difficult because we live in an evolving system.

Ms FORREST - In clinical practice those assessments are made anyway and women are supported. The question is, how much do you try to prescribe the legislation and how much should you leave to clinical practice?

Ms BEAUMONT - I think we have a number of very complex interventions in our health services today. There are a range of very complex ethical issues that we deal with on a daily basis, we have good practice arrangements around how we make decisions around those things. I see this in the same context and I do think that we shouldn't have special circumstances necessarily prescribed in legislation when we do have good practice around quite difficult, ethical decisions. The more open we are about what the skills base is and what the processes are and what the patient focus care parameters through it are, the better.

Dr GOODWIN - Marilyn, I want to go back to the conscientious objection issue. I take your point about it being preferable that a woman considering a termination doesn't actually have to go through the process of meeting with a doctor with a conscientious objection and paying the fee and all of those things. I am wondering, from a practical point of view, when you have several doctors in a clinic as to how they might advise up-front that doctors *x*, *y* and *z* have a conscientious objection to abortion. Do you have any knowledge of how it might work in Victoria, in that situation?

Ms BEAUMONT - I have seen this template in practice and so you have got a group of GPs. I think it's important that the group have a discussion. That's the first thing that is important to happen and this has created an environment where those discussions are being had. If four of them say, 'We are fine about it', this notice in their waiting room or even on their website - it says to put it on your website, make it visible wherever you need to - makes it clear which of them in the practice have a conscientious objection. I think it's really healthy to have that process in place and it would be something which I would say should happen in every GP service across the country anyway. When you go to a GP and you say, 'I'm pregnant and it's these circumstances and I'm really worried', you not want to be confronted with a 'You're a bad, bad woman' attitude. You need to be able to be encouraged to explore what it is you need to explore and so knowing that from the outset, is important. I'm happy to leave this here, but it is extensively used and available on the Victorian website.

CHAIR - We do have a copy of that. Dr Cockburn has given us a copy of that and you have also referred to it in your submission.

Mr MULDER - Just to check that, is it the same?

Ms BEAUMONT - No, this is a fact sheet with a template at the bottom.

Mrs HISCUTT - I think your statement, what causes abortions is overwhelmingly unwanted pregnancies is a classic statement which leads me on to the contraception in schools and sex education. Do you have a comment or an opinion on that? Obviously it's not adequate. Would you agree with that?

Ms BEAUMONT - I think it varies and so our Sexual and Reproductive Health paper talks about the need to have a national approach and to have information available in schools and communities.

Mrs HISCUTT - What age would you start at?

Ms BEAUMONT - I think the need to have education about respectful relationships between boys and girls, men and women, starts very early because they witness -

Mrs HISCUTT - Primary?

Ms BEAUMONT - I think it's earlier. I think that children come into primary school having witnessed quite difficult relationships between those in their family and the need to see that there is an alternative, and there could be an alternative to that, is something that we encourage as early as possible. We see the witnessing of violence against women by children has an impact very early on. I would say it's a lifelong thing and it is imbedded in respectful relationships and it's imbedded in being informed and having those things available to you which you might want to use. It's also about having accurate information about the reliability of contraception and GPs talking with women about them possibly failing if you are on antibiotics or the failure of condoms at times and why that happens and access to emergency contraception following such a failure, that it's not a one-off piece of information, it's an ongoing education. Also, we will always need to have termination of pregnancy services because of all of the failures that can happen along a pathway, not just with young women, not just with young people but with those women coming into menopause.

Mrs HISCUTT - You quote the Australian Charter of Healthcare Rights, and I'm not a medical person so this is up here. Then there is AHPRA and RANZCOG being quoted. Which is the overriding body here that has the authority to look at bad practices? Who is it?

Ms BEAUMONT - They are different bodies. The registering authorities have the right to deregister and if you were unfit to practise, I'm not involved with the medical colleges but the way the nursing profession operates is, the registering authority is the ultimate decider of poor practice if it is not a complaint that is found at law, that there has been a critical incident and the patient sues. But the Australian Commission on Quality and Safety [in Health Care] is an overall accrediting authority for service delivery. It's not about individual providers, although you do have to have an appropriate credentialing system and all of the providers within it have to be registered and ongoing registration has to be proven. They can make a complaint as a health service, but it's the standards and systems of health service providers.

CHAIR - We are done, Marilyn. We are a little over time as well. Thank you very much for being prepared to be here.

Ms BEAUMONT - My pleasure.

CHAIR - It has taken some time, I understand. We appreciate that, thank you.

Ms BEAUMONT - Could I say, I congratulate the Tasmanian parliament in discussing what I think is a really important issue for the women of Tasmania and I wish you well in your deliberations and I think it is a very healthy thing for Tasmania.

THE WITNESS WITHDREW.

Associate Professor JOANNE WAINER, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Joanne, thank you very much for again travelling to be here. You are familiar with parliamentary privilege which is afforded you as a result of appearing before these committees?

Assoc. Prof. WAINER - Yes, I am, thank you.

CHAIR - We will not go into all the detail then. Again, like every other person who has provided a submission to us, we are grateful for your written submission. Do you wish to speak to that and then we will launch into questions?

Assoc. Prof. WAINER - I do, briefly, if that is all right. Marilyn has outlined I think very clearly some of the consequences of stigma and the shame that has arisen as a result of abortion being in the Crimes Act now for more than 200 years. Prior to that, of course, it wasn't legislated for. One of the consequences is that women are silenced and so I want to speak in part on behalf of the women who are the beneficiaries or otherwise of the act. I also want to talk why private clinics provide the bulk of terminations in Australia and the failure of the public health system to deliver the care that women need and I would like to speak about why access signs are needed. They are the three points that I most want to make in my submission to you.

I claim the right to make these comments because with my late husband in 1972 I set up Australia's first publicly operating abortion service, and that was the Fertility Control Clinic in East Melbourne in Victoria. I must say that we nearly died in the attempt to set that up. There were people who wanted to kill us to prevent us doing that and it was only great skill and courage on our part that meant they didn't succeed, so we have been subjected and I have personally been subjected to extreme threats and behaviours in the more than 40 years that I have been committed to supporting women get access to safe services.

I worked in that clinic until I had my daughter and then I withdrew and spent my time as a mother - project A - looking after her and the many other children who were part of our family, and then when Bert died in 1987 I set up my own clinic shortly afterwards in conjunction with two doctors. I provided a full range of health services according to the Australian Women's Health Policy, including access to termination, and I was part of that clinic for four years before I left and became a full-time academic at Monash University working in the medical faculty and for six years part of the School of Rural Health. I was based in Gippsland so I have expertise in the provision of health services in rural areas. I was also part of the team that Marilyn was part of supporting the Victorian Parliament to come to the conclusion it did and pass the Abortion Repeal Act in 2008.

I have been deeply involved in understanding Mifepristone, the medical abortion pill and brought its inventor, Professor Étienne-Émile Baulieu, to Australia twice to talk to doctors in Australia about how that might be implemented as part of the abortion services.

I have a range of experience. I must say it has been a lifelong journey for me and one of the consequences is that I continue to act in a protective way. I don't publish my address,

I am on a silent electoral roll, I keep my details of where I live and how I behave to myself, as much as I can in this age where the international security agency in America knows everything about everybody. I have a highly-trained personal protection German Shepherd to take care of me -

Mr MULDER - Why are you telling us this?

Assoc. Prof. WAINER - I am telling you this because when we come to talk about access -

Mr MULDER - Sorry, it was an aside - you tried to frighten us off - no, it was a joke.

Assoc. Prof. WAINER - Well, it's not a joke to me because I live this on a daily basis. I have had personal threats, including to my life, and the clinic that we established in Victoria, a fertility control clinic, had a security officer killed in the performance of his duty trying to protect women and staff. These are real issues and when I get to speak to the protection -

Mr MULDER - From a personal perspective, I understand, and I know all those things and I do appreciate the fact that these are serious issues.

Assoc. Prof. WAINER - Thank you. So what about the women? In that time, of course, I have met many women who have had terminations of pregnancy and the overwhelming knowledge that I have as a consequence of that is that these women are good women and they are having abortions for really good reasons. The fundamental reason they have abortions is that they take the role of mother with the utmost seriousness. When they become pregnant and they make the decision that they cannot mother a resulting child with the level of care and responsibility and resources that they need, then they decide to terminate and that's the fundamental decision-making process that goes on. There is nothing that parliaments or anybody else has been able to do for the whole of human history to alter that process because for all of time and in every community, women terminate pregnancies that they don't believe they can continue and care for the child.

What parliament can do of course is strongly influence the circumstances and the experiences of women when they make that decision, but I will come back to that. It might appear a mystery, why, in the twenty-first century when we have access widespread information about sexuality and reproduction, while we have access to contraception, where women have slightly more authority in their lives than they used to, do unplanned pregnancies occur. Marilyn touched on this when she spoke about the amount of violence there is against women in the community. This is an unspoken epidemic. One woman is killed every week trying to escape a violent relationship in this culture.

Mrs HISCUTT - Is that Tasmania or Australia?

Assoc. Prof. WAINER - Australia and I doubt that Tasmania is an exception to the rule. We haven't yet reached a point in our evolution as a species where women hold full authority over their own bodies. One reason there are unplanned pregnancies and unwanted pregnancies is that women are coerced into sexual behaviours. Their response to that is to manage the best they can and make the decision they have to make, that 'this is not a pregnancy that I can continue'.

The women who have the abortion are also the mothers. Women have abortions and they have babies, they are the same women. Every woman - they are our mothers, our grandmothers, our sisters, our daughters, our aunties. Abortion is across all social spectrums. It occurs to women of all educational levels. It occurs to women of all social status and educational levels. It doesn't discriminate.

The silencing of these women and the inability to speak their own truth and to tell you what they are experience is, is the result of the criminalisation of abortion and you have before you, with this bill, an opportunity to change that so that women no longer will be shamed when they need a termination. I must say, nearly one in three or more than one in three women in Australia will have a termination at some time. This is an absolutely normal part of woman's reproductive health which includes menarche, contraception, menstruation every month, pregnancies that result in babies, pregnancies that result in terminations, miscarriages, ectopic pregnancies, other gynaecological misadventures and ending with menopause. This is an extremely complex system and it goes wrong a lot of the time. It's not easy and women with the best of intentions get caught.

I am really proud of the work that you are doing because you have an opportunity to stop stigmatising women for doing what they have to do.

I would like to talk a little bit about the provision of services. It has been one of the worst consequences of the criminalisation of abortion that public health systems have failed in their duty to provide this essential reproductive health service to their community, and they have been able to get away with it because it's in the Crimes Act and because they can say, 'We don't have to do that because it's a crime or it might be a crime or we might be charged'.

This is the chilling effect of having a law which criminalises abortion and it's one of the most important reasons we have to change that law and I thank you for the work you are doing. In Victoria - and Marilyn probably spoke to this very powerfully - health services don't provide terminations of pregnancies as part of their routine care. Women have to find their own way to those services; there is no fare halfway. That is complicated in particular because of a systematic provision of diversionary and deliberately misleading series of so-called counselling services that were set up by people opposed to abortion, which were designed to trap and entrap women who were looking for help. These are the so-called counselling services and I have had extensive experience of those and I'd be very happy to talk with you more about that.

There is no clear pathway and health services don't provide the care so what are women to do? As a result of that and as a result of my late husband Dr Bertram Wainer setting up the clinic that we set up in 1972, we trained a lot of doctors to do terminations and they subsequently went off and set up their own clinics. There were other doctors who were doing abortions unlawfully and then felt free to speak about what they did.

Almost all the doctors in the private sector in the specialised clinics that provide terminations are general practitioners that have been trained to do that. I have a lot of concern about parts of the bill that require the intervention of a gynaecologist and/or obstetrician because even the second trimester terminations in Victoria and in

Queensland were provided primarily in the private sector by general practitioners who have been trained specifically in the technique.

When you say it has to be an obstetrician-gynaecologist, I'm concerned about that. That will limit access to services. The reason for that is you only have 16 obstetricians and gynaecologists in Tasmania and a proportion of them - and I don't exactly how high but it could be as high as a quarter of them, or even more than that - don't want to be involved in providing termination services, so who's going to do it?

When you put those sorts of limits in, the only possible consequence can be not better care for women but restrictions on access, which I presume is the reason it's in there.

Ms FORREST - Can I clarify that point?

CHAIR - Yes, just for clarification.

Ms FORREST - You are probably aware the bill was amended in the House of Assembly from 24 weeks to 16 weeks and when it was 24 weeks it referred to the obstetrician or gynaecologist being one of those people. After 24 weeks, would you deem that appropriate that they be involved in such a decision then?

Assoc Prof WAINER - I think it's inappropriate for legislation to get into that level of detail about how you provide clinical service. It's not necessary, it doesn't help the woman, it doesn't help the doctors, it doesn't help the health service provider; there are extensive regulations in place that govern the provision of good clinical care and that's through quality insurance and registration processes which shouldn't be through legislation. Nobody has legislation that says that heart surgery has to be done in a particular way.

Ms FORREST - Or that a neurosurgeon has to do brain surgery.

Assoc Prof WAINER - Doctors are credentialed to provide the services that they provide through very rigorous processes and why would you select out termination of pregnancy to be the only exception to that?

Ms FORREST - You are saying that if they operate within their scope of practice that'll be good practice anyway?

Assoc Prof WAINER - Correct. Doctors are very careful about what they do. They do not operate outside their scope of practice because the consequences for them and for the patient can be terrible. The reason specialist termination clinics were set up by both myself and other people was that there was a complete failure of the public sector to provide this service and also large failure of the private sector to provide the service. GPs and obstetricians and gynaecologists didn't want to provide the service so there was no service. Women in those days used to have to do their own terminations or go to backyarders. It didn't stop them having abortions but it certainly coloured the experience for them. I think it is unnecessary for this act to specify who does what.

While I am talking about this, here is an example of that which is a rural example. My daughter is now a doctor and when she was an intern she was sent to a country hospital, which she was very happy to do, and at the briefing she and the other junior doctors who

were there on their introductions of the hospital were told, 'You'll get girls coming in here asking for an abortion. Just tell them we don't do that and to go away'. This was not very long ago; this is current practice and that is unacceptable for an essential health service, particularly in a rural environment where women may have not had a clear pathway to care.

It's also really clear that Catholic hospitals don't provide this service and neither do they provide a referral, they won't provide the morning-after pill, even for women who have been raped, and they won't provide contraception. One of our major maternity hospitals is run by the Catholic church - the Mercy Maternity Hospital. If you're running your public sector through religious agencies, then you are again restricting the level of care.

I want to turn now to why access zones are needed. The reason I spoke about my experience of being harassed and threatened is to set the background for why access zones are needed, because what goes on outside clinics and providers is really horrific. I would love for you to have experienced what goes on so you know what you're dealing with, and I'm probably one of the people who can tell you that because it has happened to me.

When I was working in rural Victoria there were two gynaecologists at that hospital which was the regional health centre, and neither of them wanted to do terminations but occasionally they would. Rural communities are small and word would get out and the hospital would be picketed. The staff were really intimidated by that because there was nowhere else for them to go. This was their community turning against them. It was very difficult for the staff and the consequence was a shutdown of any access to services, similar to what happened in Bendigo.

I have been at the fertility control clinic when it has been surrounded by protestors. There was a period where the Right to Life were using a book that was written by Joseph Scheidler, a United States person who they brought out here, and it is called *99 Ways To Stop Abortion*. He recommended surrounding, blockading and making a lot of noise and the reason for that was that was designed to distract the doctors from their work so that there would be an increase in complication rate. We've had that clinic blockaded so that women had to scramble across the bodies of the people in the blockade. I have seen, and I'll never forget this, a young couple who had driven to Melbourne from the country. This was probably the biggest thing they had ever done in their life. They'd found out they were pregnant, found out what to do about it, had come to Melbourne on their own, parked the car outside the clinic and were early for their appointment. We didn't have any security in place and their car was surrounded by demonstrators who were banging on the windows with placards and shouting, 'You're a murderer'. This couple were terrified and I was watching that man; he tried to care for his girlfriend and he couldn't protect her from that level of violence and hatred - people were spitting on them.

This is not sidewalk counselling, this is extreme aggression and intimidation and it's designed to frighten and that's what it does. It's also very difficult for the staff. I've been in the clinic when it's been invaded. We had people chain themselves to the operating theatre equipment and at the clinic that I set up we had demonstrators outside there every day.

Mrs HISCUTT - Professor Wainer, do you think that this exclusion zone will stop that?

Assoc. Prof. WAINER - Yes. It worked when it was applied to the Royal Women's Hospital because they were invaded. They had demonstrators outside who were blockading access to the hospital and they managed to obtain a magistrate's order saying that demonstrators may not approach closer than 150 metres to the hospital and that fixed the problem.

Mrs HISCUTT - And the police enforced it?

Assoc. Prof. WAINER - And the police enforced it because they had something to work with. I must say when we were being blockaded and harassed and surrounded, abortion was still a crime and nobody came to help us. The Melbourne City Council didn't help, the police didn't help; we were on our own. The very purpose of these actions - and there were clinics in Sydney where people used to come and put superglue in their locks, follow staff home - this is extremely intimidating. I don't know of any other group in society who is expected to endure that sort of behaviour and I don't understand why because it's pregnant women and the people who help them, we are expected to do it too. We need your help and the help is access zones. It has worked in Canada, it worked for the Royal Women's Hospital and it will work here as well so I beg you, please, keep your access zones.

These are the most important things I wanted to say. I want to finish by saying that termination of pregnancy is a public health issue. Parliament and the legislation that you pass can affect the experience of women and their families and the doctors and nurses who support them but it won't affect the number of terminations that are done, so it won't increase it and it won't decrease it. We know this because we have the evidence for that but where abortion is legal, safe and accessible, women's health improves rapidly and that's a gift that you can give to Tasmanian women.

CHAIR - Thanks very much, Jo. The first is Vanessa, please.

Dr GOODWIN - Jo, you mentioned that in Victoria, despite the reform that occurred a few years ago, the public system is still not providing terminations. My concern is that this bill we have before us could be seen as a panacea to suddenly make the public system here provide access to terminations. That has been a different experience in Victoria, it hasn't occurred so I'm just wondering why it hasn't occurred in Victoria.

Assoc. Prof. WAINER - I can't answer that because I'm not privy to the decisions that hospitals make and I'm not on a hospital board. My guess would be because of 200 years of legislation making this a crime. Doctors are reluctant to provide abortions because of that, because of the stigma that applies to doctors as well. I was a secretary of the Abortion Providers' Federation of Australasia, which my husband set up. At the first meeting that we had we got abortion providers from around Australia together. Grown men wept to be in an environment where it was okay for them - I'm talking about doctors who did abortions - to say what they did and to be in an environment where that was supported. It takes a long time to change that level of stigma.

Doctors are very careful of their public reputation and they get stigmatised if they provide abortion services. A CEO looking at a hospital budget when there are more services that he or she has to provide than resources to provide it can say, 'We won't do

terminations because there isn't anybody there who says "I really want to do this and it's really important'", so it is the chilling effect. It will change and getting it out of the crimes act is the essential first step but after that then it has to become systematic processes through the Department of Health and the reporting mechanisms of hospitals that say this is a service that your community needs.

Mr MULDER - I think you may have answered this but I missed it, has the Victorian public health system now taken on abortion since the legislation changed?

Associate Prof. WAINER - I can't tell you hospital by hospital but I know that in a general sense, no it hasn't. Overwhelmingly the public sector terminations are provided through the Royal Women's Hospital and some are done by Monash. Very few are done elsewhere.

Dr GOODWIN - Teasing this out, I am interested in the situation in Canada because you mentioned in your submission that almost all terminations are performed by general practitioners and that they tend to do it earlier was another point.

Associate Prof. WAINER - That's one of the consequences, yes.

Dr GOODWIN - I'm interested in how the situation in Canada is different and what are the advantages and disadvantages with the general practitioner approach, with them performing most of them.

Associate Prof. WAINER - They had a similar experience to that of Australia. It was in the crimes act because they have the same British laws governing there as well as the French laws. When the push came for abortion to be legalised there was a man in Canada, Dr Henry Morgentaler, who did in Canada what Wainer did in Victoria and that is say the law has to change and women have to have access to safe legal abortions and he set up a clinic.

He was charged with providing unlawful abortions and he was jailed for 18 months, and subsequently he was jailed even though the jury acquitted him. So this was a very strange phenomenon. He spent 18 months in jail. He appealed and the High Court struck down on his conviction, of course. There was no law in Canada as a consequence of that legal decision and so Canada has no law relating to abortion. It is managed and treated like any other health service.

Henry Morgentaler and others - he was the first one to he set up clinics run by GPs predominantly. That's how the GP model was developed in Canada. In the same way it is being developed in Australia because GPs run the clinics in - not all but mostly - in most of the states.

Dr GOODWIN - How much training do GPs need to be able to provide termination services?

Associate Prof. WAINER - Most of them do it under an apprenticeship model so they join the clinic and they get taught by the doctors who know how to do it.

Dr GOODWIN - In terms of RU486, which is on the -

Associate Prof. WAINER - Mifepristone is now on the pharmaceutical benefits schedule so it makes it more financially accessible to women.

Dr GOODWIN - How does that change things or how could it change things, potentially? Could you talk a little bit about the scope of RU486 in terms of how many weeks and that sort of thing?

Associate Prof. WAINER - I see that one of the other groups that are going to testify are Marie Stopes and they will be able to give you the details of that much more accurately than I can, I must say.

CHAIR - Building on that question that Vanessa just asked and GPs, etcetera, Joanne, you mentioned in your submission that current law all around the place seems to ignore the fact that we have nurse practitioners and others coming on stream, if I can put it that way, who may be capable of performing terminations. Is there anything extra than that which is in your submission which you want to build on there? Vanessa just mentioned this notion of GPs but you go specifically to not just doctors, possibly or potentially into the future.

Associate Prof. WAINER - Australia has a resourcing problem for the health work force in rural areas, and I am sure Tasmania is no exception to that. I worked in rural health for a long time so I am very aware of what that is. I am also a life member of the Australian College of Rural and Remote Medicine and these are the doctors who provide the health services in rural Australia.

One of the solutions that have been developed to that - and it's a worldwide movement, it's not new to Australia - is getting practitioners other than doctors to extend their scope of practice. That's a very carefully developed process, and in parts the physician assistant's role was developed in the United States to accommodate all the medics who came out of the Vietnam War and subsequent wars that America fights in. They are very highly skilled in first-response medical care and the physician assistant role was developed to give them an opportunity to practise. It's being piloted in Australia, in Queensland. What the scope of practice is I don't know but it's an example that the current structure of doctors and nurses is evolving - nurse practitioners, physician's assistants and so on. Midwives are now being licensed to practise independently.

We don't know where that's going to go but I think that it would be unwise for legislation to act purely on what the current situation is when we can see an evolving workforce development. I must say that I don't know of any developed country that has got there yet but I think they are all moving in the same direction.

CHAIR - On that same thread, you addressed earlier that requiring two doctors, particularly one of whom should be a gynaecologist, obstetrician or experienced in those fields, recognising that the Victorian law doesn't require a gynaecologist or obstetrician but the Victorian law, I think -

Assoc. Prof. WAINER - It does over 24 weeks.

CHAIR - Yes, so it's similar to ours but not with the overriding condition of gynaecologist or obstetrician.

Assoc. Prof. WAINER - The Victorian law does say specifically obstetrician - at least one of them has to be.

CHAIR - Does it?

Assoc. Prof. WAINER - Yes, it does, which is not a good feature. I quote the British parliamentary inquiry - we see this as very unnecessary and it has a chilling effect, as it is designed to do.

Mr MULDER - Is that for all or just post-24 [weeks]?

Assoc. Prof. WAINER - Post-24 [weeks].

CHAIR - I wanted to go to that with you in your submission and what you have indicated to the committee today. First of all, you make it quite clear that two doctors ought not to be required.

Assoc. Prof. WAINER - Yes, it's not medically necessary and if it were medically necessary then the doctor would consult with another doctor. You're getting into the details of practice which are really not your domain. Each circumstance is unique. It is like each rural town is unique - you can't speak for all rural towns. You can't speak for all 24-week terminations; you can't speak for all women who have a termination. The service has to have the flexibility to respond to the individual circumstances and all the systems are in place to make sure that that is done safely and properly. Specifying in the details of legislation who does what is extremely unhelpful. I'm at a loss to see who benefits from that, what the purpose is, other than making it difficult to provide this service in the public sector and that's one of the reasons why hospitals say, 'No, I'm not going to do it, it's too difficult'.

CHAIR - You suggest that there ought to be explicit reference to severe foetal abnormality as a consideration. The committee has had evidence earlier from our health department and they contend that if we try to prescribe that as one of the purposes then we might, by that process, limit the opportunities for the medical practitioners to appropriately make a decision or help the woman make the decision for the broadest possible circumstances.

Assoc. Prof. WAINER - Yes. I have looked at the Victorian legislation now and you are right, it doesn't require a gynaecologist or obstetrician. I was misleading you on that, it does require two - it says 'has consulted with another registered medical practitioner' - so I apologise for that.

CHAIR - Thank you.

Assoc. Prof. WAINER - There is something to be gained by having foetal abnormalities an explicit condition to be considered and that is that it allows the practitioner to talk honestly with the woman about what is really going on rather than, in the back of her or his mind, having 'Can I sign on the dotted line that says this will cause emotional, physical or social stress?' It means that they do not have to then take the extra step and

take the woman there as well about those consequences, but they can just deal directly with her and the conversation they had.

If it leads to other difficulties around signing death certificates, I do not have the competency to comment on that. But the reason I introduced it was that if you had that in there, then that is something that doctors can say,' That is why I am having this conversation because this is a fair abnormality. I am telling you what it is and what the consequences are. I have to help you make a decision.'

CHAIR - I will come back to that matter of the two doctors and, as you have indicated there, the Victorian law does not require it to be that specialist field.

Assoc. Prof. WAINER - Correct.

CHAIR - You have made it very clear that there is no need. You have covered that.

Assoc. Prof. WAINER - The British inquiry supports me on that one. It says two doctors are not necessary, you should not have to -

CHAIR - Yes. You are suggesting a further amendment to our legislation to be considered?

Assoc. Prof. WAINER - I like the legislation as it stands. I do not like 16 weeks. I think if you pass it as is, it will be a great improvement for Tasmanians. If you are going to amend it, those are things you should consider.

Mrs HISCUTT - You opinion - I was going to ask about RU486 also but we will wait for that one, Vanessa. Your personal experiences indicate to me that this is more than a woman's health issue; everyone in the community has an opinion on this. I am not saying that is right or wrong, that is just the way it is. Do you think that perhaps the reason for having two doctors to sign off might be to satisfy that community expectation? Whether we like it or not, it is an emotive issue that everyone has an opinion on. Do you think that is why it is there, to have two doctors, one being a gynaecologist or an obstetrician?

Assoc. Prof. WAINER - You are setting up a series of gatekeepers, in other words, so you do not trust women and their doctors to make the right decision. That is the message you are sending. Is that a useful message in the community?

Mrs HISCUTT - Do you think it is more of the community having an input into something that is a big social issue?

Assoc. Prof. WAINER - The proportion of the community who oppose access to safe, legal abortion is very small. They make a lot of noise but they are not very large and it is around 10 to 11 per cent. The critical point of this legislation is to remove abortion from the Crimes Act and give women the authority in their own lives to make the decisions that are going to affect them more than anybody else. When you start putting in gatekeeper components that say, 'We do not trust you and we do not trust the doctors,' I think that sends a very poor message to the community.

Mrs HISCUTT - You do not see it as satisfying community expectations?

Assoc. Prof. WAINER - My point about the community is that 90 per cent of the community wants this done. They want clear legislation that says the law has no place here and why would you subject everybody else to requirements that do not improve the health outcome for the woman?

Mrs HISCUTT - Even though doctors - you said earlier that a quarter of the gynaecologists also have a struggle with this.

Assoc. Prof. WAINER - In the UK. I do not know what it is in Tasmania but it may be that much, it may be more - all the more reason to not require two of them because you would find you do not have the medical workforce to take care of women who need to be taken care of carefully, conscientiously and sensitively.

Ms FORREST - I will take you back to a question I asked Marilyn as well in regard to the answer to a question Tania mentioned - that the availability of termination of pregnancy services within the public hospital system has not increased in Victoria since the change of legislation. I was speaking to some doctors who undertake terminations - obstetricians, gynaecologists. Some of them expressed to me the view that it is better outside the public hospital anyway but publicly funded in a clinic arrangement because of some of these issues - when you are in a public hospital you have a big list; if it were in Burnie, for example, you would not have a whole list taking up the termination of pregnancies. For example, you would have a range of other gynaecological procedures at the same time. Where you have theatre staff and even ward or day surgery staff, wherever the woman comes through, who have conscientious objections, it is a bit of a balancing act trying to deal with how you organise your list to make sure that the appropriate people are caring for the woman who is requiring a termination.

Has there been an increase since the legislation in any other publicly funded termination of pregnancy services? I can ask Marie Stopes about how they operate when we talk to them later on, because obviously there is a need and we have identified the need. There is a view widely held that it should be a publicly available, publicly funded safe service that has equal access regardless of where you live, so how is that better achieved if it is not done through the public hospitals as such or can it be?

Assoc Prof WAINER - They are very complex questions about how public service and the public hospital does deliver that level of care and I think each hospital and health network will come up with its own solutions but there probably is not a single model that fits other than the model in South Australia which has had mandated public hospital delivery of abortion services since they changed their law in 1972. Their model was to set up a free-standing clinic within the hospital grounds and that way staff could self-select to work in that clinic and they would not encounter staff who would be hostile or in any way not supportive; that seems to have worked. It does concentrate services, though, and in Tasmania they do not have enough abortions to support a service like that properly.

It is rural people who really want the services delivered where they are and they hate having to travel to get services and they do have to travel obviously for lots of services. I think, again, the approach should be that once it is out of the crimes act then the health department has to start putting it in to the service delivery and contracts with the health

systems and then it is up to them how they implement it. Some hospitals find it easier than others, but the notion that a public sector-funded health service can ignore the needs of one in three reproductive health-age women in its catchment, needs to be challenged and that can be done best once you have got it out of the crimes act through those health department processes about health service contracts.

Ms FORREST - Going on from there, one of the issues we will no doubt talk about - RU486 and with Marie Stopes as well - my understanding is that it is only available up to seven weeks at this stage which means that you have to get in early.

Assoc Prof WAINER - Very.

Ms FORREST - A lot of them do not even know they are pregnant.

Assoc Prof WAINER - No.

Ms FORREST - So, in the clinics you have been overseeing in Victoria, what are the numbers of gestations that come through and how late in the gestation would you then there need to refer to a hospital setting?

Assoc Prof WAINER - In Victoria there was terminations up to 20 weeks so they would accept referrals. The clinics where I worked, overwhelmingly women have their terminations before 12 weeks of pregnancy, overwhelmingly. So 80 per cent, it is huge. I did my masters theses on how women made the decision and I interviewed them a year after they had had their termination, most of the decision is made completely external to the health environment. They make the decision with their partners, families and they often have a network of decision-makers that is different from the one they would use for other decisions because of the shame and the stigma. If you are an 18-year-old and you are living at home and you are a good girl in the family and you are pregnant, you don't want to damage your reputation within your family so you don't go and talk to mum and dad, you go and talk to an aunty whom you have heard talking about this sort of thing and believe might be safe.

If that's the abortion decision and it's that big, the health service provides about that much. The decision is made before the women get there, overwhelmingly. The health services need to be in a position to support that decision by them and help them walk through it. Some women need a bit more help because their situations are extremely complex, so they make the decision early and they do it as soon as they can. The clearer the pathways, the earlier the termination. What sets women off their path is finding their way to the service and I know it's on the internet, but not everybody is internet-literate.

The women who are most vulnerable are the poor women, the rural women, the undereducated women, and the non-English speaking women, the people who don't know how to work the health service in any circumstance because they have never encountered it. These are healthy young women. They have never had to deal with doctors and hospitals and making these decisions. They don't know and that's why the question of conscientious objection and being able to feel a pathway out of that is so important, particularly in rural areas so they get onto us as fast as they can.

CHAIR - We are done, I think, Jo. Thank you very much. We appreciate it.

Assoc. Prof. WAINER - I wish you well in your deliberations.

THE WITNESS WITHDREW.

Dr SALLY COCKBURN WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Dr Cockburn, thank you again for travelling, another one of the people who have taken such an interest to provide the committee with good evidence that you have been prepared to travel to join us.

Dr COCKBURN - Always a pleasure to come to Hobart.

CHAIR - You would be familiar from your interaction with the Victorian parliament that you are protected by the parliamentary privilege so we won't bore you with that detail.

As you would have heard me in the introductory component with Jo, we invite you to speak to your submission and then we will pose some questions to you.

Dr COCKBURN - Certainly, thank you. Can I first say thank you very much for the opportunity to appear before the committee to speak to my submission and to congratulate the Parliament of Tasmania for tackling this important issue. I'm a vocationally registered specialist general practitioner and I practise in Victoria. I have never performed an abortion, but I have had consultations with women contemplating abortions, having had abortions and have continued to treat them after their abortions and I have seen them for many years. I'm a former chair and board member of Family Planning Victoria and held that position during the 2008 abortion law reform process. That's a voluntary position. I'm also a pro bono patron of Marie Stopes International Australia and I'm there because I feel strongly about the equity of access to sexual health information and treatment for all people.

I previously sat on the medical advisory committee for Marie Stopes clinics and that's also pro bono - I do a lot of pro bono - and on the Victorian Sexual Health Taskforce and the Mental Health Reform Council. I also work in the media on radio and television and I write an advice column for teenage girls on sex and their bodies.

As I said I wanted to congratulate you for taking the steps to legislate to decriminalise and improve access for terminations of pregnancy in your state. I support the bill in its current form with one small reservation about the 16-week change of access protocol as this pre-dates the 18-week ultrasound. I feel the Victorian protocol of 24 weeks is more practical, but having said that, if it means the difference between passing or failing of the bill I believe that clinically it's workable as it stands.

My motives for getting involved in the process down here is that I notice the same myths and untruths seemed to be appearing in the debate here that I thought we had adequately resolved in Victoria in 2008. I believe decriminalising and improving access will not lead to any unnecessary increase in the number of abortions and anecdotally I've seen no increase in the number of women presenting, requesting termination in my practice since 2008. I imagine my colleagues from Marie Stopes can comment more on those figures.

One horror myth that seems to have been pedalled in this debate is the so-called partial birth abortion and live birth abortion, which simply do not happen in medical practice in

Australia. Unless evidence can be produced, it is surely improper to continue to listen to such spurious arguments against this bill.

I'm also concerned about the nature of the arguments put against proposed section 7(2) of the bill, the conscientious objection clause for doctors. I'm a member of the Australian Medical Association, I speak only on my own behalf and not on behalf of any organisations that I'm associated with but I note they made a submission to your inquiry and they sent me a copy. In their submission I note their objection to proposed section 7(2) is based on what they allege to be a penalty associated with breach of the subsection. From my reading of the bill, no such penalty actually exists in this current incarnation.

A further note that the AMA subsequently published a media release on 12 August that now seems to claim that their objection on breach of 7(2) is that it attracts a criminal conviction. I'm not a lawyer but I don't understand how that can be so when there is no penalty attached. The clause notes clarify that this section is there as a guide to the medical board should a doctor appear before them after a complaint relating to a refusal to refer. I understand there is a matter before the medical board at the moment.

I'm not sure where that leaves the AMA position in that both of their claims are not true, I assume they are just confused. I feel that 7(2) strikes a good balance between the rights of the patient and the rights of the practitioner. I don't recall ever being canvassed by the federal AMA for our opinion on conscientious objection clauses in the Reproductive Health (Access to Terminations) Bill 2013 and contrary to the AMA's position, I do think that there is evidence in various policies and codes of ethics of the medical bodies to support this subsection and I'd be pleased to expand upon this if you wish.

Surely it is reasonable that when a doctor can't provide a lawful, clinically indicated service, the ethical thing to do is to refer this patient to someone who can. I don't mean can provide an abortion because there is lots of confusion out there in the medical profession and I get the feeling there may be confusion elsewhere that the bill does not require a doctor to refer to an abortion provider, merely to a doctor who can give an all-options discussion.

This is something that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists - RANZCOG - in their code of ethics, section 2, Doctor-patient relationship, subsection 2.6, Further opinion/referral, states:

> Doctor should offer or arrange further opinion and/or ongoing care with another suitable practitioner if:
>
> (a) the patient requests this;
>
> (b) the therapy required is beyond the individual doctor's expertise or experience;
>
> (c) the therapy required is in conflict with the doctor's personal belief or value system.

That's pretty black and white, yet the AMA did not put that in their submission. To my mind, with all respect to the AMA, I think they've cherry-picked the codes of ethics that they've looked at. I fully respect that some of my colleagues have conscientious objection to abortion and I do not believe they should be forced to perform procedures. I don't believe they deserve to go to jail or be fined, however, I do believe that if it's in conflict with their belief system they should have to only do the right thing by a patient if the patient's life depends on it, but we need a balance.

Since writing my submission, I came across some advice given by the AMA members on a conscience issue that's actually in direct conflict with the advice they've been giving on abortion. This is not in my submission but I'm happy to give it to you. The advice is for vaccine refusers. The advice states that if a doctor is confronted by a person who wishes not to vaccinate their children, the people will often come along with a form to sign that says the child can go to school. The AMA have suggested that under these circumstances there is no mandate for doctors to sign it but the AMA sees no problem in a doctor signing it as it doesn't actually say that they support the patient's decision, it just allows the child to go to school. They then go on to say: if you feel you really can't sign the form, put a sign up in your waiting room that says that you don't wish to see people like this. It has already been brought up by my colleague earlier; the AMA Victoria has actually put up this sort of way of coping with the situation within the law in Victoria.

I don't know why the AMA has a different view of the way a conscientious objector to abortion should behave, as distinct from a conscientious objector to vaccinations. I have to say I am very disappointed in the way the AMA has conducted itself in this debate. I understand the Tasmanian AMA put their media release out when there was a penalty attracted, in the original bill. They have not taken that down and I can only assume maybe the federal AMA has been a bit confused about where the bill stands. As I say, I am disappointed.

I also think there may have been misunderstanding about the word referral. From my reading of the bill it does not require any formal, clinical structured sort of referral. More importantly, it is not required that doctors, as I said, refer to abortion providers - just to a practitioner who can give all-options information.

Again, I am fully cognisant there are doctors who feel abortion is murder, that they do not want any part in the procedure and I think it is very reasonable that these people should be accommodated. I have no problem with that. However, a woman is requiring a lawful, clinically-indicated procedure and she may be in a situation where she is vulnerable. There is a doctor/patient relationship - a certain power play there. I believe doctors who feel this strongly about it should not put themselves in the position where their conscience is being conflicted and this idea of putting a notice in their surgery would mean women would at least know not to ask those doctors. I believe they should be protected from that. I do not think doctors should be exposed to things if they are a conscientious objector.

I have a conscientious objection to infant male circumcision. If patients come to see me about that, I ask them whether it is okay if I tell them why I believe that it is an unnecessary procedure on a person who cannot give consent. If they allow me to tell them, I do, and then if they say they still want the procedure I refer them to a surgeon who can competently do the procedure. I do not have that problem of the infinite chain

of command - that is what worries me. When I have spoken to my colleagues who are conscientious objectors they say, 'We will always be conflicted. You can never get away from that chain of events'. However, as a reasonable community we need to draw that line and I believe 7(2) covers that.

I hate to say it, and I am sure if they exist they are only a very small percentage of people, but I wonder if it is important to consider what the motivation for refusal to refer is? Is it protecting one's own conscientious objection or is it trying to impede the woman from obtaining a lawful, clinically-indicated procedure? The latter is not ethical, and cannot be condoned. If these doctors are genuine about trying to avoid being conflicted, I have no problem. Put a notice in your waiting room that says you do not want to see them. But, if there are doctors who are trying to prevent women from obtaining these procedures we must do something to stop it. That was why that clause was originally put in the bill. We are aware there are doctors who - and you have heard from other witnesses today - feel so strongly they will try and intervene.

On that note, I concur with things also said by the two previous witnesses. Just because I have spoken up, I have been vilified. I was told I had blood on my hands. I am told I am a murderer. I can handle that, but it is more insulting to me to infer that I will refer a woman for an abortion as a knee-jerk reaction. I take great offence at that. In fact, it was during the 2008 abortion law reform debate that, as chair of Family Planning, we decided to take a stance that we would not provide abortion services and therefore we could put ourselves up as an all-options counselling service, for conscientious objectors. So they had a safe place to refer and we would give them a guarantee that these women would not be coerced into any decision either way. I have often said, and I have been on the public record to say, I would stand shoulder to shoulder with right to life advocates to prevent any woman being coerced into having an abortion, but equally I would stop them if they tried to coerce a woman out of it. I believe very strongly in patient autonomy.

I would also like to speak, if I may, to section 9 - the access zones. I understand evidence has been given - I have read the transcripts before this committee - that section 9 may contravene implied rights of political communication. I believe the case of Lange v ABC was cited. One of the things I have been mulling over is the notion of 'protests'. I took it upon myself to speak to some of the protesters last week, and these people told me they are not political protesters. They told me they are there to help women, and they are there to save babies. They give brochures out and I am very happy to supply the committee with one of their brochures. They say 'Pregnant, Worried, Can We Help? Strict confidentiality. Our help is free'. They talk about some things that aren't quite true, but they offer them help to avoid their abortion. If it was a political protest why would they only be there - this is in Melbourne - when the women are coming in for their procedures? Why would they only speak to the women who are going in? Why not hold up placards to the passing cars? Why not go down to Parliament House? I have no problem with them protesting at other places. My concern is that this is not protesting and making a political point; this is vilifying individuals, harassing them and distressing them.

I have a study by the Fertility Control Clinic showing the attitudes of women to the protestors. They were overwhelmingly distressed by the situation. I think that these women need to be protected. They are, after all, only accessing a legal, clinically-indicated procedure. They have already gone through, I hope, information retrieval from

their GP and if they have not, they will not be going straight in to have an abortion. No one goes and has an abortion the same day. It is not a one-stop shop. I think that therefore this is not a political point they're making.

While I was there, they called out to women saying that they were there for their children, and that they could help them. They gave them pamphlets and directed them to services that offered counselling and salvation. I have no doubt that in their own minds, within their own frame of reference, these people mean well. I believe they do care deeply. Unfortunately, I don't think they understand the distress they're causing these women. The access zone needs to be there to protect these women who have made a decision, and are lawfully entitled. Certainly, their political protest can go on elsewhere, but I don't see the point of it going on outside the clinics when those women were having the procedure.

As I read the intention of section 9, it is not to stifle political communication, but to save vulnerable patients from distress. While I believe that people have the right to protest, as it was shown in Evans in New South Wales - the case relating to World Youth Day in Australia - political dialogue can be inherently offensive. But it doesn't seem proper for it to cause distress to patients accessing a lawful clinical procedure.

I believe that the bill reflects a reasonable way forward in the practice of termination of pregnancy for the women of Tasmania. I commend the committee on your interest in this important issue and I hope that what flows from this bill will be an addressing of the workforce issues.

You need to take action, because the law as it currently stands may well catch some women unwittingly? If I may just give a quick example. You talked about Mifepristone - RU486 - which is now on the PBS, and the guidelines are available. Hypothetically, a woman could legally be prescribed Mifepristone and Misoprostol, which is the other drug required in the procedure, in Melbourne. It could be possible that with good medical practice she would be asked to have a back-up place to go. It could be that she didn't tell her doctor that she was coming to Hobart for the evening. It could be that she took her second dose of the drug here in Tasmania the next day. She doesn't have to have two doctors' signatures at the moment in Victoria, but under section 134 of your act, if a woman procures an unlawful abortion, by Tasmanian standards she could be potentially committing a crime. That could actually happen now, today, tomorrow if a woman flies in and unwittingly takes the drug, gets some bleeding, presents to a hospital and says, 'Look, I'm not sure whether my bleeding is all right.' They say, 'Why are you bleeding,' she says, 'I'm in the middle of an abortion?' 'What do you mean?' 'Well, I took the abortion tablets just before.' I don't know, but I think you need to look at that aspect.

Anyway, thank you again, and I have other information.

CHAIR - Thank you very much, Sally, for that.

Mr VALENTINE - Just the 16/24 week issue. You are saying that 16 is not -

Dr COCKBURN - Ideal.

Mr VALENTINE - Not ideal and that it should be 24. So why 24?

Dr COCKBURN - Look, 24 weeks was sort of arbitrary in one sense and not in another. We felt we needed to have a situation where women could make decisions and have time to make their decision. Of those later abortions, and I think they constitute about 1 per cent, they are usually wanted pregnancies. They are usually people who have foetal abnormalities on board. These are not women who are thinking of wearing a particular pair of shoes to the Cup or something like that. It is not a trivial decision. What we worry about is that they need to not be forced into making a rash decision. To be frank, 24 weeks was probably chosen more as a comfort zone for parliamentarians voting on the issue, more arbitrarily because before that it is very unlikely that a foetus that was born would survive, it was more around the comfort zone. Obviously, the comfort zone in Tasmania is 16 weeks; the protocol change at that point, I think, is a problem in one sense, the gynaecologist - but again, if it came down to whether the bill passed or failed, I think we could live with it clinically.

Dr GOODWIN - I am going to go to the RU486 issue, just because you do mention it in your submission and you talk about medical abortions likely to become the preferred option for early terminations of the pregnancy and probably will be administered by GPs. I just wanted to flesh that out a little bit.

Dr COCKBURN - I have been over to England and sat in on an RU486 - we should call it Mifepristone -

Dr GOODWIN - I cannot pronounce that.

Dr COCKBURN - This was at a Marie Stopes clinic in London and it was actually administered by a nurse. It is about protocols and backup and once we have those things in place, and Marie Stopes is able to talk about this much more, I see no reason why a GP cannot prescribe it. We prescribe many drugs that have potential side effects - aspirin, and I mentioned it in my submission, if I told you all of the side effects of aspirin you would not touch it with a bargepole - and I think therefore we need to put in context that all of these side effects are clinically manageable and with backup it is manageable. I see in the future that it will be general practitioners who will prescribing this and it is fair to say that there can be bleeding and pain associated with it but the women that I have spoken to who have this say, and I believe that the studies show that women would say, 'I would do it again.' Obviously, there are going to be cases that you can pick out that were not good and had side effects but generally speaking, you could do that with any drug.

Mrs HISCUTT - Going back to your conscientious objector, Section 7 part 2, about the doctor. In your submission you have an alternative appropriate doctor or service would be sufficient to have in there. Just reading it through here, the way I understand it is that the practitioner must refer the woman to another medical practitioner who the first mentioned practitioner reasonably believes does not have a conscientious objection to terminations. That seems to me that if I do not want to do it and say this person over here will do them, I am then referring on to someone that I know will actually do it.

Dr COCKBURN - No, I do not read it like that and that is certainly not the intention that we had in Victoria. Could you just read it again.

Mrs HISCUTT - I will read the whole lot.

> Subject to subsection (4) if a woman seeks a termination or pregnancy option advice from a medical practitioner and the practitioner has a conscientious objection to terminations, the practitioner must refer the woman to another medical practitioner who the first mentioned practitioner reasonably believes does not have a conscientious objection.

Dr COCKBURN - That is the point - does not have a contentious objection. It does not say, 'Can provide the service;' it does not say, 'Can do the abortion;' it just says, 'Does not hold a contentious objection.' For example, it could be me. I do not provide abortion services, but if you were a conscientiously objecting doctor, you could refer to me because I will sit with the woman and I will say, 'Here are all of your options. Let us talk about it. How do you feel about your pregnancy?' I would be able to go through all of those options. I may then, depending on the outcome, and I can say I have had patients referred to me who came in saying that they wanted an abortion and I can think of some examples of where they have ended up not having an abortion. It is not going to be automatic when you make this referral to this other doctor. When I said 'service,' I meant a service that has medical practitioners.

Mrs HISCUTT - I would like to refer on to a service, because I do not know about the rest of you but it does seem to me that if I have a conscientious objection I have to pass it on to a person who does not have a conscientious objection.

Dr COCKBURN - No, but if you say on to a service that does not have conscientious objection. The whole reason for this is that these women need to go to someone who can speak openly and freely about all of their options.

Mrs HISCUTT - We might take that one up with one of the lawyers, perhaps.

Dr COCKBURN - If I may say, this was and remains a big issue but again, I would say that at Family Planning we put ourselves up as a service that would offer all options and I really need to reiterate that I don't understand why a doctor who had a conscientious objection would object to refer to me. You may say because I might refer on for abortion, 'Where does the chain end?'

Mrs HISCUTT - You provide the other options as well?

Dr COCKBURN - Yes, absolutely.

Mrs HISCUTT - Whereas this is saying, 'Who you reasonably believe does not have a conscientious objection.'

Dr COCKBURN - The implication therefore is they are free to give all options. I think it is reasonable to imply that no one is going to have a consultation about just abortion. You are going to have all options discussed. Again that -

Mrs HISCUTT - I am looking at the wording of the bill and I just struggle to see how it works.

Dr COCKBURN - It works in Victoria. Our legislation mirrors that and we are seeing that it works well. We are seeing that the AMA has been able to come up with solutions. Again, those doctors can simply say, 'Well, I don't want to see anyone requesting an abortion,' and therefore they are not even caught under that if they say, 'I don't see patients who want abortion.'

Mr MULDER - This whole thing about counselling seems to me to be that we have now injected this counselling by non-medical people, by social people, and I think we heard in the briefings - I don't think we have had it in evidence - from an abortion provider that there are two GPs, two medical practitioners there all the time - and they are trained in psychological counselling if that is what is needed. I wonder why we are now so mandating counselling and perhaps if we didn't mandate counselling for referrals, we could simply avoid all this complexity anyway. If someone presents and wishes for an abortion they don't have to be counselled. They just go like you would and consult the doctor who is going to perform the procedure.

Dr COCKBURN - I think that it is reasonable that a woman sees someone who can give her all her options honestly and in an unbiased way.

Mr MULDER - Just to interrupt you there. That is exactly what the abortion provider said they did. They do not conduct an abortion on every person who comes to their clinic seeking advice on what to do about their pregnancy.

Dr COCKBURN - There is nothing - can I just go back one step - counselling and information provision are two different things. I think it is very important that we make that point.

Mr MULDER - I am focusing on the counselling.

Dr COCKBURN - Counselling is not something that women will get automatically and they don't require it automatically. Counselling is a formal psychological process that you go through. All options information giving - if I can walk you through a scenario - a woman presents and she says, 'I'm pregnant.' 'How do you feel about that?' If she says, 'I'm in two minds, I don't know, what are my options?' Or if she says, 'I'm happy,' that is fine and we know where we are going. I said, 'Would you like to know your options?' 'Yes.' We say, 'Your options are: continue the pregnancy to term and keep the baby; continue the pregnancy to term and adopt it; or you have the availability to have an abortion.' That is information giving where we go into all the details. But counselling is if the woman then says, 'I'm very distressed, I don't know what to do,' then we may say, 'We will have some counselling sessions. Would you like counselling?' I firmly believe counselling should be available and offered, but don't confuse it with information giving.

Mr MULDER - I'm not confusing it and that is my point. Maybe we should say that a person who wants information rather than counselling should be referred to someone else, because counselling is something - I'm happy, to speak for myself, I'm happy to be provided with information. I've had a few surgical procedures and rarely do I need counselling.

Ms FORREST - I don't know about that.

Laughter.

Dr COCKBURN - I thought that counselling had been removed from the bill. I didn't think the bill still said counselling.

Ms FORREST - Not mandated counselling.

Dr COCKBURN - Not mandatory counselling.

Ms FORREST - No, if the counsellor has an objection.

Dr COCKBURN - It is about counsellors, sorry. Counsellors need to be caught under that conscientious objection thing as well, in case they are unable to give all options. I think the bill as it stands is quite clear. I think it works. It mirrors what we have in Victoria in one sense. I also think that getting into the sort of detail you are talking about is, as Jo brought up, probably getting into medical practice a little much.

Mr MULDER - That's my point. If you want counselling or you want information, why don't you get it from the doctor if it's a medical procedure?

Dr COCKBURN - It's more than a medical procedure.

Mr MULDER - If a doctor doesn't feel qualified to provide it, no doubt he will refer you to someone else.

Dr COCKBURN - We have to make sure that women aren't being coerced, that they are able to give informed consent. I think that is very important. I just worry about, and from my reading of this, the purpose of those clauses is to make sure that women have access to all-option counselling that is not biased.

Mr MULDER - Another point: you were talking about the conscientious objection and you are saying that you had some difficulty with the AMA in the fact that they would not refer someone who had a conscientious objection to abortion and at the same time you said you did not have one with the removal of the foreskin. I wonder what the difference is. Is there not a significant difference between the conscientious objection to abortion and the conscientious objection to the removal of the foreskin?

Dr COCKBURN - Sorry, I was not comparing the two procedures. I was comparing the fact that I am a conscientious objector and I do feel very strongly that young boys should not be circumcised against their will as they can not give consent. My point was simply that despite my very strong conscientious objection, I would not withhold a referral. I certainly was not comparing the two procedures.

Mr MULDER - The removal of the foreskin and the removal of a foetus, I think, is slightly different magnitude.

Dr COCKBURN - I would not even begin to compare them because it is irrelevant to compare them with my argument.

CHAIR - I do not have any other members who wish to put questions to you, Sally. We really appreciate your time.

Dr COCKBURN - My pleasure.

Mrs HISCUTT - May I have one of those brochures - is that all right?

Dr COCKBURN - Yes, certainly.

Dr COCKBURN - This was a letter from Susie Allanson. I can get the web address; I got this off the web last night. It is actually a submission to the Privacy and FOI Policy branch of the Department of Prime Minister and Cabinet. She has not put a date on it, unfortunately, but I can certainly give you the address. It sets out in appendix A a summary of the research study on the reactions of women attending their clinic to protesters.

CHAIR - Thank you.

THE WITNESS WITHDREW.

PUBLIC

Mr ANTHONY RECKIN AND **Ms MINA BARLING**, MARIE STOPES INTERNATIONAL AUSTRALIA WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - You have been here during some of the proceedings today so you are familiar with our process. We extend the opportunity to you, if you wish, to speak to your submission before we launch into questions - you are welcome to do that.

Ms BARLING - I would like to say a few quick words. Our submission is, hopefully, very clear and very simple. We are broadly in support of this bill in its current form, however any changes that we would support would be a review of whether a gestational limit is necessary. We also support Sally's earlier comments about the importance of informed consent and also we very much support the provision for access zones. I think some of the information Jo raised earlier on what it is really like for women accessing services is something that really needs to be addressed. Hopefully this bill is a place where that can be reviewed. She also made some comments about the violence, whether direct or indirect, that she and her staff regularly put up with. She is right in that there is not really any other area of work where you would have to put up with that. It is not just for women accessing services, it is for staff as well.

We thought it might be useful that we are both non-clinical. I come from an international public health background with experience in this area, both in developing countries and here. Anthony is very much operational. So we have quite different perspectives, but just to reiterate, they are non-clinical perspectives. Do you have anything else to add?

Mr RECKIN - Not really. We thought you could ask us questions about what you perceive to be the issues with this and, hopefully, with our experience in our operation, we can give you some clarity.

Ms FORREST - Can I ask, initially, how women come to your clinic? Are they referred? What is the process by which they arrive and what happens when they get there?

Mr RECKIN - We operate in four states and a territory in Australia at the moment. We operate in Queensland, New South Wales, the ACT, Victoria and WA. In WA it is very similar to what they are proposing - they need a doctor referral before they turn up to the clinic and the doctor on site then does a second referral. We find that extremely problematic because the staff at the clinic, when the person turns up, has to ring the GP to find out if the referral is genuine and the information on the referral is current and correct. We drive all our traffic through our call centre in Melbourne, so it comes through a 1300 number. All clients are spoken to by a call centre operator. They are offered three counselling sessions, whether they decide to take an appointment or not, and they can continue to do that before, after or ongoing. We see that as an integral part of the process we involve our clients with.

We also provide them with 24 hour after-care with registered nurses and we find that, when you are talking about counselling or offering of information, the nurses actually provide that service, more so than the counsellors do. We know about 20 per cent of our total clients coming through take up the provision of counselling. Basically, they are talked through the process. They are asked about their gestational limit - where they

think they are up to. We know most of our clients do not really have a true indication of where they are up to. We try to find out what the closest clinic is for them, that provides for their gestation limit.

We go up to 20 weeks in Queensland, New South Wales and WA, we go up to 24 weeks in Victoria and we go up to 16 weeks in Canberra. Basically they are told exactly what to expect, what type of procedure they want - whether they want it medical or surgical - the costs involved, and the requirements if they are going to be having sedation.

Dr GOODWIN - Do you mind if I jump in there? With the different gestational limits in the different jurisdictions, could you provide a bit of background as to why that varies. Is it the legislation?

Mr RECKIN - Not really. In Queensland it is still in the criminal code, so that causes a lot of confusion for us with resourcing and finding doctors who are prepared to provide that service. I noticed before when people were talking about RU486 - that has become a really big problem for us since it went on to the PBS. Once it went on the PBS we wanted to provide better access for women to medical terminations across Australia, especially in rural and remote areas. We had a call last week from the Pharmacy Guild in Queensland wanting to know if providing the drug was a criminal act by their pharmacist. With RU486 they can go on to the MS-2 Step website, and they have to do a training course that is approved by RANZCOG. They also have to find a pharmacy that is prepared to dispense the medication because it is an authority script. They also have to be guaranteed they can access 24 hour medical aftercare - that is normally an A & E.

What we find with rural and remote areas is that a lot of hospitals are affiliated with religious organisations, so if they are turn up saying they have been involved in a termination, they will not get that access. We are going to find that is a limiting factor in doctors being able to access the provision of RU486 medical terminations. There is still a lot of confusion about whether it is on the criminal code, and about who is breaking the law.

We were really surprised that the Pharmacy Guild rang us because at the end of day, if a doctor writes a script and it's all in order, the pharmacist just dispenses. But they are worried about their members because it's still under the criminal code in Queensland. It brings up all these barriers and that's the part of this bill that we are quite excited about and we want to support the fact that it was going to change. We feel that the barriers need to be brought down and for us to be able to provide support and do that is one of those things that happens with that. With the gestation limits across the country it comes to doctors; some doctors do have a preference and they will only go to certain limits.

We are struggling with workforce provision because we are finding that a lot of our doctors that are doing it at the moment are older. We have worked with Family Planning in Western Australia and spent quite a lot of money in putting our own training curriculum together. We are also working with RANZCOG because what we are also finding, and RANZCOG support us with that, is that a lot of their registrars are not getting exposure to abortion or D&C [dilation and curettage].

Ms BARLING - In some states where the gestational limits are lower, what we see is it won't actually reduce the numbers of terminations but those women will go to another state.

For example, we don't serve the bulk of women from Tasmania. We have about one woman every 10 days from here but we know that probably about 57 per cent of those women are over 16 weeks. If you want to see an increase in gestational limits nationally, they are the barriers that will put you towards that end. You will still have the same number of terminations but if you want to see more in earlier gestation, you need to remove that barrier. The two doctors is another barrier that was brought up earlier. Your number won't change but where they sit within their pregnancy will.

Ms FORREST - For women who come to the clinic, in Western Australia they have to be referred by a GP, in other states they can just come directly to the clinic?

Mr RECKIN - Exactly, they don't have to have a referral at all.

Ms FORREST - Do you have figures for the gestation of the women that present; how many would you -?

Mr RECKIN - I agree with what Jo was saying before; most women we see would be in that 12-13-week bracket. There are a lot of things that happen within our clients that we know most women would go through. For example, 2 per cent of the volume of people that we see in all of our clinics nationally don't proceed. That can be for various reasons: they may not be pregnant; they may have naturally miscarried that they were not aware of; they could be over 9 weeks and that's a big thing for a lot of our clients. If they are further along than what they think, it takes them a step back to want to reconsider. They could have twins and that's always another big consideration.

The whole thing about them getting there is that they go to see a nurse. The nurse walks them through the process about what they are going to be experiencing today, talks to them about contraception, makes sure they understand what they are actually there for today and then they go to see the doctor. It's always in the doctor's back of mind and we spend a lot time with our staff making sure that they can look for signs about the patients that look really uncomfortable. It may be that they shouldn't be there. There is a really big pin on the doctors who spend a lot of time with us about being quite clear about turning people away.

Ms FORREST - When the woman presents, how long would she spend with the nurse and how long would she spend with the doctor and the usual scenario for the first visit?

Mr RECKIN - Most of the clinics run up to about 16 weeks. I would say about 80 per cent of our clients are sitting on that 12-13-week cusp. Most clients will be in the clinic for three-and-a-half hours. You are normally looking at a twilight sedation but they are normally with the nurse, the doctor and the anesthetist and that normally takes between 45 minutes and one hour.

Ms FORREST - What about pre the decision to proceed with the termination? I am interested in the amount of time that is spent discussing the options with the women.

Mr RECKIN - They come through the call centre; we have our own call centre operatives who are trained. If the call centre operative is speaking to the client and they are getting the feeling that the client is not sure, (1) about why they are actually calling or (2) about where they are up to in gestation, that's when they are offered the counselling. If they are

not sure about that, we normally try to refer them back to their GP because we want them to have some sort of comfort from the fact that if they are unsure about their gestation, it normally means they have got to a point where they are not sure why they are calling us so we normally would refer them back to their own GP.

Ms FORREST - You don't do scans to check?

Mr RECKIN - Every client who comes through our clinic has an ultrasound test, whether they are getting a medical or a surgical but we normally would like to have an idea because obviously gestational limits change in cost. We want to make sure that when they are turning up there are no out-of-pocket surprises because as far as we are concerned, in the client's experience when they are turning up and going through that process, we don't want them to have to be worrying about increased costs or anything like that. We normally try to make sure as much as possible that they have a clear idea about where their gestation stage is, but I have to say, from our own data and records about 80 percent of the people coming through do not understand where they are up to in their own pregnancy if they haven't been to a GP.

Mrs HISCUTT - It's probably something you can help me out with: the RU486 supposedly is to be used up to seven weeks, but I have heard in the UK it's up to almost full term.

Mr RECKIN - Outside of Australia it's actually used for a lot of different applications so I would have to say that Australia is actually lacking in application of using Mifepristone for what it really is doing.

Mrs HISCUTT - So if it goes over that 24-week stage -

Ms BARLING - No, I think what you're referring to is when it's used for cervical priming and that's quite -

Mrs HISCUTT - I don't know, this is what I'm asking.

Ms BARLING - Globally, under World Health Organisation standards, it's for the first nine weeks but it's also used for other purposes and that includes cervical priming and that's not a termination.

Mrs HISCUTT - For induction of labour, so it can help bring on labour and you produce a live baby? Just help me understand this.

Mr RECKIN - No, it's a really hard thing - and I'm not clinical - but Mifepristone is actually a blocker for progesterone. It starts to induce the labour, that's correct, but normally, depending on the gestational limits the babies are actually injected with either Degoxin **[?tbc]** or potassium.

Mrs HISCUTT - So, euthanased first and then this is administered.

Ms BARLING - Globally, there are no countries that are exactly the same in terms of practice, like any other medical treatment in Australia.

Mrs HISCUTT - Do you think the seven-week stage is appropriate in Australia or should it be nine? What's your opinion?

Ms BARLING - Globally it's about nine weeks; with the first registration for the product in Australia it was seven weeks. The Therapeutic Goods Administration made a decision that they wanted to see more literature but globally nine weeks is fairly standard.

Mrs HISCUTT - I don't understand it but is there any chance of a live foetus?

Ms BARLING - At nine weeks?

Mrs HISCUTT - Any time.

Ms BARLING - You are looking at the size of about a grape - it doesn't look like -

Mr RECKIN - I have to say that we have 13 clinics nationally. I have been with the company for two-and-a-half years and it's never happened.

Ms BARLING - It doesn't look like a baby.

Mrs HISCUTT - What do you use it for if it's for later? In the UK, why would they use it for later?

Mr RECKIN - We don't, a lot of the hospitals in Australia use it for second-term trimester and it's for priming the cervix to start the softening of the cervix so that it makes it easier for the baby or foetus to be discharged. Overseas, in different countries, they do it overnight as well. It's an overnight procedure when they're using it and that's what happens in the UK. Depending on the gestation, it's really hard to sit here and say. Some practitioners will do it in a day, it just depends on what they are comfortable with and what their training has been.

Mrs HISCUTT - What you were talking about earlier about, the pharmacist in Queensland, the interpretation here in this bill that says to 'terminate means to discontinue a pregnancy so that it does not progress to birth', and then it says you can do that using an instrument and using drugs and using this, using that, but then it says, 'but does not include the supply or procument of any thing for the purpose of discontinuing a pregnancy' - is that where a pharmacist would fall into because he would be supplying?

Mr RECKIN - No, because it's actually 2J[?]- approved and it's also PBS-listed. What they are basically saying is there has been some information or some traffic before from getting RU486 or the like from India and Pakistan over the internet. That's basically what they are saying, that if you want to procure something that's outside of Australia, that's what it would apply to.

Mrs HISCUTT - Should that be clarified because it looks like that the woman can actually have a piece of paper but can't get it off the pharmacist because then he's supplying.

Mr RECKIN - I would be really surprised because it's PBS-listed, I've actually got to ring up and get two authority scripts so I think there are safeguards in the fact that it's being done

above-board. I think what they are trying to say is - there was a case in Cairns where the woman procured the Mifepristone from Europe.

Mrs HISCUTT - Perhaps you should insert the words 'illegal procurement'.

Ms BARLING - I think if you are going to over complicate the bill that is not going be helpful for anyone.

Mrs HISCUTT - So you reckon leave it as it is?

Mr RECKIN - I would think so.

Ms BARLING - I would possibly consider removing the 'to birth' part as well.

Mrs HISCUTT - Why do you say that?

Ms BARLING - I think about the spontaneous miscarriages. I do not know if it's that relevant to what actually happens.

Dr GOODWIN - Before we move off the RU486, in terms of the cost of that - because one of the advantages of being on the PBS is the reduced cost. What does it cost, do you know?

Mr RECKIN - Everyone was very excited when it was listed on the PBS on 1 August and it meant a reduction of the cost. The cost of the pill is about $300 so once it goes on to the PBS it goes down to the 'script cost of about $30 and then about $5 for the healthcare card holder. It is also going to depend on the independent clinician who is providing the service - what they will charge for the consultation. So the cost of the tablets is being quite heavily subsidised but the cost of the consultation - the doctor's time - is unknown. RU486 is quite heavily regulated. There has to be a two week follow-up by the doctor as well. Within our own clinics the TGA made sure that we contacted the client within three days via an SMS to check on pain and whether they were going through the process. As much as it is becoming more readily accessible, I think clinicians are going to have to look at it and think about whether it fits into their practice because it is not about a one-off consultation. There is quite a rigorous follow-up and there is reporting back to the TGA as well.

Mrs HISCUTT - I am still stuck on this with you. Do you get two pills in a pack?

Mr RECKIN - That's correct. You get the Mifepristone and you get GyMiso. The Mifepristone is normally taken in front of the doctor and then 48 to 72 hours later you need to take the GyMiso -

Mrs HISCUTT - It is not like a packet of Panadol where you take one and put the rest in the cupboard for later?

Mr RECKIN - No, not at all.

Ms BARLING - You can go online to the World Health Organisation which gives you that kind of detail of how it is used and what it does.

Dr GOODWIN - What happens if you don't take the second pill? Has that ever happened?

Mr RECKIN - Some people change their mind. We have clients who come back. They have gone home and they just feel it is not for them and they want to come back and take a surgical. That does happen. I am not sure, to be quite honest, about the number who take one pill but not the other - I do not have that information at hand.

Ms FORREST - Following on from the question Leonie was asking about the definition of 'terminate' meaning 'to discontinue a pregnancy so that it does not progress to birth'. This is more a legal question so you may not wish to explore it too far. You were not here, I don't think, earlier in the morning when we had the departmental people here and we discussed this more fully. I had a concern that you could inadvertently catch elective caesareans and inductions with a viable baby that you are expecting to survive. The advice was basically that including the phrase 'to birth' makes it clear it is about termination of pregnancy - that you are not expecting to have a baby survive. You could probably remove the phrase, but you would need to clarify -

Ms BARLING - I am not a legal person. It is unusual language to have, and I am not sure where it is from. Do you know why?

Ms FORREST - I think it was there to clarify that it does not refer to elective caesareans and things like that. You said you would like to see it taken out. I guess it is a legal question?

Ms BARLING - Yes, I would suggest it is definitely a legal question. I have not seen it in a lot of other places. I am trying to think within global health documents. You would not normally see it - it is obviously a decision for the state.

Ms FORREST - With regard to the access zones, you operate clinics in all those states - what has been the extent of the protest? How are they conducted, and is there legislation in other states that you have seen to be effective in dealing with this? You said you supported it.

Mr RECKIN - We very much support it and I think everyone is waiting to see what happens with this bill - to see how that is going to go for other states. As I said, we have 15 clinics and we get various levels of protesters. At Bowen Hills in Queensland, every day they have 40 people standing outside the clinics and that is very well publicised. In our Fairfield and Penrith clinics we have very young Muslim men that are very aggressive. They paint and use graffiti and put pamphlets all over people's cars and letter boxes and we have an AVO out against -

Mrs HISCUTT - Why hasn't your government moved to address this?

Mr RECKIN - I do not know. We have very good relationships with the police in most of our clinics and most of the time if we ring up and say we have an issue they will come and issue 'moving on' orders. But it is a big grey area. Certainly if other things are going on with the police at the time, it may not look like it is a priority but it is something that we struggle with. We spend a lot of our own time and legal resources to see how we, as a company, can stop it. For some people it is very quiet, like prayer vigils. They just sit

out the front and they are very non-interactive - they are just there and it is easy. We normally get told by the centre managers when protesters are around, and we normally have to give access to our clients through the backs of the clinics, or they do not turn up.

Mrs HISCUTT - Do you think a law passed would actually stop that?

Mr RECKIN - Yes. I think the 'right to life' people are very strong and are very passionate about what they think is correct, and I think they are always going to have a place but overall, it would just give certainty to everyone involved, knowing exactly where the parameters are and at this stage, it is not clear.

Ms BARLING - I think support for police is important as well. The trick is how you operationalise the legislation, which is where you see how well it works, but it is also about providing support to the police after the legislation passes. For law enforcement, the police need to be really clear about where they stand, what is wrong and how they can support -

Mr RECKIN - We had an incident in Victoria about two months ago where envelopes of white powder were sent to head office and two of the clinics on operating days, so we had to shut down the clinics, and remove all of the staff and our clients. We had to have the drug people and the infectious diseases control people out. That was a pre-meditated act and, after September 11, to put something like white powder into an envelope is quite extreme.

Ms FORREST - There is legislation that will deal with that currently. This is different. I understand the attacks you are suffering -

Mr RECKIN - It is really hard though. Australia Post was very not interested.

Ms BARLING - They were not sure how to deal with it. I am sure it is not dissimilar to say 20 years ago with domestic violence or something like that - it has just not quite got to the point yet of people taking it seriously. I think if we took it seriously, we would not stand for it.

Ms FORREST - Has your staff been vilified or attacked?

Mr RECKIN - As I said, one of our centre managers in Fairfield has an AVO out against one of the protestors because he followed her home, and became quite personal. That is going through a court case at the moment, which is quite troubling to be honest. It is quite hard to attract good quality staff, as it is, for the business we are in but when you find out things like that, it is really hard. You have to be up front and honest about it as well, and we are - to all of our staff.

Ms BARLING - Whilst we recognise that not everyone agrees with what we do, staff have a right to go to work and be safe. We have families and we deserve that.

Ms FORREST - Do you have any evidence of women who have perhaps had their access delayed through a non-referral by a doctor with a conscientious objection?

Mr RECKIN - One of the questions we ask clients at later gestations, because we want to know for our own information, is about why it has taken them so long to get to us. We see a shortcoming in the way we provide our services - is it a lack of education, is it the way we are getting out there, is it where we are, or what days we operate - all of those sorts of things. A lot of the time these women have been referred to a public hospital by their GP and the public hospitals, I would have to say, do not have a good idea of how to do it either. That happens quite a lot, nationally. The only place it does not happen is in Western Australia where we have a contract with King Edward Hospital, so it is a very clear path and a very clear process. We take all of their work because they do not want to do it but they still want to support the women through provision of that service.

Ms FORREST - Do they fund your service there?

Mr RECKIN - Part of it.

Ms FORREST - This is a question I have asked other witnesses: if you have terminations conducted as part of the normal gynaecological list it can create operational challenges for people who do have a conscientious objection - and I think it is everyone's right to have a conscientious objection to a certain area - we were told that in South Australia there is a clinic that is in the confines of the hospital but not part of the mainstream operating theatre -

Mr RECKIN - They go up to 22 weeks and, as I said, that service operates extremely well. We are working with two of those female GPs who were part of that process who have taken over our late-term abortion in Victoria for us but -

Ms FORREST - There are public-funded termination services in Victoria outside the hospital?

Mr RECKIN - South Australia does.

Ms FORREST - Only South Australia.

Mr RECKIN - If you are a resident of South Australia you can get fully-funded abortions up to 22 weeks.

Ms FORREST - Western Australia is partial funding?

Mr RECKIN - Partial funding.

Ms FORREST - And Victoria no public funding?

Mr RECKIN - The thing is, as a company we work with a lot of organisations and groups so we have MOUs with refuges and Women's Rights and the same with New South Wales and the ACT. With Queensland we work with a company or an organisation that is a community group called Children By Choice, so normally people who are struggling, who have come from a very low socioeconomic background or come from abuse or are Aboriginal, they normally go through them. In the last financial year we funded $400 000 in discounted abortions as a company for people who could not afford it.

Ms FORREST - That is Australia-wide?

Mr RECKIN - Yes. I would have to say that we don't get a lot of funding from the public health system. We get partial funding from WA but from the other health departments in Australia, no.

Ms FORREST - While you continue to provide that service, is there a disincentive for the states to fund it?

Mr RECKIN - It is quite interesting that you say that, because originally we used to go up to 28 weeks in Victoria and we decided to go back to 24 weeks because of our own risk. Obviously, with later gestation the more risk involved. We were under a lot of scrutiny while we were doing that and we decided as a business and as a company, and for our own insurances and everything else involved, that we were going to go back to 24 weeks and the outcry nationally, the fact that we took away that service, was quite huge but one of the reasons we did it was because we shouldn't have to shoulder that responsibility ourselves and we were hoping that the public health systems around the country would step in and support us but to date they haven't.

Mrs HISCUTT - Do you find you get many late-term abortions that are viable?

Mr RECKIN - It is a hard thing to say. Last year we were fortunate enough to recruit Carol Foreman, who is the head of obstetrics and gynaecology at the Royal Brisbane. One of the reasons why she came to us is that she provides a foetal reduction service in our Bowen Hills clinic and she wanted to operate out of the public health system; you could turn up to a hospital in Queensland and be late term and have foetal abnormality, so what happens in Queensland is that you have to have two psychological appointments to have an understanding of where you are at mentally and then it was put before an ethics committee and there was no guarantee that the ethics committee would approve that termination. Carol got very tired of working in that system because some of these women were clearly with foetal abnormalities, so she works with us outside that sphere now.

It is not a guarantee in any public health setting in Australia at the moment that if you turn up with a foetal abnormality that you are going get approval to do an abortion.

Ms BARLING - I think a lot of the arguments around viability now are quite contested. I think for those sorts of situations where someone makes a decision within the law so these are not people breaking the law, they have a right to a service within the law. I didn't see a part of this bill that mentioned viability.

Ms FORREST - No, it doesn't.

Mr RECKIN - I was interested to see when I read before about the submission for Dr Lim from the Royal Hobart gave evidence and he did not call it an ethics committee but I notice that there was no legal representation on his and that is quite unusual.

Mrs HISCUTT - On their panels.

Mr RECKIN - On their panels, yes, because most experience that we have had with that is there is normally a legal representative at the hospital because they want to mitigate risk and that is sometimes where the door shuts.

Mr VALENTINE - With respect to the gestational limit, and I think I hear what you are saying in that period, that it should not be limited, it should be up to the doctor and their client or woman; is that correct?

Mr RECKIN - We are very rigorous with our protocols and procedures, and we have to be. We are accredited by every state health department in every state we operate. We are also accredited now with the new national standards that are operating outside those health departments and we are also accredited by our own internal mechanism by MSI UK. So when we look at what we do for provision there is a lot of policy and procedure about what we do and how we do it. We have a national medical advisory committee to which our doctors are credentialled every 18 months and they keep getting re-credentialled. We have quality improvement meetings once a month for all our staff and clinicians and that is reported every month to our senior management team. We really make sure that when we are doing that, that we sit very comfortably, that we can provide those provisions and do it in a way that we feel gives the client the best way to make an informed decision in a non-judgmental environment.

Ms BARLING - Having a gestational limit, the concern with that is that women then tend up having to travel. If the objective of having the limit is to reduce terminations late in the pregnancy, that is not the way to go about it. Also there is no evidence, it is not practice that removing that will mean all of these women will suddenly be rushing into clinics in the later weeks. That is a furphy.

Mr RECKIN - It is quite interesting when this debate comes up - that when you change the law that all of a sudden abortions increase. What you will find is that abortions do not increase. It is when that client can get to the operator at the lower gestation because when these laws are in place there is a lot of confusion around provision. They could go to a GP and the GP is not sure whether it is in the criminal code or they do not have that thing, so it delays that process by a week or two and all of a sudden they are into a later gestation. For your own people in Tasmania at the moment, we know that with both the providers here, one goes to 13.6 weeks and one goes to 13 weeks and it is not hard to miss that.

Mrs HISCUTT - In your submission you have the travelling distance - over 100 kilometres affects the pregnancy. Do people have to travel that distance, in your opinion, to access services that are not available in their local place or do you get a few women who access services out of area to be out of the area?

Mr RECKIN - Definitely. We have done a lot of research. Western Australia and Queensland are very much the same land area. In Western Australia there are two private providers servicing that whole state, so of course they are going to have to travel. In Queensland we have five clinics servicing the same sorts of areas; we know that the further north you get the less provision there is. We did a lot of research when we were applying for RU486 and we spoke to a lot of women about the reasons why they chose medical over surgical and whether they would travel. We know that there is a percentage - I think it was about 6 per cent of the women - who travelled for termination surgically,

would prefer to have it locally if they could. But there was about 40 per cent who said that they liked going out of town.

Mrs HISCUTT - Where no-one knows them.

Mr RECKIN - Exactly. There is a classic case: Toowoomba is very right-to-life and we have tried to gain access into that; we have quite a lot of referrals and it is probably and hour and a half west of Brisbane. We went into that city and spoke to all our preferred providers about setting up and they said, 'We love what you do but we do not want you doing it in this town.'

Ms FORREST - To go back to your service provision, are you using RU486 now or not?

Mr RECKIN - Yes.

Ms FORREST - Do you have a 24 hour clinic?

Mr RECKIN - No.

Ms FORREST - They have to be somewhere nearby for that help. Do they come back to you if they have a complication during the night?

Mr RECKIN - We provide 24-hour after-care, manned by RNs and basically it is about triaging. If they are falling within the limits that we have, that we feel comfortable with, it could be that they have not listened when they have come to the clinic and what they are going through could be quite normal with heavy bleeding or pain. But if it falls outside the algorithms that we have set ourselves, we would refer them straight on to accident and emergency. We would normally ring the local accident and emergency for them and say that this person is coming so that they are not just turning up. We give all our clients the come-through discharge information so if they have to go to an accident and emergency or GP, the GP and accident and emergency understand what they have gone through and we have known people where the accident and emergencies have turned them away.

Mrs HISCUTT - Turned them away?

Mr RECKIN - Yes, because they have been part of an abortion.

Ms FORREST - Universal healthcare doesn't seem to work when it comes to termination of pregnancies and this is part of the problem.

Mr RECKIN - When you have 90 Catholic hospitals in Australia that is not an unlikely occurrence.

Mrs HISCUTT - It shows the deep-rooted contentiousness of the issue in the community.

Dr GOODWIN - What are the implications of turning someone away in those circumstances?

Mr RECKIN - Terrible.

Dr GOODWIN - Is death -

Mr RECKIN - I am not clinical but it is not good, to be quite honest. It has a lot to do with blood loss and their mental state at the time as well, but it has happened. We are very clear about what we give them because we do not want them to be treated for something else and that is why we give them the discharge information. We are very clear about that because we know our clients turn up and they leave and they are not listening to what we are telling them. We make sure they have that information.

Ms FORREST - A couple of questions: how long does it normally take for the medical termination and is it that much different from an incomplete miscarriage?

Mr RECKIN - No, not really. Basically the medical terminations have to have a follow-up within two weeks and normally we have a good understanding of whether that has worked. They will come back and do a urine test and have another ultrasound and if they are still not sure they will do another blood test to see if the BHCG levels have reduced. If that still isn't clear they could get offered another dose of the GyMiso or they could be put through. We run our medical clinics right next door alongside our surgical clinic, so if they have to have a D and C we can get them in straight away and that is part of the cost.

Ms FORREST - What is the usual expectation for the straightforward effective termination from taking the first dose?

Mr RECKIN - It's quite high, it is about 97 per cent.

Ms FORREST - In what time frame?

Mr RECKIN - In the two weeks.

Ms FORREST - If I took the RU486 today, when would I reasonably expect the bleeding and pain to happen to indicate that I have lost the baby?

Mr RECKIN - It starts within 72 hours because you have to take the second lot of GyMiso; that is what initiates it.

Ms FORREST - After taking that how long?

Mr RECKIN - Normally, at the 10-day period we would expect that it has happened.

Ms BARLING - The actual pain, I think the part that you are talking about, where you might get some of those side effects?

Ms FORREST - Yes.

Ms BARLING - From a non-clinical answer it might be, say, six hours - after six hours to 12. It is really a non-clinical answer.

Mr RECKIN - Six to 72, but we give our clients a Webster pack of Panadeine Forte and two Naprogesic to take home with them because we normally find that if they take it after they take the GyMiso it gets them through that pain threshold.

Mrs HISCUTT - How many days off work would you need?

Ms BARLING - It would be up to you. Many women might decide to have the first tablet on a Thursday or Friday so the process happens over the weekend.

Mr VALENTINE - It does not always work, though, does it?

Ms BARLING - It works most of the time, so there is a very small failure rate, but that is recognised as part of the registration.

Ms FORREST - Essentially it is just like a miscarriage. You are causing a miscarriage.

Ms BARLING - Yes.

Ms FORREST - For a woman to turn up at an A and E on the advice of the clinic who maybe was not prepared for the pain and bleeding because she was not really listening at the clinic or whatever, as far as dealing with her it is like dealing with a woman who has miscarried. Is that a fair statement?

Ms BARLING - Yes.

Ms FORREST - It should not be beyond the realms of a public hospital to be able to provide that level of service?

Mr RECKIN - No, because if they turn up and they said they were just miscarrying they would be seen.

Dr GOODWIN - I was interested as to where else Marie Stopes International operates, apart from the UK and Australia.

Mr RECKIN - Forty-four countries.

Ms BARLING - Our focus is on developing countries, so we are very focused on access to family planning and also on eradicating unsafe abortion. While we have a model in Australia that is for all intents and purposes a commercial model, any surplus funds we generate go towards our programs in developing countries.

Dr GOODWIN - Do you operate in any other developed countries?

Ms BARLING - The UK.

Dr GOODWIN - You are not in Canada?

Ms BARLING - We are not in Canada and we have a small office in the US, but that is not a clinical set-up.

Mr RECKIN - We're in Mexico City as well, so the rest would be classified as developing countries.

Dr GOODWIN - That is really your main agenda - working in developing countries?

Ms BARLING - That's what we do.

Mr RECKIN - Definitely.

CHAIR - Mina and Anthony, thank you. We do not have any further questions lined up. We appreciate you taking your time to be with us, both for your submission and your evidence today.

THE WITNESSES WITHDREW

Mr BEN BARTL, COMMUNITY LEGAL CENTRES, AND **Ms SUSAN FAHEY**, WOMEN'S LEGAL CENTRE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome to you both. You are protected by parliamentary privilege while in these proceedings so nothing you say can be challenged legally by anybody. If you choose to make comments outside and reflect on the proceedings of such a committee, you are not protected by parliamentary privilege. You are welcome to make comments to whomever you choose but, if there are matters which could be challenged at law, then you do not have the protection you are afforded here. Would you like to speak to your submission?

Mr BARTL - I am here as the policy officer for Community Legal Centres Tasmania. We are very supportive of the bill as it stands and we support the right of women to decide on pregnancy termination. We would like to see the upper House support the bill.

Rather than speaking generally to our submission, I would like to take the committee to the specific question of buffer zones, or access zones, and some statements made by senior lecturer Michael Stokes when he appeared before the committee a few weeks ago. I have prepared some additional submissions about that which I would like to share with you.

In his evidence to the committee, Michael Stokes seemed to suggest that the 150-metre access zone may be unconstitutional. He made the point that it may be unconstitutional unless there is very strong evidence that demonstrations outside medical facilities were to have negative permanent health outcomes for patients of the clinic. We would make two points about that. One, there is strong evidence that demonstrations outside medical facilities could have negative permanent health outcomes for patients. We would also make the point that this was perhaps putting the bar a little bit too high.

First of all, the evidence that demonstrations outside medical facilities could have negative permanent health outcomes for patients was addressed in a US Supreme Court decision, which addressed this very issue of whether access zones breached the US constitutional right to freedom of speech. On the third page of the submission I have provided to you, you can see that the United States Supreme Court heard from doctors in the US who were able to speak to the impact many patients of these clinics had to face. These included women exhibiting higher levels of anxiety and hypertension, which caused these women to need a higher level of sedation and increased the risks associated with the surgery. The noise from the protesters could be heard within the clinic which caused stress to the women both during surgical procedures and while recuperating and, finally, that some women turned away because of the crowd, that is, they were afraid to run the gauntlet and returned at a later date, meaning that the health risks to them could be increased.

If Michael Stokes' concision is accepted there has to be strong evidence of negative health outcomes for the women and we would say that there is that evidence. We would also draw to the inquiry's attention a study released from a masters student in Melbourne who looked at women at Melbourne's Fertility Control Clinic and I believe the number of submissions to this inquiry have referred to that evidence.

The second point we would make is that Michael Stokes' bar, we would say, was putting it a little bit too high. We would say it is not whether there is a serious and ongoing negative impact to the health of the patient but rather whether the buffer zone is a proportionate response and, in our view, 150 metres is a proportionate response to the harassment, the intimidation and/or the impediment from accessing the premises that these women, these patients are likely to encounter.

Dr GOODWIN - This provision and the 150 metres, is it broadly the same as the Victorian provision?

Mr BARTL - As I understand that, no state or territory in Australia has a buffer zone.

Ms FAHEY - Victoria attempted and it was excluded. It is more similar to the Canadian provision and they initially put one in in Canada. It was then removed and then the behaviour continued so they had to re-implement it, is my understanding. It is an adaptation of what they have in Canada and British Columbia.

Dr GOODWIN - Canada is 50 metres?

Ms FAHEY - Yes, Canada is 50 metres.

Dr GOODWIN - And they have not had any challenges to their 50 metre buffer zone apart from that initial -

Mr FAHEY - Initially they took it out but they put it back in.

Mr BARTL - There has been a constitutional challenge and that again is raised in the submission. Most recently, in the case of [inaudible], and there were some comments made by the judges in that case, but basically in the United States and in Canada it has been held back and buffer zones do comply so long as they are proportional to the rights of free speech in those countries.

CHAIR - Have you finished your presentation, Ben?

Mr BARTL - Yes.

Ms FAHEY - I will just add to what Ben has said there because this is what you do when you go on leave, I observed a protest outside the East Melbourne Clinic last week just to see. As part of getting my head around this, I have talked to a lot of people and tried to understand all the different points of view because there are a lot of points of view on this. If I can just reiterate what Dr Cockburn said earlier, that people outside the clinic would probably feel that they are not threatening because in Melbourne they have to stand behind a line, but for someone who was not actually walking up to access the clinic it was quite intimidating to see these people lined up, even though they were doing it quite peacefully, because on one side of the line you have people lined up trying to hand you pamphlets and on the other you have a security guard and someone with a big tag that says 'Friends of the East Melbourne Clinic' there to help get people through if the crowds get too large and to escort them in. Although we generally only have one or two

people outside our clinics here, we say that the impact that one person with one sign can have on one woman walking through is significant, ongoing and lasting.

We urge you to maintain the access sites. We think that the evidence is certainly there through Susie Allinson's research. I think her research found that just under 80 per cent of women who had crossed through or passed any form of protest, whether it was silent or not, had long-term lasting emotional and psychological impacts. We would urge you to maintain that. We think that it is a necessary inclusion. Just because we do not have hundreds of people standing outside the clinic - I think we have all seen the photos of the protestors - albeit silent but wrapped around the street around Michelle O'Byrne's office when the bill was first introduced. It is not necessarily something that will not happen to the clinic here. It was not something I would have expected to have seen - children on lawns with signs and people wrapped around, albeit silently, in Tasmania, but we have seen it and so I do not think it is a long stretch to say that could happen to a clinic here.

With regard to our submission, I am happy to take questions if people prefer that or I am happy to walk through the submission. I know that there were a couple of questions earlier about the conscientious objection and the referral. I think you had a really good question earlier - the question of referring to another medical practitioner who does not have a conscientious objection. If you like I can speak to that.

Mrs HISCUTT - Yes.

Ms FAHEY - I think the question was 'Does it fix it?' If a doctor has a conscientious objection and is having to refer to another medical practitioner that they reasonably know or think would not have a conscientious objection and you wondered about the inclusion of the word 'service' instead. What I would say to that is that you can feasibly give someone a pamphlet to Family Planning because they have counsellors, they have medical practitioners. The reason that you need to refer to someone that you reasonably think would not have a conscientious objection because if you have an objection - say I'm a doctor who has a conscientious objection and I refer to Ben who I know has a conscientious objection, the patient winds up still in the same situation. They do not have someone who can speak to them objectively.

I think sometimes there is an assumption that a doctor who does not have a conscientious objection to termination of pregnancy is therefore somehow pro-abortion and that is not generally the case. It is just someone who feels that they can actually discuss it.

Mrs HISCUTT - It was mooted earlier that if you did, in a scenario as you just said, and Ben was pro, that the first doctor would then still feel like he was betraying himself by referring on.

Ms FAHEY - Absolutely. With some of the doctors that I have talked to that is a problem. I think you will find that there are some people who have a very strong view for personal, ethical, religious or whatever reason, that any participation in any referral, even though if you send someone in Family Planning, Family Planning in Tasmania do not conduct terminations, they will then make the referral on. They would still feel that they are still in a chain of events that would maybe lead to a termination and that would not be satisfactory to them. I think on balance we have to look at a woman's right to have that discussion at least.

There is a proportion of women who because they discuss having a termination does not mean that they go on to have one.

Mrs HISCUTT - You have no strong objections to inserting 'or a service'?

Ms FAHEY - Yes, I would, because if you inserted 'or a service,' if we had a doctor who was strongly against termination, and there are doctors throughout this process who have come out and said things like, 'I'll leave the state,' or 'I refuse to adhere to that,' they would then send someone to the Pregnancy Counselling Support Service and they have a view, they have a conscientious objection. You wind up with someone going to a service that is effectively a pro-life service. They could comply with that necessity.

Mrs HISCUTT - What about a prescribed service? As we have said before, we can regulate that.

Ms FAHEY - I think it would be unnecessary because even then within the codes of conduct, and I think we have all heard there are multiple codes of conduct in play here for various sectors of the medical profession. The thing that rings through all of them is basically that doctors who have a conflict of interest need to refer to someone who does not have that conflict of interest.

Mrs HISCUTT - That, in itself, is a conflict of interest.

Ms FAHEY - You have to weigh it on balance between the patient's rights to full and objective information. I think sometimes with law you have to be very careful about putting too many things into it because then it can get confusing while you try to tighten it down and make it really specific. That is when you are inadvertently have unintended consequences and big loopholes, so I would say it is fine as it is; it works in Victoria because for the doctors who have a conscientious objection, the ones that have a very strong belief, I do not think that there is anything that you could put in there that would appease that.

The evidence that we have had today suggests that doctors should put up a sign in their practice so that they are not put in that position; there is a degree of self help here that could be implemented, such as putting up a sign saying, 'Doctor such and such does not refer for terminations. If you want to discuss it, talk to this other doctor or go to Family Planning,' if it is a pro-life practice. As they are, the provisions are perfectly fine; I would not tweak them and add in service providers because there are a few ways too many that you could get around that. If you start prescribing services, then if you have one that is defunded or one that is nearly funded, you have to keep going back and redoing that.

Mrs HISCUTT - I did not think that was a problem, updating the list.

Ms FAHEY - They can update a list but if you start prescribing them, then sometimes the lists do not get updated on time, so we have to be really careful about safeguarding conscientious objections on the one hand but also making sure that women have that right to all of the information because, as I said, for a woman who might want to talk about terminations, looking at some of the case studies that have been heard here,

sometimes she will not know if she has the support or what support is available to her. Once she has talked to someone at Family Planning, she knows that the support is there and she decides to go ahead with the pregnancy; some will decide to go along with the termination. I think to that end the provision it really is fine. Does that help with that at all?

Mrs HISCUTT - Yes, a bit.

Ms FAHEY - I think the other thing -

Ms FORREST - You made an interesting point, Susan, that someone who does not have a conscientious objection is seen to be pro abortion, which is probably a long way from the reality because in my experience and in talking to a range of medical practitioners, no one is actually pro-abortion. They are pro-choice or pro giving the women a full range of options. This whole referral thing - and the only good point about it for a prescribed service or whatever - there is some merit around that but that is only my personal view. Family Planning does not conduct pregnancy termination in Tasmania and I think in Victoria they do not do it there If a doctor has a conscientious objection to referring to Family Planning it means that service will not provide the terminations, that absolves them from the direct link, which is what some of the doctors have expressed, and because Family Planning has doctors who work there, then that covers both bases because a lot of the nurse practitioners are very adept and able and make it a practice to provide that advice, but sometimes you need that medical advice as well. If services were prescribed that were able to provide that, do you see that would not work? I know you have an objection to it - you think it should be left as it is.

Ms FAHEY - With careful drafting you could do it but you would have to be very careful of unintended consequences. I think the suggestion that there could be a brochure or pamphlets done by the department referring people would be an easy way to go and have the combination. I do not know that you need to legislate to do it but there certainly needs to be the option to refer for counsellors, doctors and owners; you could do that. I do not think you need to do it but you could draft it.

Ms FORREST - Despite all that we come back to the medical code, the [inaudible] code of ethics that [inaudible] under the referral that the referee generally. For any doctor who must operate under the medical code it is very clear that they have to refer.

Ms FAHEY - It is very clear. What doctors are being asked to do in this legislation is nothing outside of what they should be doing. If they are doing what they are supposed to do in practice, they would be doing it. In talking to colleagues at Family Planning, the Hobart Women's Health Centre and a number of other organisations we talked to while we were lobbying for this - the Women's Legal Service has been working on this for two-and-a-half to three years, and we are probably the latecomers to this - we have heard a lot of anecdotal evidence - and the reason we have pushed for this provision, as well as the one for counsellors to refer - of women going to doctors and doctors telling them, 'Abortion is illegal in Tasmania, you will just have to find a way'. They are not giving them that option. It is one of those things if you come across a doctor who has a conscientious objection or a pro-life position. At the moment some of them are quite happily saying that, which is problematic. The point you made is true - nobody I know is

pro-abortion. They are talking about having choices and people making decisions based on their own personal ethics, morals and beliefs.

Ms FORREST - And a full range of information about the risks and benefits, all options.

Ms FAHEY - I have been called 'hero baby killer', 'pro-abortion', 'abortion protagonist' - all sorts of fun names - all by people who have never stopped to ask me my view on it. I believe it is very easy to say that if someone doesn't have a conscientious objection therefore they must be pro-abortionist. That is just not the case; it means they may have another point of view.

Ms FORREST - Dr Cockburn used the example of circumcision as well, and that is something I will have to deal with and face as a midwife. I understand that concern.

Dr GOODWIN - In relation to those doctors you mentioned who might have said to the woman, 'They are illegal in Tasmania', maybe we could give some of them the benefit of the doubt. We have heard that there is this mythology about what the current provisions say around termination.

Ms FAHEY - I think with some it is quite deliberate and with others it is a misunderstanding of the law. That is one of the reasons we have been involved, because women and doctors are quite confused about the law. The way it is written is confusing, and there is a bit here and bit there in the Criminal Code. It is not ideal.

Dr GOODWIN - With the provision, particularly for the doctors around conscientious objection, we have had the discussion about the fact that their medical guidelines already require them to disclose or refer or both. What additional benefit is there in having it in the legislation? If it is merely restating what they are already required to do in their guidelines, what additional benefit do you think there will be in having it in the legislation?

Ms FAHEY - We know some of them, for whatever reason, are not following those guidelines, so for clarity what our group of organisations effectively lobbied for was to have a bill that said, 'This is the law regarding termination of pregnancy', so it was very clear and didn't leave anything open to interpretation or confusion. That is why we wanted that put in there. From the Women's Legal Service perspective we had anecdotal evidence that for whatever reason doctors weren't making referrals so, although we knew all their codes said they needed to, they weren't. There needed to be that reinforcement and that's why we need it in there. At the moment it's not working. The doctors, if they're following their codes, should know that they need to make that referral. They should not get themselves in a position of compromise.

Sometimes a patient will come in and say, 'I'm pregnant, what do I do?' It may be they did not know their medical practitioner was someone who had a conscientious objection and it may be at that moment they find out. What we are looking at here is having a complete piece of legislation so in 10 years' time we are not back here before you saying, 'We need to change this; this isn't working'. Our organisation is lobbying very hard to put some things in here that maybe initially might not have gone in so we have complete legislation that is easy to understand and read. If this bill passes, and we certainly hope it does, we would be putting out information and distributing it as an organisation

explaining the bill. We would be more than happy to do educational stuff for women and doctors, to say, 'This is what the bill mean',' so that once and for all everybody understands it, so we are not in the position we are in now where not everybody understands what the situation is.

Dr GOODWIN - In a discussion we had this morning with Dr White and Cherie Stewart there was mention of the situation in Victoria and the AMA Victoria policy position and guidance on this issue of referral. It is probably fair to say there has been a bit of fear about what the word 'referral' means. It would appear from the information we received this morning that it would be sufficient to just give the patient the name of maybe Family Planning or another service or another GP rather than a formal referral. I believe there is still some confusion around that.

Ms FAHEY - Maybe the word 'refer' is one of those things where medicine and law have collided a little bit. 'Refer to' means to give them a pamphlet, if that's how you want it. I do not think you need to put a definition in there but you could say 'hand them a pamphlet.' Talking to a few doctors, they see 'referral' as pulling out the pad or getting on the computer. I think it might be the APRA code - I know Audrey Mills gave everyone a copy at the briefing - that spells out what 'refer' can mean, and it would not be outside of that. Maybe it is a bit of education saying, 'You understand "refer" as breaking out the referral pad and writing something down. You don't need to do that. You simply need to give someone this brochure and that would be a referral for the purposes of the legislation.'

Mrs HISCUTT - How would we go if we transferred 'refer' to something like 'provide'? It would then be 'a practitioner must provide the woman with information'.

Ms FAHEY - You could use alternate wording such as that, but you have to be very careful with what they provide. It may be too general or too vague. I know when people started raising the issue of 'refer' I sat down with Cherie Stewart and numerous other people who are far cleverer on this issue than me, trying to think of different words and everything we came up with had a different connotation, meaning or understanding. Even within the medical profession there are varying degrees. Even through these hearings I think Caroline de Costa said it is not problematic to use the word 'refer', but others have said there is confusion about 'refer' because of what they understand it to be.

In talking to doctors and people in the medical profession, my understanding is that there is a varying level of understanding or acceptance as to what that word could mean for them. As a lawyer, I believe it is the best word for everybody because lawyers understand what the word 'refer' is, the general public understands what the word 'refer' is. The problem, obviously, is with the doctors where there is a varying level of understanding. If you felt you really needed to, you could put something in there to say, 'This is what "refer" means for the purpose of this bill'. I think that's overcomplicated and unnecessary. With a bit of education there could be better understanding of it. I don't believe it is problematic but it comes down to people's understanding of it. I accept that some medical practitioners have an issue with it. I do think the provision has to stay there, though.

Mr VALENTINE - I am interested that in your submission, you talk about an amendment being needed about truth in advertising; perhaps you might like to cover that?

Ms FAHEY - This has probably been circled around; one of the provisions that we initially said that we thought should be in the bill was truth in advertising and that whether for some of the pregnancy counselling services, for example - I think that the ladies who spoke on behalf of the Pregnancy Counselling Support Service, and I know I have probably got their name wrong - do have a conscientious objection and they said, 'We do not counsel and provide advice.' They have the word counselling in their name so I think some of those organisations, if they had to say that they have a pro-life ethos, then they can easily avoid a situation of conscientious objection because at the moment they sound like they just regenerate counselling services when we know that they do not. I know that they gave you their code of conduct from following Pregnancy Health Australia, which is actually a pro-life organisation.

That was something that we said would be handy to put in the bill; it is probably not essential but it is one of those things that we would be saying at this point, 'Pass the bill as it is,' but that would be something that would avoid the situation that those ladies said they would find themselves in because people would know that they should probably ring Family Planning then because they will cover the whole spectrum.

Mr VALENTINE - I think they were considering that counselling in its pure sense is not giving advice - it was simply helping the person through their own thinking, their thought processes and that would come down then, I suppose, to the definition as to exactly what counselling means.

Ms FAHEY - I think different people have different views on what counselling is and what is involved and there are different methods of counselling; some involve almost advice or plan of attack-type processes throughout and some of it is actually listening; it really depends. That was one of the reasons why we were pushing for the provision for referral on counselling because again, we know that there are services that have a view and that that is not always apparent initially, so just to avoid upset for them having someone who may want to talk about termination, and of course for a woman who might be feeling really vulnerable and lost, it would be quite confronting and we know from an anecdotal level that it is very confronting to ring an organisation that does have a pro-life view when you want to have what would probably be one of the hardest discussions you will ever have.

We do know that some of those organisations do not refer on; that is why we feel that it is really important that they also have a referral mechanism there and it is why we felt there needed to be a penalty there so that there is no point telling someone you have to do something if then they do not do it and there is nothing sitting there to give them an incentive effectively to do it. That is why we felt that the referral and the penalty provisions for counsellors were necessary; they do not have the same level of professional scrutiny or code of conduct that the medical profession has.

Mr VALENTINE - You are basically supporting the bill. You say you do not want a gestational limit in your submission; how does that sit with what currently exists at the moment which obviously is it not no gestational limit at the moment?

Ms FAHEY - There is currently no gestation limit. I think for us ideally in the bill we would have one doctor, one woman and whoever she wants to involve, and no gestation limit.

The RANZCOG guidelines are very clear on what obstetricians and gynaecologists should be following and how they should treat a patient along with other codes of conduct, and at the end of the day these people, the doctors, obstetricians and gynaecologists, you would hope and I think are very highly trained people who know how to handle this and I think, as was pointed out earlier today, generally once you get past a certain point of gestation there will be an obstetrician or a gynaecologist or both involved because it becomes more complicated. So for us, we think that if you start to lower the gestation limit, you will see people who will terminate because they think, 'Oh my God, I am going to have go through these other hoops if they do not understand it properly. I live in Smithton or Scottsdale or somewhere like that; it is hard to get somewhere. I am just going to have to go and do it,' and they may terminate earlier.

There is some evidence that where gestation limits come down people will say, 'I have to make a snap decision, otherwise someone is going to say "No," or I am going to have to explain to somebody why I want to do this,' and so I think it was a mistake to put a time limit on there - it is human nature that if someone says 24 someone will say 18, someone will say 16 and someone else will say, no make it 14. Being fairly frank, I think gestation limits are about personal comfort; people have pictures and I have seen some of the stuff you have been getting. It is pretty bad. People have a view and they think that if they lower the limit then somehow that makes it better. It does not; it limits the time doctors and women have to make decisions and we start cutting out scans and it is just making it more complicated, so I think no gestation limit as we have now, is the best way to go.

Obviously, I am not a doctor, but that is what the Victorian Law Reform Commission's final report on abortion found; it is what the UK House of Commons Science and Technology Committee found. Again, people who know their stuff have said that this is where it should be and I think we have to rely on the fact that our doctors are very capable and able to assist women with this. We have to give women the credit; they are not going to run out and it is being suggested that people will start having terminations at 38 weeks; no-one is going to do that; no doctor is actually going to assist in that.

Ms FORREST - It is called an induction of labour.

Ms FAHEY - Exactly. I think we need to look at real situations and real life scenarios. Only 0.7 per cent of terminations happen after 20 weeks and it is nearly always for severe foetal abnormality or because in the lower part of that 0.7 per cent because there is something critically wrong with the woman carrying the child, so I think we need to look at that realistically and say, 'We are talking about a very tiny percentage.' People are not going to sit around and say, 'I have plenty of time because there is no limit.' We only have to look at the statistics now - there is no limit in Tasmania and most women who want to have a termination will go within the time. Something like 99.3 per cent of women do it in under 20 weeks; we need to look at that and say, 'We are talking about a very small percentage and these are the people who need to take the guidance from their doctors. They are doing it for a reason; they are not doing it on a whim.' We need to step back from the hype on that and say, 'Yes, these are critically ill and critical situations that people have in those terminations.

Ms FORREST - I want to clarify a point with the President.

Ms FAHEY - Not if it is with my maths.

Ms FORREST - With the gestation limit, it is not a strict limit - it is a change of process making it more onerous, so that there still will be no limit as far as the gestation period at which you could have a termination, but it would change the process. You believe that that change of process at 16 weeks is unnecessary; is that true?

Ms FAHEY - I think it makes it onerous. If you start putting time limits on people and limits on doctors, you will force decisions. People are not going to do it any more quickly or any more slowly because there is no limit on it. My understanding is, and I have read so much that I could not quote exactly which study, but there are plenty of studies saying that women generally know within a reasonable amount of time whether or not they are going to continue with a pregnancy. Basically, they will make the decision; what we are doing here is saying that after a certain point in Tasmania you have to fly to Victoria, which then makes in unaffordable for some people and it is easier to say, 'You just have to ring the clinic.' That is fine if you are inside a certain time limit in Hobart or Launceston, but if you are in Smithton or anywhere further out and you cannot drive, you have to catch a bus; it takes two days and there is no overnight accommodation. It becomes expensive and traumatic and if you are a young person it is even worse - we have a fairly high teen pregnancy rate in Tasmania so that should not be seen as a cure, but that is a reality.

Mr VALENTINE - Ben, does your organisation basically have the same stance as that?

Mr BARTL - Yes, we support the Women's Legal Service and I think our submissions basically supported women.

Mr VALENTINE - Thank you.

Mrs HISCUTT - One quick legal question. In the bill before us it says that a physician has to take into consideration a woman's current and future physical, psychological, economic and social circumstances. When I saw these all listed I thought somebody else is going to come up with something else that should be considered and perhaps these words should be more general. There was an example of that this morning when someone suggested that perhaps gross abnormality of the foetus should also be considered. When you start listing things like this, there is always going to be something that someone can think of later. Do you think it is best to have them all listed as they are or should a more general term like 'the physician should take into account any matter which he deems necessary' to be replaced with that?

Ms FAHEY - Section 164 of the Criminal Code says that in assessing medical practitioners may take account of any matter which they consider to be relevant. My understanding is that the reason that it was drafted listing those four fairly broad terms is because doctors did not understand that social and economic circumstances, for example, could be deemed relevant. In a bid to make this clearer, it has sparked a bit of a debate by having those four provisions in there but those provisions - mental health, physical health, social and economic factors - were determined in court cases starting in 1971 and 1972, and there is a really good summary of that in the Victorian Law Reform Commission report which I dropped off for all of you. I am sure you have all read them.

There is a good summary of that. Michael Kirby, now retired, expanded that and it has been accepted that it was not the decision on section 164; it is accepted that those are the four factors because they are used in a lot of assessments that doctors make, not just on this - they are the four common things that are taken into consideration. I would be really opposed to getting into things like gross foetal abnormality and, as someone asked this morning, 'What is gross foetal abnormality?' There would be people who think a club foot is that just because their child is not perfect, whereas I would that that would be a really bad way to go. I understand that some doctors say they would like to be able to tick something other than mental health if they are dealing with one of those women who is in the 0.7 per cent where there is a really gross foetal abnormality and they do not want to tick mental health for the mother; frankly, that is a factor. If you have a baby that you desperately want and you find that it is going to die shortly after birth you are going to have a mental health ramification.

Mrs HISCUTT - I keep hearing a lot of comments about how we have to trust the woman for what she wants - she knows what she wants, you have to trust her. Is this not a great opportunity to trust that our medical profession is not going to make silly decisions? Is there a need to have all of those descriptions in there because medical practitioners do the right thing, they try to do the best that they can; would it not be best to left to them, to trust them to make the best decision?

Ms FAHEY - Ideally, this legislation would say that termination of pregnancy occurs with the woman's consent and that in examining the situation, medical practitioners can take account of any matter they consider relevant, end of story. That would be ideal.

Ms FORREST - All the way through.

Ms FAHEY - Yes, all the way through. We should be trusting our women and our doctors to get this right.

Mrs HISCUTT - Obviously, about a quarter of doctors have a conscientious objection so they are not out there willy-nilly just saying, 'Yes.'

Ms FAHEY - And they don't. The thing is what people say. I have heard the phrase 'abortion on demand' used so often, particularly in the media, and it is wrong. No woman can go in and demand an abortion. If the doctor says, 'I do not want to do it because you are too far along, or because I have a blanket objection, or I do not think a cleft palate is a reason to do it, or I do not think whatever reason is a reason to do it,' the doctor can just always say no.

Mrs HISCUTT - You do not think there is any advantage in taking those descriptions out and replacing them with a more general term?

Ms FAHEY - You would need to do education if you did, because the reason that we have gone to those core descriptors is because the doctors did not understand that general descriptor in section 164.

Mrs HISCUTT - This will be taken out of the Criminal Code so they won't be -

Ms FAHEY - You could take the provision out of the Criminal Code and insert it instead of that, but you would need to do a fair bit of education to get them to understand that that provision basically means those four things because they are the four things that -

Mrs HISCUTT - I am led to believe that the biggest threat for doctors not doing it is because of the Criminal Code.

Ms FAHEY - Yes, it is and that is why it is not happening, apart from foetal abnormality or death in utero or severe illness on the part of the woman in public hospital systems.

Mrs HISCUTT - And that won't change even if we lift it out of the Criminal Code, so we have been told.

Ms FAHEY - You would hope that they would or that there would be a provider who could do it. That, obviously, would be a matter for the health department because in any given time you could have a doctor in, say, the Royal who has a conscientious objection and they won't want to do it. Obviously, that should be supported, but then there should also be people employed who do not have that view because otherwise we have heard plenty of evidence of people being sent by organisations who are paying for people to go interstate and have terminations because they cannot access them here and that is a problem.

Ms FORREST - Following on from that point before I go to another one, Susan, from a legal point of view and I am happy to do the clinical stuff and you do the legal stuff here.

Ms FAHEY - That would probably be good.

Ms FORREST - In subsection (2) of 5 where it says, 'assessing the risk referred to in subsection (1)' about the mental and physical risk to the mother, 'medical practitioners must have regard to the woman's current and future physical, psychological, economic and social circumstances.' Can that mean that they can also consider foetal abnormality?

Ms FAHEY - Yes.

Ms FORREST - It does not exclude it. It is saying these four things they must consider, but it does not stop them considering the life outcome or the health and wellbeing outcome for the foetus, does it?

Ms FAHEY - No. I think you have to look at it from the point of view that a foetal abnormality, particularly one that would not be life threatening but severely debilitating, does have a very big impact in pretty much all of those areas because you are looking at a child who may have extremely high needs, so that is clearly a financial issue. It is going to have a mental health issue. You are talking about parents who may decide that if they are having a child with a really severe disability they will not have any more children, or it might be the fourth child and they would say, 'Look, if this child is going to have these problems, how are we going to care for our other children?' It is a major consideration because it is a financial issue; much as that might sound deplorable to some people, it is. It is going to have a financial, a physical and a mental health impact, so it does have all those issues.

It would be quite discriminatory to put something in there about having a foetal abnormality, gross or otherwise, because there are plenty of people who would have been the baby with the foetal abnormality who lead very good lives and productive lives. I think they would object and frankly I think it would be quite deplorable to say that a disability is a reason to terminate and there would be a lot of people who would be pretty angry if that was the case.

Mr VALENTINE - Stephen Hawking.

Dr GOODWIN - Correct me if I am wrong, Ruth, with your clinical knowledge. There are foetuses with abnormalities that are fatal, so they will not survive beyond hours, days or whatever and that is to be distinguished from other cases where there might be foetal abnormalities but the baby is going to be viable.

Ms FORREST - A classic example there is trisomy 21 or Down Syndrome. Some of those babies will have lethal congenital heart defects and they will die. You do not always know that. If you get a diagnosis of trisomy 21 that is what you get, but you are not sure of the extent at that stage. Some parents might consider that they could not deal with it socially, economically, mentally or whatever, but it is not lethal. Once you start to prescribe the lethal anomaly then you come into all those areas where we are making judgements about what we as parliamentarians believe is right.

Ms FAHEY - It is one of those things that people need to be able to make the decision based on what they think they can cope with and be able to do that without shame or stigma because some people would openly say that they could not handle a child with high needs. It might be because they cannot because of work or their lifestyle or because they already have however many children or their own needs. There would be some people who if they found what would be a fatal abnormality they would continue with the process as their decision would be, 'Two minutes with my child is better than none.' There would be other people who would say, 'I cannot go through that,' and make the decision to end it.

That is why we need to make this legislation such that people who are going through things like that can do so without guilt and shame. A lot of the rhetoric against termination is based on stigma and shame. I know a lot of people who have seen the Emily's Voice billboards and TV ads and have been quite traumatised by them. Even though they are very subtle, if you have been through that it makes you feel guilt and shame. When we are devising legislation it needs to be something that is reflective of what community standards and beliefs are; that is, the majority of standards. The family planning survey from May last year clearly spells out that the community is greatly on board with something in this. Close to 86 per cent of people believe that it is an issue for a woman and her doctor; then in varying degrees, but still all the majority view that this should be a process that is available.

That is the other thing we should remember - that we are supposed to legislate what the community standard and belief and greater morals are, even though it is a really tricky, emotive topic. The people who are against this for religious reasons are never going to have a termination or are unlikely to and they are never going to change. But there are a lot of other people who may or may not have a view on it and we need to respect both sides of that. This does that.

Ms FORREST - Another legal question. I know that you have listened to most of the witnesses and we have discussed this in the past. I am interested in your legal view on clause 2 with the interpretation of the definition of 'terminate.' To discontinue a pregnancy is that it is not to progress to birth. Have you formed an opinion on that as to whether it has been left in or taken out in view of inadvertently catching up with elective caesarean sections and induced labours?

Ms FAHEY - It is clear that it is meant, for the purposes of a termination, to provide clarity, which it does. I have thought about it and you could take it out but that would cause some confusion. If you have 'does not progress to birth,' that does take that confusion out and provides clarity as to what it is meant to be. Effectively, if you put it before a court it is understood that the sole intent of a termination is to deliver a dead foetus or a dead baby - however you want to put it. If someone challenged it, having 'to birth' in there does provide that clarity, particularly when you look at in view of what the understanding of 'terminate' is.

Ms FORREST - And birth - I think Cherie mentioned the *Macquarie Dictionary* definition of birth being about independent life.

Ms FAHEY - Yes, and I think Cherie is completely correct on that because if you look at that dictionary definition, which is what the court would do, it is intended that there be life. Terminate: the clear imputation of that is that it is not meant to be and to reiterate what Sally Cockburn said earlier - there is no partial birth termination; there is no live birth termination. The sole aim of a termination is to deliver the death of a foetus or baby, however you prefer to put that. I think it is fine as it is and I agree with what Cherie is saying after a lot of thought about it.

Mrs HISCUTT - When you talk about 'does not progress,' there are no options for a foetus other than termination or to birth, there is nothing else that can happen, is there?

Ms FAHEY - No, it is life and death.

Mrs HISCUTT - So why does it need to be there because it just says 'it needs to discontinue the pregnancy so that it does not progress'.

Ms FAHEY - I think it is really just put there so that it is completely black and white and it is really clear so that there is no -

Mrs HISCUTT - But we have just decided that there are only two options - it is only termination or birth.

Ms FAHEY - It probably would not hurt to take it out but I think leaving it there gives that bit of clarity to make it really, really clear.

Mrs HISCUTT - I just can't see what else you could do if you don't give birth or terminate, that is it.

Ms FAHEY - No, it is one or the other really. I think it is to try to avoid people implying in something like a C-section or another procedure like that so -

Mrs HISCUTT - It is still a termination or a birth.

Ms FAHEY - Yes, but a C-section it does terminate a birth and then it brings the pregnancy to an end, but the intention is that there will be a life at the end of it, whereas with termination the intention is that there will be a dead baby or foetus, however you prefer to put that. I think it is there to provide that clarity.

Ms FAHEY - Can I just answer one thing that Leonie raised earlier on the Poisons Act?

CHAIR - Yes.

Ms FAHEY - You raised the question of the pharmacy stock ;on that I think you were asking about the procurement of -

Mrs HISCUTT - It does not include to the supply of procurement.

Ms FAHEY - The supply and administration of pharmaceuticals, drugs and all that comes under the jurisdiction of the Poisons Act, so this legislation doesn't need to mention it because it goes back to the Poisons Act. As long as a pharmacist and a doctor do the correct prescription supplied in an appropriate way under the Poisons Act there is no issue at all. If someone tried to buy RU486 from India or another country, that is a problem.

Mrs HISCUTT - That is how you see this.

Ms FAHEY - Yes, and it has been drafted really carefully. There was a lot of policy work to make sure that the Poisons Act was right and pharmacists and nurses didn't get caught up, but the problem with RU486 is that at the moment if you leave the law as it stands it is not going to be easily or at all used in Tasmania while you have to have two doctors doing it from the start because you effectively need two doctors to prescribe the one medication.

Mrs HISCUTT - So adding a legal supply or procurement is neither here nor there?

Ms FAHEY - Entirely unnecessary, in my view.

Dr GOODWIN - It is interesting because the Victorian legislation has a specific provision around supply of -

Ms FAHEY - Different legislation.

Dr GOODWIN - Yes, but obviously they are equivalent of a Poisons Act which is probably different to ours, but I do not know.

Ms FAHEY - Yes, and I had a really long chat with everyone involved in formulating that bit because I think, as you know, I did an initial rough draft in an ideal world as what I would like to see in the legislation; I had followed something similar to the Victorian legislation and it was because I had actually listed the provision in the Poisons Act, I

made a bit of a boo-boo: 'No, the Poisons Act covers that provision and we don't need it here because that's where our legislation differs'.

Dr GOODWIN - Do you know, or could you let us know, which provision in the Poisons Act covers it?

Ms FAHEY - I will put something together and shoot it through to you.

Mrs HISCUTT - There could be a couple of them, depending on whether it is nurses or pharmacists.

Ms FAHEY - Yes, easily done.

CHAIR - Thank you very much.

THE WITNESSES WITHDREW.

Prof. MICHAEL PERMEZEL, PRESIDENT, ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF GYNAECOLOGISTS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Professor Permezel. You would have appeared before parliamentary committees in your career?

Prof. PERMEZEL - Alas, not. I have only been president for seven months and no parliamentary inquiry as yet. But I did sit on a panel with a Victorian inquiry.

CHAIR - We indicate to you that you are protected by parliamentary privilege while in these proceedings. Outside here you may have a request made of you by the media to make some comment on RANZCOG's views of what is happening with the proposed law in Tasmania. You are not afforded parliamentary privilege outside here, whereas in here you have that complete protection for anything you say. We indicate that you exercise some caution in terms of potential action against you outside here.

We have your submission and we are grateful for that. Do you wish to speak to the submission to build on any of the matters that you have raised in there?

Prof. PERMEZEL - Our position is in the summary key points. First of all, we applaud the Tasmanian legislature for looking at this difficult area and I think it needs some courage on behalf of politicians to address these difficult issues. It is pleasing to the college to see Tasmania looking at this legislation. One issue for us is the lack of consistency across the different jurisdictions. We are primarily a teaching body and it is difficult for our trainees, who move from state to state and jurisdiction to jurisdiction, to come across quite different legislative conditions as they move around Australia and New Zealand because we are a bi-national college.

We absolutely support the provision under the proposed legislation that practitioners with a conscientious objection are respected and not compelled to participate in the process, but we recognise that that needs to be balanced against the right of women to obtain the information they need.

I heard with interest the previous speaker speak against the two-tiered system. There is a two-tiered system in Victoria with which we have some familiarity. The issue of two-tier or not, as I think I heard some of you respond that, is there a big difference between the two tiers in that below-tier or above-tier termination will still be possible, but just the existence of a tier certainly has some symbolism which I think the community probably is reasonably appreciative of, that there is a difference between so-called early and so-called late termination.

We do not strongly believe that the two-tier system should be abolished, but we do have some concerns about the gestation of that tier. Sixteen weeks is earlier than the college would wish to see and I think in the first draft of the legislation it was 20 weeks, was it not?

Ms FORREST - Twenty-four.

Prof PERMEZEL - Twenty-four, yes. We were surprised that it has come back as far as 16 and that that might impact upon reproductive choices of women. The issue, and again I was very interested to hear the last speaker - witness - speak about the anomalous foetal condition and it is an important - I do not know whether she is there, she is - but she spoke extremely well and I think the legal connotations of the anomalous foetal condition is a very difficult area in law, obviously, but also a difficult area for a clinician where, as she said, anomalous foetal condition can mean many things.

The wording of that particular paragraph just needs to be looked at closely because I do not think it is - rather the college does not believe that it is reasonable for a practitioner to have to say that the woman has psychological problems or will have psychological problems as a consequence of the procedure. On the other hand, it is really the woman's perception of the impact of that anomalous foetal condition on her that constitutes the grounds for termination and not the anomalous foetal condition itself, because if there is no impact on the woman then, absolutely rightly, the woman will want to continue with the pregnancy and needs to be fully supported in that choice.

I think if worded in terms of the impact of the anomalous foetal condition on the woman, but just the current wording - and I heard it again recited just before - the current wording does have at least an implication that the grounds are through some psychological adverse impact. I think that at least merits some consideration, but the college could live with that current wording. Just some more thoughts about whether anomalous foetal condition could come in in some way through its impact on the woman.

Dr GOODWIN - Can I just jump in there because we had some suggested wording this morning.

CHAIR - Maybe if we just -

Prof PERMEZEL - Sorry, I have only one more small point to make and that is just that the college is certainly opposed to a panel. We have seen panels operate in different jurisdictions and panels create a number of problems for all those associated. I do not know whether the panel issue has been debated, but it is addressed in our submission.

Dr GOODWIN - It was raised.

Prof PERMEZEL - From the point that the issue of termination of pregnancy is such a private and personal issue, to have to have that addressed by a panel is unfair to all those involved, unfair to the clinicians and the woman, and so I think the college position on the panel is pretty clear.

That would be my opening remarks.

CHAIR - Thank you. If I can start, I was going to refer to that foetal abnormality matter and you have been very precise about that in terms of the current wording in the bill, which is somewhat similar to the current act, not withstanding it is somewhat similar in the Criminal Code. I am just looking at the simplicity of the Victorian legislation, so that if the medical practitioner reasonably believes that the abortion is appropriate in all the circumstances, would that seem to you to be - and then it goes on with the second opinion, as it were - in Victoria there is still that overarching requirement - rather than try

to, as we have done here in our bill, talking about making some assessment about a greater risk for the circumstances set out - physical, psychological, economic and social - whereas the Victorian act is very simple.

Would that solve the problem and allow that consultation between the medical practitioner and the woman to reach that conclusion?

Prof PERMEZEL - Just addressing that on the fly, as it were, I think there is this concept of a global appreciation. With the four items - I think there are four items that are listed currently - there is an implication that it is on one or A, B, C or D and that then becomes a ground, whereas I think that as a clinician and certainly as a teacher - an enthusiastic university teacher - one tries to teach the global appreciation of clinical, psychological and total patient welfare as a broad concept.

So I think the wording, as I have heard it from Victoria, does look more globally at the entire patient encompassed and all the circumstances pertaining to that patient. So in some ways I think, just as you have worded it, that the Victorian wording does seem to be more along the lines of what the college would like to see.

CHAIR - I throw that into the mix from the standpoint that if it is accepted that this new bill embraces the proposition that it is a piece of medical legislation rather than criminal legislation, then something that concise reinforces that notion of it being as between the doctor and the patient.

Prof PERMEZEL - Yes, absolutely, and again I heard the previous speaker say very well that we have to respect that doctor-patient relationship. So many spheres of medicine, whether it be dealing in on a day-to-day basis - I am an obstetrician dealing with child birth and there are inherent implications in that doctor-patient relationship and I think that wording 'implied' puts faith back into that doctor-patient relationship.

CHAIR - I suppose to round that out I probably should go on to the other part of that section of the Victorian legislation which -

> 'After the medical practitioner reasonably believes in all the circumstances, there is a follow-up in considering whether it is reasonable in all the circumstances the medical practitioner must have regard to some things... one of which is all relevant medical circumstances ...'

that is an obligation -

> 'and the woman's current and future physical, psychological and social ...'.

So they list in the Victorian legislation three of the things that we do - physical, psychological and social - but they do not list 'economic' as a consideration. It does not say that they are the only things you take into consideration but clearly there is that obligation to have regard to 'all relevant medical circumstances' and those other things but not limited to them.

Prof PERMEZEL - I think the college really would think very positively about that Victorian legislation. One issue that I am sure the committee has heard discussed is the

issue of the patient who presents under duress and perhaps, because of pressure from outside agencies, is presenting for termination of pregnancy and I think the medical practitioner, patient and community all need to be protected from that event and that there should not be an 'I' - I, as a health practitioner, would want to feel that the law supported me in the 'I' as a medical practitioner acting as I thought was in the best interests of the patient and that the patient, merely on request - just because the situation is being requested - not necessarily, again, I teach this to the medical students - you do not have to do everything a patient tells you; you have to make a global assessment of all the relevant circumstances pertaining to that patient and together make a decision as to what medical treatment would be in the best interests of the patient, which is more or less as that Victorian legislation espouses, as you have just read it to me, to make an assessment of the patient and in so doing you need to consider all the relevant facts.

Dr GOODWIN - We have been told that for various reasons there has been a reluctance among the medical profession in Tasmania to perform terminations because of uncertainty around the law - not just the fact that it is in the Criminal Code, but also the meaning of the words in the Criminal Code, which are quite broad at the moment in the circumstances where the termination can legally be performed. That is part of the reason for including these four key things: psychological, economic, social and physical relating to the woman. In relation to the foetal abnormality issue, another suggestion this morning would be to add on other implications of the current pregnancy continuing to those four key words.

What we are struggling with at the moment is whether to be quite prescriptive about the circumstances in which a termination can be justified or broader and what the implications are going to be for doctors. What are they going to be most comfortable with, what is going to encourage them in their belief that they are acting within the law? That is what we are grappling with, trying to cover -

Prof. PERMEZEL - I understand the dilemma. It is a difficult area of practice but the wording that Mr Harriss just read seems to encompass that. If I can paraphrase it, I think it is acting in the interests of the woman's health but in making this decision, considering all the following matters, it does seem to be nice wording that doesn't imply that it necessarily has to be pinned down to a specific indication, but reminds the health practitioner that some global assessment is necessary and is not simply a medical decision based on abnormality.

Dr GOODWIN - So that wording 'all relevant medical circumstances' would pick up the foetal abnormality issues?

Prof. PERMEZEL - That's right. One important thing for the foetal abnormality is that foetal abnormality per se isn't a reason for termination. I am sure you've heard many people say we have to value all human beings and it is really the woman's perception of the foetal abnormality that the college would regard as the issue, not the foetal abnormality itself. I believe it is wrong to list foetal abnormalities as an indication for termination. If something such as that were to be listed, it has to be related to the woman's perception of the impact of the foetal abnormality. The foetal abnormality is not grounds for termination. The college would believe it is the impact of that abnormality on the woman that becomes the issue, but not necessarily to the extent of psychological disease. It is a bit concerning that there is an implication that foetal

abnormality necessarily causes psychiatric disturbance. Nevertheless, there can be impact without psychiatric disturbance and I will leave it to the clever lawyers to work out how to best phrase that.

Ms FORREST - When I read your submission it concerned me - I want to clarify the fourth dot point in your summary which recommends anomalous foetal condition be added to the grounds. What we are arguing here is that we don't add it to the grounds - and correct me if I am wrong - but rather reflect good clinical practice, which is a gynaecologist or obstetrician making a clinical judgment with the woman once she has all the information about the risks and benefits of proceeding with the pregnancy as opposed to terminating the pregnancy.

Prof. PERMEZEL - I appreciate that that does reflect a change in the college's position from what is in the document, but again, that wording we have just heard does allow that where three or four things are cited, there becomes a necessity of adding a fifth.

Ms FORREST - More encompassing of all medical conditions.

Prof. PERMEZEL - The necessity of adding that no longer applies. It is better because anomalous foetal condition should not be an indication itself but by the impact on the woman, so that considering all circumstances there would seem to be a way around having to include the anomalous foetal conditions, so a much better suggestion than this document.

Ms FORREST - An anomalous foetal condition should not have to result in a diagnosed mental illness for a woman to have a termination?

Prof PERMEZEL - Correct. So I am endorsing the suggestion of the honourable Mr Harriss -

CHAIR - Paul will do.

Prof PERMEZEL - That wording is indeed better than that the college suggested in this document.

Mr VALENTINE - Chair, does that mean that part 2, 5(2) when it talked about in assessing the risk referred to in subsection one the medical practitioners must have regard to the woman's current and future physical, psychological, economic and social circumstances, doesn't it therefore run that ought to be as global as possible as well rather than stipulating -

Ms FORREST - It is really the whole of clause 5 you need to consider. Subsection 1 as well as subsection 2.

Mrs HISCUTT - As we say, it is a matter of trust in our doctors.

Prof PERMEZEL - I think there are issues again and it is not just under duress. Any medical practitioner in any situation in medicine must believe that the treatment that they offer is in the best interests of the patient and if there is going to be a substantive deterioration by virtue of, say, a termination of pregnancy in the patient's psychological

welfare, then the procedure is contraindicated medically, whether in law or not you need to act in the best interests of the patient. If a particular procedure were going to lead to a substantive deterioration relative to not doing a procedure, then that procedure should not happen. I think the wording has to reflect that to say that the medical practitioner, to some extent, who acts in the best interests of the patient is acting within the law.

Ms FORREST - Should it not also be within the scope of practice of the clinician to cover that area as well?

Prof PERMEZEL - Of course.

Ms FORREST - Then that makes subclause 3 superfluous, because if [inaudible] is taken from the clinician making that decision or it will be conducted by someone with the appropriate skills.

Prof PERMEZEL - We are talking about section 5(3)?

Ms FORREST - Yes.

Prof PERMEZEL - I think there are issues there; this is whether it should be a specialist obstetrician or not. Is that what you are referring to?

Ms FORREST - Yes.

Prof PERMEZEL - I think there are issues there to do with service provision and I think the college would prefer that that clause remain; it was something that the board of the college discussed but increasingly, and outside termination of pregnancy, just practice in women's health, there are issues of patients unexpectedly being referred to hospital with complications of varying sorts, whether it be from home birth or delivery in small units, and late termination of pregnancy would be another potential situation and the board quite liked that potentially, given an obstetrician-gynaecologist's involvement, potentially the person to whom a complication would be referred who had some involvement in the decision-making processing at an early stage, so that was how I interpreted that. Not an inability to make the decision but it necessitated that any point of referral was involved at a relatively early stage.

Ms FORREST - The point I was making is that for a late term, particularly if it was 24 weeks but even beyond 16 I would suggest in broad terms that currently, and maybe not in the future, but a specialist obstetrician and specialist in gynaecology would be involved; it is within their scope of practice. It is not in the scope of practice of a GP to conduct a 24 week termination.

Prof PERMEZEL - It can be. In fact, in Croydon in Victoria that was indeed GPs and not specialists performing all those late terminations. They weren't specialists.

Ms FORREST - They would have had to have additional training, wouldn't they?

Prof PERMEZEL - Yes, additional training but they were being performed in essentially - and again I don't know the details, particularly of Croydon - but perhaps the committee knows better than I, but it was essentially a day procedure facility; late terminations were

being performed and the hospital being used in the event of complications didn't necessarily know issues that were happening, and I can see that there may be benefits for the hospital that would receive complications to know that this was happening so the involvement of a specialist who will inevitably will have links to higher levels of care should complications develop is a positive thing in this legislation. We discussed it with the board of the college and they felt that that was positive in that the recipient of any complication referral would have advanced warning that that was happening.

Ms FORREST - I hear what you are saying. In that clause, though, the medical practitioner who specialises in obstetrics and gynaecology could be a GP with specialist experience because if they are going to operate under AHPRA's code, the medical code, you couldn't work in a clinic like that without some specialist training because it would be outside your scope in practice.

Prof. PERMEZEL - Again, the lawyers will know better than I, but I would have thought that who specialises in obstetrics and gynaecology implies a specialist in obstetrics and gynaecology, i.e. AHPRA registered specialists which essentially means a Fellow of the college, so a GP with an interest wouldn't be referred to as someone who specialises in obstetrics and gynaecology, I don't think, but the lawyer could argue either way. I think the word 'specialist' has a special meaning in terms of AHPRA and the specialist registration and that would be a Fellow of the college.

Ms FORREST - We are seeing AHPRA at a later stage so we can clarify that with them anyway.

Prof. PERMEZEL - Perhaps better wording for that might be 'who is a medical practitioner who is a specialist in obstetrics and gynaecology' as opposed to who specialises in it as specialist defines somebody who is a Fellow of the college and would be experienced in the management of mid-trimester pregnancy loss, whether it be no experience at all in termination of pregnancy but looking after unexplained foetal death in utero in middle pregnancy and having to terminate a foetal death so it is the spontaneous mid-trimester labour. They are quite difficult pregnancies to manage and it is good to have the expertise around these potentially complex cases.

CHAIR - Still on that same theme, Tony?

Mr MULDER - It wasn't quite that theme; it was the theme we started on which was the legislation.

CHAIR - No, it is on that notion of the terminations and the more simple wording, possibly.

Mr MULDER - I think I have an overarching question. We have heard a lot about this being a medical procedure. This is something between the doctor and the patient and they always take into account all these circumstances. Given that view, I wonder why we would bother to have legislation around it at all. What is your view on just let us abolish the crime of abortion in the Criminal Code and then treat it like any other medical procedure?

Prof. PERMEZEL - The college view would be that the community would want greater reassurance in this difficult ethical area of practice, greater reassurance that proper - I

need to think of the right wording - certainly there is a community expectation that termination of pregnancy will not be treated like Panadol for a headache nor even treated like the management of cancer. For the community there is an expectation that this will be treated differently, this is a big issue -

Mr MULDER - More than just a medical procedure?

Prof. PERMEZEL - Exactly, but that is a community expectation. The doctor-patient relationship, I would suggest, is not a lot different; in fact the college would believe, as I said before, it is an intensively personal and emotive issue and again I heard the last speaker say something like, no woman approaches this in a light-hearted or - it is the most intense and personal decision a woman ever makes and I would suggest that the clinician working with her very often is in that same sort of intense relationship. I think that as a medical procedure, while clinically it is very similar to managing cancer or managing childbirth or many of the other things that an obstetrician does in practice, the community perception is that it is something entirely different and I think that is why you are all here today because the community doesn't regard it in the same medical context as those other procedures.

Mr MULDER - We have heard evidence early today on the point Ruth was making and they were saying that they did not see a need for specialists in obstetrics and gynaecology; they were not necessary.

Prof PERMEZEL - Ever? Don't need any specialists for the [inaudible]?

Mr MULDER - It was in the question of the second opinion under the current bill and the current law one of those people has to be a specialist in obstetrics and gynaecology. The issue raised was that we do not need two opinions because two medical opinions are two medical opinions and if the consent is there, valid and justified under all other circumstances, why does it have to be a specialist in obstetrics and gynaecology to express that opinion to be part of that procedure?

Prof PERMEZEL - Two opinions. It is not a medical necessity because you are right; if one doctor has made a value judgement then the other doctor is likely to make the same judgement. There is a community expectation that you, as representing the legislator, have to meet that community expectation. Words have been used in discussions around the Victorian legislation of what the community would reasonably expect. With late termination, the Victorians believed that there was an expectation that at least a couple of doctors would be involved, but not a panel. The point that you made about whether it needs to be a specialist obstetrician-gynaecologist is a very fair point. The board discussed, as I said before, the reason that we quite like having a specialist obstetrician involved, is because there is that potential involvement if there were complications. That may be circumstance dependent. I cannot see a downside having a specialist involved. All I can see are the positives of somebody having advance notice of what is going on in the event that there were complications. I do not think that it is something that the college feels passionately about. There was a to-and-fro discussion at the board of the college that there are some advantages.

Mr MULDER - The point that the member for Murchison was making this morning, that the requirement for no undue specialist to be involved in this process is actually more

complex in Tasmania, given the rural conditions. Someone said that we have a total of 16 specialists, a quarter of whom probably have a conscientious objection to this. That starts to limit the field if you are at Queenstown and find yourself pregnant.

Prof PERMEZEL - Yes, but we are only talking about the specialist for late termination - beyond 16 weeks. Beyond 16 weeks you would want to know that there was a specialist obstetrician and gynaecologist available in the unlikely event of complications. If you are in Queenstown then the specialist obstetrician certainly needs to be involved in the process and have discussed with the practitioner in Queenstown, if it were to take place in Queenstown. I do not know how big Queenstown is -

Mr VALENTINE - Not very big.

Prof PERMEZEL - That specialist obstetrician may well advise that practitioner in Queenstown that the patient ought come to Launceston or Hobart or whatever the nearest centre is because in the event of complications there are not the facilities in Queenstown to match it.

Mr MULDER - This becomes an argument for the two-tier model, then.

Prof PERMEZEL - Yes. As I said at the start, the college was not necessarily opposed to the two-tier model but mainly because we think that there is a community expectation that there will be a different set of circumstances for late termination.

Mr MULDER - What is the difference in the procedure for early versus late rather than trying to put a number of weeks to it?

Prof PERMEZEL - That is essentially a technical matter that varies. Early termination can be performed medically or surgically - medically by RU486, and we heard that mentioned before, followed by prostaglandin and therapy which is relatively recently introduced to Australia. The traditional method is by curettage, which is surgically evacuating the contents of the uterus. That would be happening very commonly up to 12 weeks without hesitation in somewhere like Queenstown.

Ms FORREST - You would not do it at all in Queenstown.

Prof PERMEZEL - Wouldn't you?

Ms FORREST - No, you would do it in Burnie.

Prof PERMEZEL - In a small town it would very commonly be curette; remember that in having this conversation we are talking about miscarriages as well. Quite commonly a foetal death in utero, an embryonic death, will be diagnosed at 10 weeks, 12 weeks, exactly the same circumstance as a termination of pregnancy and there need to be sensible measures around the management of that. Clearly, up to 12 weeks it could be done in a relatively small centre. The likely complications is going to happen at any time with any medical procedure, as you know, but the likelihood is so low that you would be comfortable about it happening in a relatively small town without specialist back-up. A curette for a miscarriage, a curette for a termination of pregnancy.

Beyond 12 weeks it is increasingly complex and you would like to be in a town that could manage complications. As the gestation gets advanced beyond 16 weeks, then curettage ceases to become a possibility. Between 12 and 16 weeks some doctors have the expertise to manage by what is called dilatation and evacuation, but relatively few and I do not know whether anyone in Tasmania has that expertise. My expectation would be increasingly after 12 weeks that it would be managed medically, for instance, by inducing uterine contractions and resulting in spontaneous expulsion.

Mr MULDER - It is pretty safe to say that after late - without trying to put a week on it - that later-term surgical terminations would also pose a greater risk to the woman. Does the risk increase with the gestation?

Prof PERMEZEL - Undoubtedly. The risk remains small, but undoubtedly there is an increase in risk with advancing gestation and one hears in - I said that dilatation and evacuation is uncommon after 16 weeks, but there are centres where it is done up to 22 or 24 weeks, but certainly I would be very surprised if that were to happen in Tasmania. The risks are very small, but they will increase with advancing gestation. A six-week curette for a miscarriage is - I wouldn't like to say it is amongst the safest surgical procedures, but six weeks miscarriage - there would be hundreds done every day, maybe thousands. It is a very common procedure. As the gestation advances the risks go from one in 300 000 to one in 100 000.

Mr MULDER - You start to move out of the area where you are doing curettes into surgical.

Prof PERMEZEL - As you move into medical terminations, administering medication and waiting for the uterus to contract, then the probability of an adverse outcome, a haemorrhage or whatever, increases to a matter of 1 or 2 per cent instead of 1 in 100 000. They still are very uncommon with mid-trimester termination, but it does progressively increase as the gestation increases until you get to term birth, when it becomes very risky. The likelihood of a haemorrhage with a term birth is 4 per cent unless you are under a natural third stage and it is 8 per cent. As the gestation increases the risk of haemorrhage will increase.

Mr MULDER - When you talk about dilation and -

Prof PERMEZEL - Curettage.

Mr MULDER - What is it, evacuation?

Prof PERMEZEL - Dilatation and evacuation, that is sort of like a dilatation and curettage but done at a later gestational age; beyond 12 weeks it would be called dilatation and evacuation, before 12 weeks dilatation and curettage. It is just semantics; essentially they are both surgical procedures, but clearly getting technically more difficult with advancing gestation.

Ms FORREST - I can get you a gynaecology textbook if you like.

Mr MULDER - No, to be honest with you, we throw these terms around and I think it is helpful for me to understand the difference between someone being administered some drugs, either through pills, or an intravenous or an intramuscular injection, or someone

entering through the vagina into the womb and basically a physical extraction. That is what I am trying to get the risks out.

Prof PERMEZEL - No, you are absolutely right. All of that last one is surgical, whether it is a curette before 12 weeks or an evacuation after 12, that is all called surgical termination and the entirely medical thing is medical termination, which can be done earlier and can be done late, but it depends on the uterus contracting and expelling its contents.

Mr MULDER - Thank you. I will save you to interpret the gynaecological terms, because I would probably have to anyway.

Ms FORREST - Medical termination can be carried out with vaginal medication as well as oral, as well.

Prof PERMEZEL - And intravenous and through utero.

Ms FORREST - Yes.

CHAIR - Ruth, we are away from that topic and move back onto other questions.

Ms FORREST - Michael, I am not sure whether you were here when we were discussing the definition of a termination in section 3 of the bill, which does say to terminate means to discontinue a pregnancy so it does not progress to birth. I raised some concerns earlier - for example, you had a woman with a breeched baby on board, may be birthed vaginally before and was keen for a vaginal birth, felt she was coerced into have a caesarean - people are reluctant to do vaginal breech births these days - and felt afterwards she didn't want to have a caesarean but ended up having one. An elective caesarean, discontinuing a pregnancy using an instrument or combination of instruments [inaudible] it was expressed that this was a concern.

Does having in there, 'so it does not progress to birth', rule out births such as caesareans and induced labours where you are bringing the pregnancy to an end by artificial means? There has been the suggestion that we just take it out because it doesn't have any detrimental impact. Some people thought having it in created that confusion. After a lot of thought and discussion with various people, it seems it would be best to leave it in to separate out the fact we are only talking about termination of pregnancy where there is no intention of having a live baby born, so that it is distinct from elective surgery or induction of labour. Is it an issue for you?

Prof. PERMEZEL - I heard the previous discussion with interest. We read this legislation and made our points, but I think the wording 'so that it does not progress to birth' is ambiguous and doesn't clearly describe what is meant by termination of pregnancy. Just as you have said, the wording you used was, 'there is no intention to proceed to a live birth.' When we induce labour for an FDIU it is still a birth. A severe pre-eclamptic who is induced at 22 weeks, is that a termination of pregnancy?

Ms FORREST - In the strict sense of the word, it is.

Prof. PERMEZEL - I think so, because there is no intention to have a live birth and yet nobody opposes that maternal life-threatening physical condition. I am concerned that the wording of that definition doesn't encompass - birth is the wrong word; it is better - the wording that you used 'there is no intention to procure a live birth'.

Ms FORREST - A number of obstetricians I have spoken to have expressed some reservations about this, but the legal interpretation is that when you look at the context in which this is being used, and you have to look at the context of the bill, if the court were interpreting this 'to birth' would be looked at in terms of what the *Macquarie Dictionary* says about birth. It says something along the lines of being born with independent life, whereas a baby that is born dead does not have independent life if we already have a foetal death in utero or the premature baby with the pre-eclamptic mother. There is not an expectation you are going to have that live birth.

Prof. PERMEZEL - So you are saying the *Macquarie* definition of 'birth' means that that wording is okay?

Ms FORREST - Yes, that is what the legal brains suggested too.

Prof. PERMEZEL - I don't know the *Macquarie Dictionary* definition of 'birth', but in a practical context around the hospital we talk about birthing at 22 weeks and of birthing of a foetal death in utero. It is all birthing, so it would seem the *Macquarie* definition should be updated because it should reflect the way the word is used in practice.

Ms FORREST - I have looked after 22 weekers and 32 weekers right through with foetal death in utero, but psychologically it is important for the woman to refer to it as the baby being born. In a strictly legal sense, though, what makes us feel good does not necessarily need to be reflected in legislation, does it?

Prof PERMEZEL - Yes, that is true but the *Macquarie Dictionary* should reflect the common parlance and it sounds like the wording in the *Macquarie Dictionary* in no way reflects the way the word 'birth' is used.

Ms FORREST - There are more definitions; that was just one of them.

Prof PERMEZEL - Okay.

CHAIR - I might indicate, and I am referring to a current definition in the Criminal Code; the committee might need to get its mind around or take some advice on that because that talks about a child becoming a human being completely proceeded in a living state, so there may be some connotations around that as to our law, rather than expecting you, Professor Permezel, to specifically go too far with us. We may need to get legal advice.

Prof PERMEZEL - Okay. Could I just say, though, because a termination, say at 23 weeks or 24 weeks, might progress to birth, a termination of pregnancy could progress to birth. Say there were a severe a cardiac malformation and for whatever reason, as we said before, the impact on the mother is such that she and the practitioner make a decision to have the process of termination of pregnancy, that foetus would be born or could be born alive, therefore it is birthed but it is still a termination because the neonatologist in this context -the foetus cannot survive - is not going to put the baby through a whole lot of

traumatic cardiac surgery at 24 weeks if it has no hope of success so it has been birthed, it is a termination of pregnancy and this wording does not work.

Dr GOODWIN - Can you explain how that is a termination of pregnancy? The baby is just left to die, do you mean?

Prof PERMEZEL - No, no, that isn't what happens. The baby is taken up to the nursery and given all comforts and is treated, but it is not put through the trauma of surgery, which is painful and unpleasant if there is no hope of survival. The labour was induced at 24 weeks because - we could talk for hours - has anyone talked about maternal syndrome or mirror syndrome? That is a situation where a sick baby can cause the mother to become very unwell, so that through an ischaemic placenta which might be the case in cardiac disease, because of cardiac failure in the foetus the placenta becomes ischaemic - it then liberates some bad substances that cause the mother to develop hypertension and potentially life threatening condition so it becomes medically indicated to deliver the foetal abnormality because of some impact on the mother down the track.

We said if it is pre-eclampsia no-one is going to debate, but this might not be severe pre-eclampsia yet, but a condition that is liable to develop in which there is no hope of the baby surviving. If we leave it then the mother is going to get sick - why wait for her to get really sick? Medically, it becomes a reason to do something now rather than wait for her to get sick and then do it because she is sick; why not do it now and stop her getting sick in the first place? So we would call that a termination of pregnancy because it has been done with no intention of producing a live, ongoing human being, but it would be done at 24 weeks , it would be a birth and that wording does not work.

Dr GOODWIN - Yes, I see.

Prof PERMEZEL - It is a very common situation because severe foetal abnormalities are being diagnosed at 20 weeks most commonly, some earlier, some later and sometimes there are serious concerns of the future impact, not a current impact, but a future impact on the maternal health and if the child isn't going to survive the mother is offered. You can have the baby at 32 weeks or 38 weeks or whenever it would naturally happen but you could get really sick in the meantime because of an impact on the placenta of this condition or you could have the baby now at 24 weeks and avoid that potential deterioration in your health that could be life threatening but we would deliver you before it was too bad and that is almost the most common situation is doing it earlier than you would have to do it because the outcome is so bad.

Dr GOODWIN - That is an induced birth situation?

Prof PERMEZEL - It is a termination of birth though, definitely, because there is no intention and all the statistics when they are reviewed by the consultative counsel and all statistically it is regarded as a termination of pregnancy because there is no intention of procuring -

Dr GOODWIN - But it does result in a life birth whereas -

Prof PERMEZEL - It may result in a life birth. Sometimes the process because the contractions at that early gestation there can be a deterioration in the foetal condition.

Ms FORREST - The cord is pretty fragile.

Prof PERMEZEL - All of that but on a number of occasions the foetus is born alive. So I don't think that wording is right.

Dr GOODWIN - With a late term termination, are there circumstances where the foetus' life is terminated before the contractions start?

Prof PERMEZEL - Has somebody talked previously about KCL injection and the possibility - ?

Dr GOODWIN - I think so.

Prof PERMEZEL - That has been discussed.

Dr GOODWIN - So you would not use that in those circumstances?

Prof PERMEZEL - The whole issue, and I clearly don't practise in this area myself, but with practitioners who work in this area of practice it is my understanding that it is an issue for the woman. Again, recommendations can be made, but something of the sensitivity of the issue you are describing is almost entirely an issue for the woman. If she is going to give birth, some practitioners will offer her the option as to whether or not she wishes the baby to be born alive or not. The same would apply even in the severe pre-eclampsia situation where the mother really has no choice, she has to give birth or she will die herself, but sometimes the practitioner, which is the situation I am more familiar with where I work, that a woman can be really sick but has to give birth of a baby that is going to die after it is born. Would they rather the baby was going to be born alive and take a few breaths or would the mother prefer that it is not put through the gasping and labour when it is not going to survive? It is an issue for the mother to decide.

Ms FORREST - Some women cannot contemplate carrying a dead baby inside them in those circumstances, too.

Prof PERMEZEL - It is entirely the issue, and you can imagine the complexity of that counselling and the support that is required. There is no need to tell this committee, but for these women it is the biggest thing in their entire life, and the poor thing might be 45, having her only pregnancy and it has been a disaster because she got severe pre-eclampsia and cannot possibly go on. We had just such a case a couple of weeks ago. They are incredibly difficult situations.

Ms FORREST - Five or 10 years to get pregnant or more.

Prof PERMEZEL - Intensely difficult counselling and support.

CHAIR - No more questions?

Prof PERMEZEL - Can I just say a couple of things that are probably in here, but just to make sure that the committee is aware? It is just a couple of technical things that I think the college would want to make sure that the committee is across.

One is the highly complex situation of a multiple pregnancy, where there is discordance for a serious abnormality - even a lethal abnormality, but that if the woman has to decide - and there is no problem with this with the legislation - but just in case they are attempting to change it for any reason - I think you just need to be across this multiple pregnancy thing. If one of the twins has a lethal abnormality and the other one does not and is okay, the mother does not want the one with the lethal abnormality be put through being born and all the traumas of the first week of life with hypoxia and all the things that might go with it.

The mother does not want, on the other hand, to endanger the other twin. She could have an injection that would protect that affected child from a difficult first week of life, but she does not want to put the other twin at risk because if she has the injection at 22 weeks, when it is allowed in some jurisdictions - I know it is not covered by this bill - but in some jurisdictions where they do not allow it late - she has to make the decision early, which then endangers the healthy twin, whereas legislation such as proposed allows that decision to be deferred until, even if she comes into labour, the other twin is going to be fine because she is 35 or 36 weeks or whatever. Again, it is difficult decisions between women and their practitioners, but that ability to defer that decision until the okay twin is okay, is very important and your legislation is fine as proposed, but we just want to make sure that you did not change it in a way that the woman was forced to make a decision when she was endangering her good twin.

There are some other conditions where Cytomegalovirus infection - has that been covered at all? CMV is a condition where - it is quite important, it affects about, it might be, 1 in 1 000 children have a disability as a result of CMV. The thing about CMV is that 95 per cent of those affected are perfectly fine. In the old days the woman was under pressure - 5 per cent severe disability, 95 per cent okay - to make a decision early when 95 per cent of them are going to be okay, whereas your legislation and the Victorian legislation allows the woman to defer that decision until late in pregnancy when it becomes obvious in ultrasound whether it is in the 95 per cent that are perfectly okay or the five per cent that are affected.

Dr GOODWIN - At what point in the gestation is the ultrasound done?

Prof PERMEZEL - Not until 34 weeks, quite late in pregnancy. People wonder why you would ever do a termination late in pregnancy and practically you do not ever do terminations - or extremely rarely would you do a termination late in pregnancy; there are these very peculiar, rare situations, but you have to write legislation that works for the whole community, not just for a few individuals.

Ms FORREST - CMV is contracted early in the pregnancy and that is where the problem lies.

Dr GOODWIN - You know you have it but you do not know what the impacts are going to be until quite late in the pregnancy.

Prof PERMEZEL - One more last point that I am sure that the college would want me to make, and that is at the threshold, and again not relevant to Tasmania but just in case you are tempted to change, with a panel and some legislators change from no panel to panel

at a gestation - it might be 16 weeks or whatever - that really puts the woman under terrible pressure at 15 weeks and six days that if she does not decide today she is going to have to go to a panel tomorrow. That it the worst situation for the woman, her family and all the people supporting her say, 'Decide today, decide today because tomorrow it is a panel and you have to go through all the trauma of a panel who may or may not agree,' and so forth. I know that is not a problem for your legislation at the moment but just in case you are tempted to change.

Mr VALENTINE - Is it best not to have a limitation, then?

Prof PERMEZEL - As I understand it, the way that I read it in your legislation, there is not a big change between the two tiers, between 15 weeks and six days and 16 weeks that the practicalities of the change are, as I understand it under the proposed legislation, relatively small, as the last speaker said and as you agreed.

Ms FORREST - Two doctors.

Prof PERMEZEL - Two doctors - one doctor instead of two doctors and I was going say, 'You have to make the decision because tomorrow you have to go to two doctors instead of one.' They are going to say, 'Take your time, it is fine, tomorrow we have to go to two doctors but we will support you.' It is good being able to tell a woman, 'You have time, do not feel under pressure, this is a really big decision and you are going to want to do that in a very considered way. You do not have to decide tonight because you are 15 weeks and six days.' It is commending the currently worded from both those points of view but I am worried that you will walk away and change it. I think that you need to be aware of all those situations.

Dr GOODWIN - Your suggestion is that we increase the 16 weeks to 20 weeks.

Prof PERMEZEL - In some ways 20 weeks; it is not my suggestion. I am speaking on behalf of the college. The view of the college was that 20 weeks would work better than 16. We appreciate that there is not a huge difference between 16 and after 16, so why would it matter if it was 16 or 20? There is symbolism but not a huge difference.

Mrs HISCUTT - It comes back to your earlier comment about meeting community expectations. It was 24 and then 20 and then 16 because of community pressure. That would be why that is.

Dr GOODWIN - I thought there were some diagnostic tests that could be done later than 16 weeks that become relevant.

Mr VALENTINE - 18.

Dr GOODWIN - So in that sense, there is another reason for increasing it to 20 weeks.

Prof PERMEZEL - Yes, especially as Mr Harriss has said, that wording that he gave before, I think that all practitioners, perhaps I am wrong, the wording as proposed 'an assessment of the patient considering all of the relevant factors' - the threshold is really a community expectation. It is not really going to be a change in practice that is going to make the woman feel under pressure to make a hurried decision. The two-tier system has not got

the college worked up. There is symbolism for people who think that it is entirely the woman's choice but the college wants the best care for women and the best care is by enabling the woman to make a considered decision and not feel under duress or pressure.

Mr MULDER - We heard from a member of your college - that is the area that he specialises in - who argued from a personal perspective and I want to pick up a point you are arguing with your colleague's position that he thought that 14 weeks was an appropriate cut-off because all we are doing at that particular point in time, for all practical purposes, is changing it from a one-doctor test of consent to a two-doctor test of consent for reasons. So it seems to me that whether it be 14 weeks, 16 weeks or 28 weeks. it really isn't such a sticking point.

Prof PERMEZEL - I think that comes down to, who was the Queenstown person?

Mr MULDER - The example.

Prof PERMEZEL - Because I would argue that the specialist is a good thing to have because there is the support there, the tertiary support, that high level support that is more common after 16 weeks and if you bring then that back to 12 or 14 or whatever then you really are eliminating the possibility of that happening because of the practicalities of getting a tertiary opinion. Remember these are getting less and less common as gestation advances so there are a lot of women who will be requesting terminations around 14 weeks because that is when the results of a lot of the tests come back at that gestation - the amniocentesis or chorionic villus sampling - and things are getting organised. If you bring that back you are going to be driving many women who are seeking termination into the big cities and out of the moderately-sized regional centres.

Ms FORREST - And also rushing in to make decisions when the villus diagnosis may not be known.

Prof PERMEZEL - Well, yes.

Mr MULDER - If the diagnosis is made after 14, 16 or 28 weeks, that does not affect the operation of the -

Prof PERMEZEL - I see what you mean. If it is important for them that they don't have to go to a big city they are going to feel as though they have to make an early decision so they can stay in their moderately-sized town. It is never going to happen in a small village; it shouldn't, and nor should a miscarriage be managed in a little village like 100 years ago. If they are in a moderately-sized town I can see if that came back too early they are going to feel as though they are going to have make the decision a bit earlier otherwise I am going to have to travel to Hobart and that is inconvenient because I have four kids at home and it is difficult.

Remember a lot of this is happening - the really serious chromosome abnormalities - are often happening in that older age group with many children at home and it can be very difficult for them socially. Psychologically, we said, it is the most demanding decision that a woman ever makes but the practicalities of managing this with four kids, some of whom might be growing up and at school, it can be very difficult for them.

I think that earlier thing does create - if you come back much earlier than 16, you then create a whole lot of issues of mobility of patients having to go to bigger centres.

CHAIR - We appreciate your evidence, Professor Permezel.

Prof PERMEZEL - Good, thanks very much.

THE WITNESS WITHDREW.