PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY 23 AUGUST 2013.

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 INQUIRY

ARCHBISHOP ADRIAN DOYLE, ARCHDIOCESE OF HOBART; AND **Ms BELINDA CLARKE**, DIRECTOR OF MISSION AT CALVARY HEALTH CARE TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome Archbishop Doyle and Belinda Clarke. You are protected by parliamentary privilege while you are before this committee, so nothing you say in here can be legally challenged by anyone. But outside the confines of a parliamentary committee, you do not have that protection of parliamentary privilege. You are entitled to say anything to anybody about your views as to this matter but any reflection on what happens in here that gives you that protection you should be cautious about in the media. The media invariably wants to talk to people who make presentations to parliamentary committees. If there are things you say in here that may be sensitive and that somebody may want to challenge legally, you are protected here but not outside.

Although we have your submission, we extend an invitation to people who come before us to speak to their submission if there are points they want to specifically draw out. It is also for the public record, bearing in mind this is being recorded and subsequently transcribed. There may well be matters you want to build on.

Archbishop DOYLE - Thank you for the opportunity to address this committee on what on think all of us believe is a most important subject with very serious ramifications. I know that all of you come face to face with these issues, which are life and death issues at the end of the day. I understand that in your role you are trying to find a way to respect the life of the infant child and also respect the rights and needs of the mother, the doctors and nurses and the father of the child. I accept that the basis for the discussion today is the legislation that has already been passed by the lower House and not the morality of the issue. However, I cannot but say that the view I hold, and indeed the view I have to defend as the leader for the moment of the Catholic Church, is that abortion is a direct intervention bringing about the termination of what is already a human life. In our view, it is greatly contrary to the moral law.

My role is that of damage control, of trying to make a contribution to the discussion but to persuade you to minimise as far as possible the effects and extent of the legislation currently before you. I realise that since the original proposal was circulated, the time line was reduced from 24 weeks to 16 weeks, and that is a start. But there are still a number of elements in this legislation that are of very serious concern.

The fact that the minister did change a feature of the legislation is significant. Maybe it already became obvious that out there in the community there was great disquiet about the figure of 24 weeks. As we know, it is possible for a child born at that time to survive, perhaps with a huge amount of medical care and assistance, but we do it because

we know that here is a human life - the very beginning of human life that could expand and grow in a way that we anticipate. There are other concerns in the bill around conscientious objections, the emphasis given to the counselling, and also the suggestion about the access zones.

The submission, which you have a copy of, is basically a rerun of a submission that we made back at Easter time to the original draft bill. There are a number of points that I mentioned which perhaps I could cover as well. I say there that it is easier to obtain state-sanctioned medical killing of people whose lives have just begun. The bill is an alarming indication of how we in our society treat those who have no voice and that the Catholic Church is strongly opposed to it on those grounds.

There is a suggestion that it updates the Victorian legislation, but in fact I think it goes a long way further than that legislation in terms of criminal and monetary penalties for conscientious objectors, 150-metre access and the possibility of the woman performing a self-abortion.

There are amendments, I believe, which add to the complexity and uncertainty for counsellors, women in need and medical providers. The emphasis in this legislation is that this is just another medical procedure and should be considered as such. I believe, and the Catholic Church would believe, that it is the ending of a life; it is not just a medical procedure. I believe that there are in the bill unacceptable interferences into the freedom of doctors and nurses who refuse to take part or to sanction the deliberate destruction of human life.

There is also the counselling issue. There are two ways of counselling. One is about making a decision about which path to go down, but the predetermined counselling - and they are two separate things.

It is a case, I think, in this bill of removing sanctions from one area and yet they are added in another. There is no reference in this legislation to the unborn child. I find that quite incredible. This is about a human life and the beginnings of human life, and that there be no reference to the child is a grave omission. While there is a suggestion it decriminalises abortion for doctors and women, it criminalises conscientious objectors and the freedom of speech. I think we, and you as members of parliament, must never stop asking the basic question about how our laws and our services care and protect the weak and the vulnerable.

I have Belinda with me. Belinda is the Director of Mission at Calvary Hospital here in Hobart and a part of Calvary Health Care Australia. I think in the submission it says that there are 75 Catholic hospitals throughout the country and they, too, could be affected by this same legislation if it continues the way it is.

CHAIR - Does Belinda want to speak to that area of concern?

Ms CLARKE - In how it will affect the hospital?

CHAIR - Yes.

Ms CLARKE - I think we obviously as a Catholic Health Care facility support the objections from the Archbishop as being part of the Catholic Church. More specifically and in supporting the AMA is the subclause (7)(2) around conscientious objection in that medical practitioners are being limited to have conscientious objection. The Catholic Church would say that that is a clause that is not in line with our Catholic teaching and our code of ethics and it also raises a question that the termination process is not a black and white issue. I do not feel that medical practitioners either object or do not object. This is a decision around an unborn child and as such deserves due process in decision-making.

I know that, Frank Brennan speaks very strongly on this point about the medical practitioners having to refer on to someone who does not conscientiously object to termination. What does that actually mean? A medical practitioner may object at 16 weeks but may not object at 4 weeks. They may have an objection depending on the context of the case. I think that that clause (7)(2) limits the ability for good ethical decision-making within our medical practitioners and within our hospital.

Mr VALENTINE - I realise how stressful you see this whole situation in terms of termination in your faith. I am wondering whether you could reiterate your position on the circumstances, if any, under which termination could occur?

Archbishop DOYLE - It is a really difficult question, departing as I do from the fact that termination is a termination of a life, so I cannot just comprehend or tolerate that position. It is a difficult situation but I understand that we are talking about the law as it currently exists and I certainly do not want any loosening up of the law as it is now. I think really that this bill should be discarded and we should leave things as they are. I am not happy with that but under the circumstances it is a case of damage control.

Mr VALENTINE - I am thinking of things perhaps like where the life of the mother might be in danger or those sorts of circumstances.

Archbishop DOYLE - In the Catholic health care code, there is a provision. Maybe we can mention it.

Ms CLARKE - As you know, we are bound by the Catholic code of ethics and within our code it does state in 2.28 that if the mother's life is at risk, I might just read it for you:

> In some cases a woman may develop a life or health-threatening condition for which the only effective and available treatment is one that would endanger the life and health of her unborn child. Such treatment is permissible provided the risks to the woman's life or health posed by her condition are at least comparable to the risk the treatment would pose for the life or health of her child and provided any harm to the unborn child is an intended goal and it is important nor a means to the treatment of the goal. **TBC**

So within our Catholic code there is that clause that does allow for ethical decision-making in terms of the context of the situation and putting the unborn child and the mother's life as equal.

Archbishop DOYLE - It is known as the principle of double effect. What we cannot accept is that the intervention to terminate the life of the child is the means by which you resolve the medical problem. But if you address the medical problem and it has as a consequence, it is a terrible consequence but it could be in some ways acceptable to treat the medical problem of concern at the time.

Mr VALENTINE - What you are saying is that there no black and white answer in all of this is. So, severe foetal abnormality, for instance, where the likelihood of the child surviving after birth is unlikely, would that be dealt under the same circumstance?

Ms CLARKE - Every circumstance would be taken in terms of the individual context and you would have to look at the risk to the mother's life. In any ethical decision-making process where this is involved that is the mother's life, and for the unborn, it is a slippery slope when we start talking about abnormality.

Mr VALENTINE - Where do you stop?

Ms CLARKE - Yes, so it is contextual. Both lives are equally important. We don't make a judgement on what that life looks like.

Archbishop DOYLE - Also, it could be sadly that the child be born with an abnormality but the mother is perfectly healthy. We are talking about a situation where the mother's health could be affected for a completely separate reason - it could be cancer or something else where an intervention may have the consequence of placing the child at risk. I wanted to address that other issue which is also very important.

Ms FORREST - I have a few things I want to go over and I will start with conscientious objection. Do you agree or not that it is important that the avenue of conscientious objection exists? I certainly respect your views and the way you see this whole issue. I understand it is a difficult you find yourselves in, particularly in providing your health care. There are other areas that medical practitioners and nurses may object to. Sometimes they may object to prescribing contraception, particularly with a Catholic background. Some may object to male circumcision for newborns which is still legal in this country.

There is a range of areas that people may have a conscientious objection to. Is it not right that there is a provision that allows the doctor or nurse to identify that objection, and say, 'I'm sorry. I can't help you with this any further'? It may be that after a certain time that is the point - that they cannot do it any further and it is for them to decide where their conscientious objection sits. That person still wants information and wants to get the full range of risks and benefits of proceeding with a particular course of action or not. Is it not right that that provision is there to enable that process to happen?

Archbishop DOYLE - I think there is a statement in there from Archbishop Hart in Melbourne about the totally unacceptable interference with the freedom of doctors and nurses who refuse to take part in or sanction the deliberate destruction of human life. We cannot support any provision which puts doctors and nurses in a position where they might have to go against what they personally believe.

Ms FORREST - My point with due respect, Your Grace, is that it actually gives them that capacity not to have to participate. The only time when they have to participate under the law is if there is an emergency. With an ectopic pregnancy, effectively the only way to deal with that where the mother is not going to die is a termination. If a woman presented with an ectopic pregnancy that is on the point of rupture, in Calvary would they take that woman to theatre?

Ms CLARKE - All treatment would be case-by-case, but yes.

Ms FORREST - So in that case when the mother's life is seriously at risk you would conduct a termination, even if a doctor had a conscious objection. If he or she were the only one to do it at the time, obviously if you could call someone else in. Does not this provision give that doctor the option to say, 'Sorry, I can't help with this but Dr Smith can'. I see that this provision actually provides the opportunity for a doctor or nurse to have that objection and be respected. In doing so, they do need to say to the woman that they will be given information about where they can get further assistance with decisions you make regarding ongoing care of your pregnancy - which may be continuing it or it may be terminating it.

Archbishop DOYLE - I understand the problem we have with this is that doctor is obliged to refer people on to somebody who is going to enable the procedures and that would be in favour of the procedures taking place.

Ms FORREST - We have had a lot of discussion around that and you may not have read all the transcripts - I am sure you have better things to do. But one of the suggestions has been rather than just going to a medical practitioner, it could be to another service. For example, Family Planning provide a pro-choice framework but do not do terminations at all there. They have medical practitioners who work there who will discuss the full range of options. The AMA in Victoria put out a statement about conscientious objection that basically said that a doctor giving a woman the name of another service, such as Family Planning where they can get the information, is all they need to do. They treat it like a conflict of interest, such that once the woman says she wants to consider termination, at that point the doctor then declares a conflict of interest and says, 'I cannot discuss this any further with you because of my personal views' and sends her to another service.

Ms CLARKE - I think it is making that criminal, though. I think the AMA would say that to make a non-referral a criminal act is what they object to. I know there has been an objection about the AMA conscientious objection, saying that they want that removed from the bill as well.

Ms FORREST - This is one of the reasons we are taking it out of the criminal code and putting it into a health-based legislation. So if a doctor does breach their duty, they are dealt with under AHPRA as opposed to under the criminal code. This is one of the reasons why this legislation has been brought in. It is to remove that criminality aspect of it, so it can be dealt with as every other medical procedure is. If the doctor does the wrong thing, or it is thought that they have done the wrong thing, they can be tested for unprofessional conduct or professional misconduct under AHPRA. That supports the need to move out of the criminal code into the health-based regulation.

The other area mentioned was the 16 and 24 weeks. Currently in Tasmania a woman can have termination up until the time of birth. It is under the criminal code. It requires the approval of two doctors. This legislation does not change that. After 16 weeks, that remains exactly the same as it sits at the moment. It was originally 24. It did not mean that terminations do not occur after 16; it means the process changes to provide another level of involvement of medical practitioners.

I am struggling to see a real concern about wanting that to go back to the way it is. Currently, a woman can access a termination at any stage during her pregnancy, provided two doctors concur with that decision.

Archbishop DOYLE - Maybe I did not put it quite as clearly as I should have. The 24 weeks was a matter of very serious concern for us and out there in the community and always will be, even now, whatever the provisions of the legislation. Coming back to the 16 and bringing into play at 16 weeks procedures which were not going to be in play until the 24 weeks - that is an improvement. I still struggle with the whole thing. That is where the dilemma lies.

Ms FORREST - I accept that. With all due respect, it is probably a difficult challenge for you no matter when it happens, and I respect that view.

Mr MULDER - Thank you for your submission. I think it draws into quite stark relief, the issues that are involved here. At the heart of this is: is this just another medical procedure or is this the destruction of a human life? I think that is a point where you can say that this is where the two different sides to the debate have an issue, and I do not think it is resolvable.

The other area that you talked about was the conscientious objection and that was covered in the response to Ruth's question. The area I have some qualms about is the idea that the access zones somehow or other are limitations on freedom of speech. Would you like to explain that a bit more? We could perhaps have a discussion about why that is such a heinous, terrible thing to put into this legislation.

Archbishop DOYLE - It is the right to have freedom of speech. The right to protest is one I think we all hold dearly, even though we may not be happy with the people who are taking up this right. People need to behave with respect and treat other people with dignity. Here in Hobart, I believe the Church of St Joseph's is within 150 metres of one of the locations where these practices take places. Father Gerald Quinn over many years has been one of the greatest defenders of human life protection. If he were to speak out in that church, according to the way I understand it, he could be in difficulty with the law. If the law is not going to be implemented or never going to be put into practice, I do not believe that is a very satisfactory state either.

It is quite a unique situation that has developed here. It probably has no parallel anywhere else. It is our belief that if we uphold the right of freedom of speech and freedom to protest, then this should not be part of this law in this particular case.

Mr MULDER - In the second reading speech, it says you are not allowed to distribute things - 'communicate, exhibit, send, supply or transmit to someone'. We have been told, for example, that St Joseph's sits within that 150 metre radius but things said inside the

church that are outside the hearing of anyone accessing that zone are not captured by this. Does that alleviate your concerns? The access zone provisions are targeted at communicating to people entering or within the medical facility. So it is not a question of you and I having a beer in the corner hotel saying these things. It is a question of if we would be communicating issues to them. Does that relieve your concerns about the freedom of speech issue you raised?

Archbishop DOYLE - In a way it does not. The fact that St Joseph's happens to be there is probably a bit accidental.

Mr MULDER - The advice we are receiving is that it is irrelevant that it is in there, provided you are not standing on the steps of St Joseph's protesting and targeting people in the other zone. I am wondering whether that eases your mind a little on that issue?

Archbishop DOYLE - I suppose it is better. Why are we identifying just this particular issue? Are there possibilities of protest about other things that are not mentioned?

Mr MULDER - That is a very good point because some of us would like to see it in the forestry industry, for example. These sorts of provisions would be very useful for society. We will take it on board. I just thought I would like to tease that out for you to explain the advice that we are getting about these access zones.

Archbishop DOYLE - I heard one of the members of the lower House saying that he believed that human life begins with conception and he strongly defends the right of people to protest. Yet somehow or other in this particular instance there are other factors in play which mean that those particular values are not given the weight that I think I would expect them to be given. You people know this. This is what you are battling with all the time on many of these ethical issues in trying to say, 'I know it is this, but there is also that'. I think the heart of all this is a desire on the part of certain people to give predominance to the position of the woman in this case. That is important but there are other factors that have to come into the discussion as well. That is the challenge I think that we are all dealing with.

Mr MULDER - We do have laws, for example, that stop people from entering into your Mass and disrupting it or being offensive, or doing those sorts of things. To me, I think, those protections do exist in other spheres and other areas of life. This is a particular case where what drives this behaviour is something that I think you would perhaps consider inappropriate - some of the abuse, the vilification, the throwing of pig's blood and all those sorts of things that have occurred in these places. No one denies the right of people to say those things; it is the way you go about them and that is the sort of behaviour that is being prohibited here.

Archbishop DOYLE - I do not condone any of that behaviour. Sadly, I know that there are instances but I do not support it and I do not think it does anything for the cause. I regret very much that we have to go to this kind of point in order to ensure that that kind of behaviour does not continue.

Mr MULDER - I think that is the point is somehow or another we do need this legislation to gain that balance. It is the freedom of the right to say whatever you want, wherever you want or to engage in what amounts to threatening and intimidatory behaviour, and

actually treating these people with the dignity they are entitled to, even if you do not agree with their conduct.

Dr GOODWIN - Your Grace, I just wanted to ask you about a couple of things. The first one is just around that very strong objection to the 24 weeks original provision that you talked about. Was that specifically related to the fact that a baby born at 24 weeks is viable and could well be saved through medical intervention?

Archbishop DOYLE - Yes, I think it was.

Dr GOODWIN - The other matter I just wanted to expand on is this issue around counselling. While there has been a change to the original provisions in relation to conscientious objection for medical practitioners. Originally there was a penalty provision, but that has been taken out now, because the intention is that it would be dealt with through the regulator for the medical profession, but for counsellors there is still a penalty provision in this bill. I just wanted to get a bit of an idea of the counselling services offered by the Catholic Church and how this will impact on the ground if it is passed?

Archbishop DOYLE - Within the Catholic Church the agency that would provide most of this would be within Centacare. They would be trying to help the person come to grips with what is a very serious situation. I think that they would be trying to provide them with as much support as they can, maybe to see the child through to full term. Adoption procedures or support for single mothers could come in if required and then the wraparound services. I am sure within the community there are recognised Catholic doctors who also would be of the same mind. It is providing the woman who has a very serious issue with the very best possibility to make the most informed decision. Allied to this is that we hold the view that the long-term consequences of what the decision is are exactly that - they are long term. The Rachel's Vineyard process, which again we sponsor is proof that these things for certain people simply do not go away.

We have become much more aware of the long-term, prevailing consequences of sexual abuse. We all thought it would stop straightaway. Well, it has not, and it does not. I suspect there is a parallel with this situation with women going for years and years regretting the decision they made at the time. Rachel's Vineyard would be an example of trying to redress the situation emerging many years later.

Ms CLARKE - I agree that it is critical for our counsellors to have a process that allows for good decision-making.

Dr GOODWIN - If a woman comes to Centacare and wants to consider the prospect of termination, amongst all the options available, the impact of this would be that Centacare would have to refer her on to another service.

Archbishop DOYLE - That then places in jeopardy the capacity for Centacare to do what Centacare does. That has a serious flow-on effect of these kinds of provisions if they come into law.

Ms FORREST - Only in that aspect, though. Centacare provides a vast range of services.

Mr VALENTINE - In the circumstance where a woman wishes to investigate other options that are not necessarily supported by the counselling services that is provided; it does not stipulate specifically that she is going to choose an abortion service but simply other services that are available to her. In other words, you are not physically referring her onto an abortion service; you are simply providing her with a list of other services that are available. Do you see that as something your services may be able to do?

Archbishop DOYLE - I do not know how they would manage that particular situation. The Centacare people are saying, 'We can't take you down the track of providing you with support and help and other things required if you are going to pursue the path of termination of the pregnancy'.

Mr VALENTINE - But she may not know that at that point. She simply might want to know the other extended options and get further information around the issue of termination before making a decision. She may not be going there to make that decision. She might simply want to know other information about termination. I wonder whether handing a list of services to that woman would be something that you could see your service providing.

Archbishop DOYLE - I can see the problem but I do not know how they handle it.

Dr GOODWIN - You would have similar counselling services operating in Victoria under the auspices of the Catholic Church. Do you know how they worked their way through the Victorian provisions, or is there not a conscientious objection provision Victoria for counsellors? Is it only for doctors?

Archbishop DOYLE - Under clause 7 there is reference to a statement by Archbishop Hart who is the Archbishop of Melbourne and he says, 'The bill is a clear breach of the human rights of doctors and nurses, forcing them to act against conscientiously held moral, cultural and religious beliefs'. I think they have had the same problem there as you are articulating.

Dr GOODWIN - We heard evidence about the Victorian provision and how that has been interpreted by the AMA and the guidelines that they have issued. What was suggested was that it would be sufficient for a doctor who had a conscientious objection to abortion to hand the patient either a pamphlet with perhaps the details of a family planning service, for the sake of argument, or the name of a another doctor who did not have a conscientious objection to abortion. That would be sufficient to satisfy the requirements of the Victorian legislation and presumably this legislation as well. We are trying to get an idea of how that would sit with the Catholic Church.

CHAIR - To assist there, I would mention to Vanessa and Your Grace that in Victoria it is only an obligation on medical practitioners as to conscientious objection, so your services would not confront that circumstance in Victoria as to counselling.

Archbishop DOYLE - But the concern is that the way that it sits at the moment, it could apply here and that is just an example of where this proposed legislation went further than in Victoria. Although it was said at the time that it was bringing it up-to-date with Victoria on a couple of these things, this is one that went considerably further than that.

Dr GOODWIN - In terms of the Victorian AMA guidelines, how did the Catholic Church feel about that proposal of handing over the name of another doctor or the information about the family planning services? Presumably this is already happening for Catholic-affiliated medical facilities in Victoria because of the Victorian legislation.

Archbishop DOYLE - Unless it has been changed, the problem in this legislation was that the doctor had to send them to somebody who he knew would take them down that path. That is where the problem was.

Dr GOODWIN - We have also had some discussion around this term 'refer'. What we have been told is that it has a different meaning in the medical profession's sense compared to the legal sense here. For the purposes of this legislation, we have been told it is the same as Victoria. 'Refer' is not a formal written referral - as in, 'I refer you to this doctor'. It is simply giving them the name of another doctor or service, and that would satisfy the 'refer' aspect of this legislation.

Ms CLARKE - In terms of confidentiality, how does the counsellor envisage that would look like? If you do not refer you are getting a fine - I do not know how much - but how would you enforce that?

Dr GOODWIN - The fine provision I do not know in relation to the counsellors. I guess a complaint would be made and then someone would take action. I do not think they would be going around policing counsellors - well, I hope not.

Archbishop DOYLE - The common understanding of referral when you get a referral from your doctor is that he is referring you on to somebody who is going to do the kind of thing that he accepts and that you believe you need. This seems to be just tinkering around a bit and saying it is 'refer', but in another sense. The common sense, I think, is the understanding that you get referred to a specialist because he or she is going to do the things that you specifically are looking for and need.

Ms FORREST - In practice, if a GP refers a person to a specialist or another doctor because they cannot provide the service that the person may be seeking, there is no guarantee the specialist or other doctor will provide the service the GP refers for. We see that happen all the time. Some people get a bit unhappy about that because they think that is what they are going to have. It then becomes the judgment between the patient and the doctor whom the patient was referred to, to make a decision about the best outcome for their care. Regardless of whether it is a formal referral or a referral such as the AMA in Victoria suggests could occur with just giving the name of another service, it is not necessary that any particular course of action will be taken. I think we need to take it into the context of practical reality as well.

Your Grace, you did read again Archbishop Hart's comments that this forces nurses and doctors to act against their conscience and/or moral or cultural or religious beliefs, but it does not. It allows them to express that conscientious objection and not act. I think we are reading this the wrong way. It actually gives them the opportunity to say, 'I'm sorry I don't wish to discuss this any further because I object'. It is the same when someone is asked to sign off parents who choose not to vaccinate their children. There is a process around that and they can object to that as well; some parents have a conscientious objection to vaccination. There is a process around those things to enable people not to

be forced to do a thing they have an objection to. The only time it can be overridden is if there was an emergency where someone's life was really at risk.

It just concerns me that you are saying that people are going to be forced when this provides that protection. Admittedly, there is a penalty for not doing it.

Archbishop DOYLE - I think you have to try to make sure that there is only one way of reading these things and not a variety of different responses or interpretations.

Ms FORREST - That is part of the reason for having the second reading debate too. It is so you get some of these things on the record, but in a practical sense too. I have worked as a health practitioner and can see how things work in practice.

I agree with the point in your submission that the government should perhaps concentrate more on improving education services and support to reduce the need for termination. They are doing a bit at the moment, which is a positive thing in itself. Along that line, I think in the Catholic Church there is still an objection to the use of contraception. Some doctors will not prescribe contraception. That creates a bit of a conundrum for some people. We are not just talking about single women here. A significant number of terminations are carried out for married women. Some of them may have several children already. The majority of terminations are carried out very early, which you may or may not be aware of. The only ones that are likely to be occurring beyond 16 but certainly between 24 are where the mother's life is at risk or the baby has some lethal abnormality generally.

Is it fair to say that we do need some sort of framework in law that provides for a safe service to enable those terminations to occur? In spite of your objection to termination generally, because it ends the life of an unborn baby, is there not a need for such a framework?

Archbishop DOYLE - This is the dilemma I am in I suppose. As I said at the start, I am probably here to encourage some damage control to keep it to the very minimum. I still do not remain comfortable with that either because we have gone back with all of the issues that you mentioned. They are very important ones at the end of the day because this is about the life of an innocent yet-to-be-born child that is still human in my view and the view of many I believe. We as a society have to support to protect that as well.

CHAIR - I probably will accept your invitation in that submission to contact you so that I can understand more about Rachel's Vineyard. I intend to do that, in terms of that counselling and assistance process. We do not have any further questions for you. We are grateful for your submission and for the evidence which you have given to the committee today. Our usual process is to provide copies of our report, although they are on the web. We are done for the moment, thank you.

Archbishop DOYLE - It emphasises a concern which we all have about the seriousness of the issues and sometimes I wonder whether my mind is quite as sharp as it used to be.

Ms GOODWIN - I think it is pretty good, Your Grace.

Laughter.

Archbishop DOYLE - It has been a privilege of being in this role. You have made a wonderful contribution to the society and carry a lot of responsibility and that is how I view all of you. I have great sympathy for that role that you have and a respect for it too.

As I was coming up the stairs today I realised that it is something that we need to do. Maybe while the Speaker is still in the job he would be able to help us out - my father's photo is down there in the House of Assembly. My brother wants us to have a photo with his photo behind us, but I am sure Michael will be able to organise that.

CHAIR - Correct.

Mr MULDER - We look forward to the tweet.

Laughter.

Archbishop DOYLE - Thank you.

THE WITNESSES WITHDREW.

Ms LISA McINTOSH, AHPRA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you for attending and welcome to the proceedings of the committee. Have you appeared in front of parliamentary committees? It is important that we indicate to you, while in this process are afforded the same protection of parliamentary privileges that member of parliament are. Nothing that you say here can be challenged legally by anybody, anywhere because that protection of privilege. Outside of here, you are not afforded that same protection, not withstanding that you might wish to speak to the media and have recorded or reported comments that you make as to the proceedings.

We suggest caution in terms of how you might repeat your view because outside here if you say things which are legally challengeable then you are exposed to that. With that can we get you to take the oath and then we will proceed.

We invite you to make some comment as to the AHPRA process. This is an opportunity for you to do that and for us to raise questions as a result. We have the various codes of conduct and so we understand components of them, I suspect. We welcome your comments please.

Ms McINTOSH - I am here as a representative of the AHPRA and as you are aware AHPRA currently regulates the health practitioners in Australia. Many practitioners fall within that legislation which is the National Health Regulation. As a registered health practitioner, practitioners fall within the remit of the national law and the respective boards. AHPRA is the administrative arm of the board so it receives notifications or complaints on behalf of the boards that fall within the remit of the national law.

They are assessed by various committees and if a committee believes that the public is at risk then they can apply various sanctions under the national law. Those sanctions may include conditions that restrict practitioners practicing some way; they can also suspend a practitioner's registration for a period of time. They can't cancel a practitioner's registration; they can actually refer serious matters to a tribunal. It is certainly open to a tribunal to cancel someone's registration under the national law.

I did provide some further documents that set out information to both notifiers and practitioners and I'm happy to answer any questions or clarify any issues in relation to those documents.

Ms FORREST - One of the big areas that is concerning a number of people, particularly health practitioners, is the conscientious objection and the need to refer. They deal with doctors under this because councils are not registered under the national health law at this stage. With that comment to refer, if someone had a complaint and believed it should be sent to AHPRA, what sort of process would that take? How would you have to demonstrate that you had been denied access to someone who would provide a full range of information services to you?

Ms McINTOSH - Essentially a notifier or someone who felt aggrieved by a registered practitioner would fill out a form and state that, saying, 'I wasn't provided sufficient information' or 'I was denied information on the basis that someone had a conscientious

objection'. There is a document, the Medical Board of Australia Guide to Good Practice, that informs practitioners of a standard of practice that the medical board deems reasonable. There is a section in there that identifies quite clearly that you are required to refer to another practitioner; that it is not appropriate to merely state you have an objection, and that would be the end of it.

The medical board has dealt with issues such as that, not particularly specific to termination of pregnancy. It may be vasectomy or similar types of things where a practitioner has an objection to referring to another practitioner for the purposes of undertaking that. In that case, they have been cautioned.

Ms FORREST - Moving away from termination for the moment, let us consider the circumcision of male infants. There are a number of doctors who will still do that, I believe, and there are some who will not. Is it the mother or the father of the baby who would lodge a complaint that the doctor would not refer?

Ms McINTOSH - Yes, lodge a complaint with AHPRA. It can be verbal - we receive verbal complaints where a member of the public will ring up and say, 'This is what has happened' and we will facilitate the reporting of that and take it from there.

Ms FORREST - Under the Victorian legislation that has the requirement for those with a conscientious objection to refer, have you had any complaints come through AHPRA? I know they are both fairly new processes, but have you had any complaints regarding a failure to refer?

Ms McINTOSH - In relation to terminations, no, we haven't had any at all - not within this state. I am not privy what is happening in other states, but not within this state.

Ms FORREST - No, in Victoria.

Ms McINTOSH - I could take that on notice. Whilst it is a national scheme, each state regulates its own practitioners and receives notifications in relation to its state practitioners. I would not be able to tell you today about Victoria but I can forward that information to you.

Ms FORREST - In Tasmania we do not have that requirement yet, but they have had it for a little while in Victoria.

CHAIR - Was that as to a doctor who will not refer?

Ms FORREST - Yes, was not referred, where it has been a problem and there has been action taken.

CHAIR - I was looking at a case where there was.

Ms McINTOSH - We could certainly provide that information to the committee in relation to Victoria.

Ms FORREST - It is very clear in the medical practice code of conduct that there is a framework. This may be a question you are not able to answer, but why do you think

there is such a resistance to this clause that merely states what is required of medical practitioners under their code of practice and what they are regulated under?

Ms McINTOSH - In relation to?

Ms FORREST - Our proposed law here and what is currently in Victoria - there is a requirement to refer if you have conscientious objection. It is clearly stated in the medical practice. It is also in the RANZCOG guidelines. AMA has other codes that also require it. The Victorian AMA put out a piece that talks about the conscientious objection, saying that all the doctor needs to do in those circumstances is provide them with the name of another doctor or service. Why do you think it is such an issue?

Ms McINTOSH - I probably cannot answer that. There has not been in discussion, probably because it has not come up within our local board in relation to these matters. In my experience, where there have other matters, such as where there was a hesitation or there was a lack of referrals for a patient wanting to undertake a vasectomy, that the committee felt very strongly that whilst someone may well have an objection to that, it is an obligation to referral. On that basis I cannot see that they would have an objection to this. They would follow that same principle, I would have thought.

CHAIR - On that same principle. This bill makes it clear, as I think the Victorian legislation does, that there is an obligation to refer because of holding a conscientious objection. Has there been any discussion that you are aware of as to disclosing the conscientious objection? Then, if the pregnant woman is happy to continue on for a time, receiving, as our legislation is intending, pregnancy options advice and at some stage making her own decision that she is not happy with where things are going. Rather than the obligation to refer, does this shift the onus to an obligation to disclose conscientious objection. Is that anything that has crossed your path or your consideration?

Ms McINTOSH - It has not. But I think implicit in those guidelines is that disclosure and I would have to review the document again. I do not think there is that obligation to disclose. My exposure to the medical board would be that disclosure would be prudent in the circumstances. It may well be open to say that there is an obligation to disclose in the first instance so that the patient is aware of the views of that medical practitioner. Then it is open for her and her partner to continue to engage with that practitioner or to ask for that referral.

CHAIR - Yes. It is a different focus and I have thought of that over the journey of this committee specifically with regard to counsellors of the obligation to refer on. But as we have had this discussion I was thinking of proposing this to the committee at some stage. But now I am thinking, if it a reasonable proposition, it is a reasonable proposition applying to medical practitioners as well rather than that specific obligation because you hold the conscientious objection to refer. No choice - refer. Then there would be criminal sanctions for counsellors for not referring.

Ms McINTOSH - That is where we come into some issue there because counsellors are currently not regulated, so they do not fall within the remit of the national law and I am not aware of any code. I am sure they probably have that but counsellors do not fall within the remit of the national law and medical practitioners do.

Mr MULDER - This bill criminalises an abortion without consent. The idea that abortion in all cases in now decriminalised is not quite correct, I would suggest, because an abortion without consent is actually a criminal offence under the consequential amendments to the Criminal Code. Let us say, for example, another medical procedure, an amputation of a limb, for example, was done without consent, what would be the recourse or the sanctions and the procedures for achieving those sanctions be?

Ms McINTOSH - The issue, regardless of what type of procedure that has occurred, is the consent.

Mr MULDER - A procedure without consent, and I realise there are exceptions with emergencies, etcetera, but what are the procedures that would be gone through if a medical procedure were conducted without consent?

Ms McINTOSH - Without consent, that would clearly be a notifiable event, so it would be conduct that would fall within the remit of the national law. I guess we have to have notice of it in the first instance. If we did, then the board or committee would proceed on reviewing that information. They might decide that this is significant; if you proceed without consent, they can take immediate action. That is action that can happen within hours of receiving notice. They could suspend. They could put conditions on that practitioner's registration. That could be that they are unable to perform surgical operations until such time -

Mr MULDER - Could it be referred to the tribunal?

Ms McINTOSH - It could.

Mr MULDER - Would it be referred to the public authorities for prosecution for assault or something?

Ms McINTOSH - It could be as well, so where we would then engage with the DPP in relation to that. It would depend on the amount of information. Certainly, immediate action, and given that the board can act very quickly, we often do not have all of the information, but the board or the committee has sufficient information to determine that it can form a reasonable belief that they need to take action to protect public health and safety. Part of that immediate action requires that the committee or board take further action and that could be an investigation, it could be for police if it has sufficient information and immediate referral to the tribunal.

Mr MULDER - What is your organisation's position, then, in regard to the need to have a special criminalisation of this medical procedure without consent when in fact those avenues already exist for medical procedures? Why do we need a specific one?

Ms McINTOSH - I probably would not be able to talk to or have a view on that, but I can state that there are sanctions within the national law that can protect public health and safety and deal with this matter around consent.

Mr MULDER - The national law you are referring to is?

Ms McINTOSH - The Health Practitioner National Law which regulates all health professionals in Australia; all medical practitioners fall within the remit of that law.

CHAIR - I think we have finished, Lisa, both with the two documents which you have submitted to us along with your correspondence, I think our questions in relation to AHPRA are covered and we thank you very much for being here.

Ms McINTOSH - Thank you.

THE WITNESS WITHDREW

PUBLIC

Dr MICHELLE WILLIAMS, AND **Dr JAMIE BRODRIBB**, COUNCIL OF OBSTETRIC AND PAEDIATRIC MORTALITY AND MORBIDITY WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Thank very much to you both for giving of your time to be here with the committee. Do I need to explain to you the protection of parliamentary privilege which you have afforded?

Dr WILLIAMS - No.

Dr BRODRIBB - No.

CHAIR - Do you wish to speak to your submission and draw out in particular any matters, and you might like to take that invitation, given that these proceedings are recorded and subsequently will be transcribed, so you might want to provide measures on the public record?

Ms FORREST - Could I also ask if they could explain the role of the council so that it is on the record, too?

CHAIR - Go ahead, Michelle.

Dr WILLIAMS - The Council of Obstetric and Paediatric Mortality and Morbidity is a legislatively prescribed body - and I am nervous speaking in front of lawyers - which is independent of government and are employers which has a remit to look at prenatal obstetric and paediatric deaths and serious morbidity in the state of Tasmania and provide advice to the government, the coroner and the general community about ways in which we can improve mortality rates in mothers, infants and children. We collect data in the form of perinatal and obstetric surveys and analysis of the morbidity or mortality reports at the hospital, in order to further classify deaths and look at how things can be changed.

We share data in a confidential fashion with equivalent bodies on the mainland and submit a report to parliament yearly.

Ms FORREST - It is getting much more timely now than it used to be.

Dr WILLIAMS - We are working very hard at that, Ruth; it's been a lot of work. There is a lot of data to be collected, especially in the obstetric and perinatal side that's really quite complex but very important for improving data, so we needed to do it well. Now it is working better. Probably it is best to speak through the submission I made. We appreciated as COPMM being asked to contribute some professional advice and evidence through this committee, based on our experience through looking at the data in Tasmania of infant death, prenatal death and maternal death.

As a combined body of experts in various fields, we have representatives from the College of Midwives, from the College of Obstetrics and Gynaecology, the College of General Practitioners and the College of Physicians Paediatric Division. We represent a range of experience across the medical spectrum involved with pregnancy and childbirth. Our submission is very medical and I think it is really quite relevant to the committee.

One of the most pertinent points we found as a body looking at the proposed legislation was the emphasis on gestation.

Gestation - and this is Dr Brodribb's area of expertise - is not always easy to determine, particularly when mothers present late or when there are foetal anomalies and having very firm definitions of cut-off dates can be difficult to enact clinically; that is a very important point. We use period dates, date of the last menstrual period, foetal size and the development of the foetus as part of our marker but it isn't always a completely accurate science.

We also had a problem within gestation with the changing viability of foetuses given the advancement of neonatal care. Ten years ago it was common that if infants were born under 28 weeks their viability was considered questionable and there was the thought that there may be a significant chance of disability in infants resuscitated. The improvements in both antenatal and neonatal care have meant that it is common for 28-weekers to survive without any complications and the lower edge of viability has decreased.

Twenty-two-weekers have been successfully resuscitated and are often viable. They do carry a very high risk of serious disability - it is around 50 per cent of pregnancies born at 22 weeks - however, resuscitation of those infants is an option that parents may be given if the infant is born in good condition. As paediatricians and obstetricians, we need the committee to be aware that termination of labour in the late second trimester would involve induction of labour and the potential delivery of a live-born infant.

We, as a committee, have some concerns about late terminations and need to be cognisant of the risks that that poses for medical practitioners if families change their minds, for example, for a live-born infant. It is uncommon but possible, certainly if we get dates wrong.

Ms FORREST - Are you going to another point?

Dr WILLIAMS - We have lots of points but we are very happy to answer questions as we are going in case I speak too much medical jargon.

Ms FORREST - Just on that point, we have been told by a range of witnesses that the majority of terminations occur before 12 weeks.

Dr WILLIAMS - Absolutely.

Ms FORREST - Only a very small percentage of terminations occur at this stage where you are likely to get a baby who is born live and the majority of those are the foetal abnormalities or some other problem or serious maternal illness, which is a real challenge, obviously. The baby is healthy and the mother's life is in danger, which is probably unusual, but it does happen.

Dr BRODRIBB - Cardiac arrest.

Ms FORREST - Sorry?

Dr BRODRIBB - Cardiac arrest. It is a termination of pregnancy that precipitates the cardiac arrest.

Ms FORREST - It is really rare circumstances we are talking about here. I think one of the risks with this discussion here, what we are seeing in some of the public discussion that goes on, is that it seems to be the common thing, that we are going to terminate all of these babies.

Dr WILLIAMS - It is a really good point, Ruth. I am making this point only for some terminations at the end and I think it links very well without point that we think lethal and severe foetal abnormalities should be grounds for termination earlier as well, because a severe foetal anomaly is the most common cause for a request of termination in the second trimester. That is certainly our involvement in the neonatal unit where an infant would either succumb soon after birth, in the first year of life or early years, or carry a very severe disability with very little chance of quality of life. These are not minor abnormalities that we are talking about. The South Australian legislation prescribes that the child who suffers from such physical or mental abnormalities as to be seriously handicapped is one of the conditions for lawful termination in South Australia and we think that is a very sensible addendum to the legislation. It is a minority of cases. The majority are first trimester by a long shot.

Ms FORREST - That does present the challenges of perceptions about what is a serious anomaly and Jamie, you have come across women who would think a cleft lip is a serious anomaly that would warrant a termination, potentially right through to a nanocephalic baby.

One of the concerns that has been raised by others in this area is that we acknowledge that it can be disingenuous to suggest that a woman is having a termination for mental ill health when clearly the baby has a lethal abnormality. But by naming foetal abnormality without specifying conditions, which it cannot do and we should not do either, there is a human rights issue there. The people in disability areas will say, 'Who are we to say what is right and what is wrong? Should that not be done individually?' And of course there will be an impact on the mother, regardless of the outcome with a baby with a severe malformation.

Dr WILLIAMS - I think, as a paediatrician - and Jamie may speak differently to this as an obstetrician - children are born to a family and I think perception of disability is incredibly important. We know that raising a child with a disability is harder for parents; there are some exceptional parents who do it brilliantly, but we have a lot of families in this state who are under pressure and children with special needs are over-represented amongst the child protection cohort, both those reported for full care and those removed from their families. They are very hard children to place; they have fairly horrendous existences and I think we cannot discount the family's perception of the child's disability and their ability to cope with that child.

It is very important, as severely disabled children are very hard to foster, they are very hard to adopt and in my practice as a paediatrician, a significant proportion of my cohort of poorly treated children are kids with special needs born to families who are already struggling. I think that perception is very important.

Ms FORREST - I will take you back to the bill as it is written in the schedule. It is a very valid point and when we look at part 5 of the bill - I am not sure you have it in front of you - but when we are looking at this as the reasons after 16 weeks, which is what we are talking about really, a termination can occur but two doctors have to agree that it is reason to believe the continuation of the pregnancy will involve greater risk of injury to the physical and mental health of the woman and then, in assessing that risk, they must have regard to the woman's current and future physical, psychological, economic and social circumstances. So, when you are talking about a baby with disabilities born into a family, then we are looking at the social and economic circumstances and the mother's psychological health as well.

Dr WILLIAMS - I think we should look at the child's quality of life as well, that is, part of our right to life is the right to quality life and to exist without suffering and I think that this is all mother focused, which is good because the mother is carrying the pregnancy; however, the potentially disabled foetus is not mentioned and I do think that should be a separate category within this area. I hear what you are saying about the vagueness of serious physical and mental handicap, but I think each case does need to be evaluated differently because a cleft lip, I agree, is a minor anomaly, but if that is combined with a genital or a cardiac anomaly - the risks are more than cumulative, they multiply.

Ms FORREST - I accept that, but this has been raised as a concern by other groups, that once you take that out and make it a separate indication, you then bring in all those areas of where you draw the line -

Dr WILLIAMS - Where do you draw the line with the mother's physical and mental wellbeing? It's there and it is an individual case between a family and their doctors at all times.

Dr BRODRIBB - One of the difficulties with the act as it has been is that the focus is on the mother. The mother has to carry an enormous amount of guilt because the way the act is worded she carries all the responsibilities. It is her mental or physical wellbeing, and that is very unfair on the mother. They carry this psychological burden for the rest of their lives; it never leaves them. I had a short time working in psychiatry during my resident years and I was surprised how often women brought up the issue of termination of one of their babies as one of the factors that was paramount in their psychological ill-health. I would agree with Michelle, I think the time has come to acknowledge there is a human rights issue. As you are probably aware, in the UK it went to the House of Lords in regard to doing terminations for Down syndrome on that basis and it was accepted by the House of Lords, otherwise the termination for that indication would have stopped. It would have probably changed the whole issue of termination of pregnancy for abnormalities.

It's an issue we probably ought to be addressing because it's not fair to load it on the mother. If we have the ability now to make diagnoses about the wellbeing of babies and have an understanding of what the consequences are long term, we should be able to use that new technology and new information wisely.

Ms FORREST - You said it could have potentially stopped any termination for an abnormality, so how did the UK deal with it in its legislation?

Dr BRODRIBB - I haven't read their legislation recently, but I don't think there is an issue now. We are talking probably about 20 years ago when that happened. It was when the issue of diagnosis, doing amniocentesis and the like, really came to the fore in the 1980s and had to be dealt with by the community.

CHAIR - Jamie, were you able to put that proposition to Michelle O'Byrne when the bill was being framed?

Dr WILLIAMS - We met with advisers - I went as chair of COPMM - and we raised that very strongly. It is something held very much in the minds of those who work in the hospitals in paediatrics and obstetrics. I believe Boon Lim spoke to you last month, as head of WACs at the Royal, and he has a very similar view.

CHAIR - And RANZCOG. I can only presume then that you would be somewhat disappointed that that provision isn't in the bill?

Dr WILLIAMS - Very. I think it's time.

Dr BRODRIBB - One of the things that is important is that with the change in technology and how that is applied, assessment of the normality of babies is now done at about 19, 20 or 21 weeks simply because the ability of ultrasound to assess what is going on inside that baby - and that has gone ahead in leaps and bounds in the last decade - the ability to delineate what is going on is better with the advanced gestation. It used to be 16 weeks, so if a decision was made to terminate a pregnancy it would have to occur before by a **[? 11.19.28]** defined under the law. For the last 10 years now I have reviewed all the stillbirths in Tasmania and reported on those. In the most recent one almost 50 per cent of our stillbirths were terminations for foetal anomalies in the 20-25 week group. What technology and the change in medical practice has done is to move a group of so-called stillbirths or pregnancy failures into the period of viability, which has raised a whole lot of issues that have not been raised before, perhaps with the exception of Down syndrome, which the community has had to grapple with for quite some time.

Mr VALENTINE - Is that 50 per cent over 10 years?

Dr BRODRIBB - No, just in the most recent report.

Dr WILLIAMS - Annual report.

Dr BRODRIBB - Annual report. It is not designated as such in the report for various reasons, but that is the reality of what has happened. We don't have any data in Australia on the reasons for termination of pregnancy across the reproductive spectrum. In the United Kingdom there is a thing called 'extended perinatal mortality', where in fact they all register terminations at any stage because we need to know what is happening to the pregnancies and why they are failing. There is a whole cohort of pregnancies that fail. The reality is, as we said earlier on, the vast majority of terminations are under 12 weeks for social reasons, but once you get beyond 12 weeks, where you can get your first diagnoses from very good ultrasound, we are seeing pregnancies terminated for medical conditions and we have no data on that. I think one of the submissions that we put from the council was that all termination data should be collected so we actually know what we are dealing with.

Ms FORREST - Isn't that as simple as adjusting the prenatal data collection forms to include that?

Dr BRODRIBB - No, not as simple as you think.

Ms FORREST - No?

Dr BRODRIBB - The prenatal data forms are filled in through the maternity units whereas terminations are done - as you know - inside and outside hospital, and the ability to get data is hard enough now and to check that the data is valid. If you go that step, Professor Joe Corry[?] started doing - in fact, he started the first natal data collection in Australia and he did gynaecology as well, which really emphasised the difficulty of getting data outside the maternity setting. He emphasised that the data wasn't filled in. If it was filled in, it was incomplete and a lot of his time was spent sending forms back to doctors and hospitals to get the data. He was particular, a bit like a dog with a bone, with it. If we were to do we would have trouble.

Ms FORREST - No, we don't want forms to come back every week in the mail.

Mr VALENTINE - He was tenacious.

Dr BRODRIBB - He led the way and he showed what to do, but I don't think we could do that. I think in South Australia if there is a termination that has to be notified.

Mr MULDER - As a separate thing, but something about that whole idea. Would it be appropriate then to put that sort of notification in here so that we get a handle on what is happening and why?

Dr WILLIAMS - We made that submission in our report, really just to get an idea of trends, what is happening. Is it serious cardiac disease? Is it spina bifida? What problems are leading to termination? It would be useful data in a public health forum.

Mr MULDER - I don't know if you are aware but I have a question on the notice paper with regards to this sort of information that I asked in May, and we are still waiting.

Dr WILLIAMS - It's because we don't have that data.

Dr BRODRIBB - You might get the numbers from the Medicare item numbers, but you won't get the reasons.

Ms FORREST - It is probably better to be in the regulations under the bill rather than the act itself, when you think about what acts are called and what regulations are called, though. Have you had that discussion at all, whether it would be part of the regulations? Was there any indication -

Dr WILLIAMS - Which regulations, sorry?

Ms FORREST - You have regulations that sit below your act. Your principal act sets out your policy position -

Dr WILLIAMS - Are you talking about ours, of COPMM, or yours?

Ms FORREST - No, the regulations that sit below this act because I'm sure there would be regulations that would be put out if this is passed at some stage, with the more of the nuts and bolts in it.

Dr WILLIAMS - It's not as important as -

Ms FORREST - It's not the principle, it's how it works. It may be something to be put in the regs.

Mr MULDER - Do we need it in the law somewhere that we do?

Dr WILLIAMS - I think the one concern would be harassment potentially of people having terminations who are identifiable. For example, if you had a genetic disease that ran in your family and you chose to terminate an infant who was found to have the same serious abnormality, there would be the risk if we had identifiable data that you could go back and identify patient data. That's why we do not do it under COPMM because we bound to keep patient confidentiality. It would need to be within your act, but we would need to have provisions for patient privacy.

Mr MULDER - A lot of the stuff is often dealt with, isn't it, by you get the form and no-one can go and look at the evidence itself? But you do get trends and issues which are raised at a macro level at which all identifiable data is stripped. It is a sure fact that you cannot totally de-identify material in a place like this. You then come up with a balance of maybe you do not identify a particular genetic trait and you describe it as a genetic trait so that it is not at that level of identification. That is a question of the process around it. It is a thing than can be got over but I am sure that the work you are doing is an indication perhaps that you think that the general population does need to understand what is happening and the trends and concerns.

Dr WILLIAMS - My take on it is more for a medical and public health type of thing. If we are getting a big jump in spina bifida cases, do we have enough folate in the community? It is really to add to the live born data. We know there are concerns, for example about gastroschisis, which is an abnormality of the anterior abdominal wall where the intestines are out and there is some question as to whether that is related to increasing cannabinoid exposure. Knowing that sort of data across a community would be incredibly useful for us if we had the live born and the termination data. I do not know how much good it would serve the community generally, but the community loves watching things like Big Brother. They love living other people's lives.

Mr MULDER - There is a difference there between it. We will come back to this issue when I talk more generally about the need for criminal law at all.

Dr GOODWIN - I want to tease that out a little bit more because that is something that concerns me - that we may not have a good understanding of the incidence of some of these abnormalities or conditions. Can I get it clear in my head what we do know? We know from the live births the incidence of some of the conditions that you are talking about, but we do not know from the terminations.

Dr WILLIAMS - Correct.

Dr BRODRIBB - We do it beyond 20 weeks.

Dr WILLIAMS - Those who have induction of labour and deliver the baby, the baby is registered as stillborn and we know about the congenital anomaly then.

Dr GOODWIN - Right, because those procedures take place in the public hospital system and they are recorded. For the pre-20 weeks, would that be picked up anywhere else in the system with scans or anything like that? Does that data feed in anywhere?

Dr BRODRIBB - There is no formal collection process. The difficulty is that we are identifying major abnormalities at 12 weeks, particularly of the brain, and those pregnancies will be terminated because we know what the outcomes of those anomalies are, even at 12 weeks. To get any temporal trend about what is happening within the community in terms of abnormalities and given the interaction of the environment with reproduction, as we understand very well now, we have no data about that unless it is collected from the point at which we identify this.

Dr GOODWIN - That is potentially a pretty significant gap in our knowledge base.

Dr BRODRIBB - It certainly is.

Dr WILLIAMS - That is something that we have been grappling with at COPMM level and will probably come back. It perhaps does not need to be confused with this as the major issue of this legislation, but it is something that we need to look at in terms of improving the health of the Tasmanian public, which is our remit. We need to get the right data to do that properly.

Dr BRODRIBB - It goes back to what you were saying, which was that we felt that there should be a section in the act that identifies a foetal reason for termination and that goes back from that too.

Dr GOODWIN - Has the Menzies Centre been on to this issue at all or do they raise it as a concern?

Dr WILLIAMS - Not yet. We are small numbers too, though, Vanessa, and for some things it is hard and we would need to combine data with the mainland to get significant trends. We see changes anecdotally but we need big numbers for good statistics.

Dr GOODWIN - Are you seeing anecdotal changes in the incidence of some of these abnormalities that you are talking about?

Dr WILLIAMS - Absolutely.

Mr VALENTINE - To clarify, when you were talking about the burden of the decision being on the mother, were you saying that this information being available would help the mother not to feel so burdened by it?

Dr BRODRIBB - What I am saying is that I do not think that the reason for the termination should rest on the mother's shoulders alone. As Michelle said, it involves the whole family. Marital break-up after major abnormality of babies and disabled children is well recognised, so it is potentially a very destructive process socially. My feeling is that the mother shouldn't be one who has to carry the responsibility; in other words, it is signed out for the psychological or physical ill-health of the mother.

Mr VALENTINE - How do you see this bill being changed to cope with what you are suggesting here?

Dr BRODRIBB - By including a category 4 definition of termination for major or lethal anomaly where there is serious handicap, along the South Australian lines.

Mr VALENTINE - Can you put your mind to the wording on that?

Dr WILLIAMS - We have, it is on page 2 of our latest submission, part 6.

Mr VALENTINE - Thanks.

Dr WILLIAMS - We did the work for you. That again, Rob, was something we debated along Ruth's lines - what wording we should use because there is a lot of opinions and we in the end as a group thought that that was the best definition in the other legislation and other acts and proposed acts.

Ms FORREST - On that point, isn't the term 'handicapped' no longer a term that is used?

Dr WILLIAMS - Correct, it is not used. Physical disability is used rather than handicapped but the South Australians use 'handicap' and we are happy.

Ms FORREST - They are a bit behind in some ways.

Dr WILLIAMS - They are.

Ms FORREST - But we get the general drift of what you are suggesting.

CHAIR - If we can go back then to where you were going, Michelle, please?

Dr WILLIAMS - Yes, I think I got to part 2, which is an obstetric point, that there is a difference in potential medical risks in terminations in the early and latter parts of pregnancy and that we believe terminations at more advanced stages of pregnancy should be carried out in a recognised medical facility, in a hospital preferably, particularly when the mother has other risk factors that would make the risk of a termination of pregnancy higher, such as previous caesarean section, so I think that is quite well explained in our submission.

Foetal reasons is our part 4 which we have already discussed at length.

Now a very - I shouldn't say 'controversial' - but part 5 reiterates our point that infants delivered by induction of labour or termination of pregnancy may be live born.

Dr GOODWIN - Can you expand on that? Because we did hear some evidence about this area and I think, from memory, we were told that the parents might be given a choice to have their baby injected with potassium -

Dr WILLIAMS - Prior to.

Dr GOODWIN - Is that right?

Dr WILLIAMS - That is offered in some places, yes.

Dr GOODWIN - In some places?

Dr WILLIAMS - Yes. My understanding, as a non-lawyer, is that the lawfulness of that act is unclear in the current legislation. The option is for the baby to be born and be offered comfort care only, so no drips, no IV feeds, no oxygen, and cuddled by the parents until it succumbs. It depends on the age of gestation and the abnormalities, and Jamie may have more experience with this than me.

Dr BRODRIBB - It is a very real difficulty and the opportunity for a parent to decide whether their child should have potassium chloride so that they are not born alive does get discussed with them. Some don't want it. There are a lot of implications of a baby being born alive that don't necessarily involve the couple; it involves the nursing staff in the hospital where there is a live baby. It might even involve a paediatrician because there is a live baby and the legality is difficult once you have a live baby in terms of how you do things.

Dr WILLIAMS - At 22 weeks it is considered completely ethically normal to not resuscitate an infant because of the very high risk of disability that that infant carries, so if a mother spontaneously went into labour at 22 weeks - we are not talking termination here, we are talking spontaneously went into labour - we would actively discuss - at 22, 23 and even 24 weeks - what the family wanted their child to receive as care. Infants screaming at birth would be offered resuscitation unless it were against the parents' wishes. I think the difficulty that Jamie alludes to is that staff have very different views when a baby is there - should we or shouldn't we? - and it is a very tricky and vexing situation. We often see the long term of an infant struggling in intensive care for a period of months and then succumbing, which is why the no-treatment option is offered - comfort care only. It is very difficult when the parents have made a clear decision that this child's life is not going to be sustainable in the long term, that the child will die from anomalies. To have that infant born alive and staff urging resuscitation is a very difficult situation.

Dr GOODWIN - In terms of the baby being offered comfort and how long it may live, does that vary from hours to days?

Dr WILLIAMS - It is usually hours. It depends on the anomaly, though, and the vigour of that infant, the intrauterine environment. It is all pretty variable.

Dr GOODWIN - I imagine it would very traumatic for all parties concerned.

Ms FORREST - And we can't lose sight of that.

Dr WILLIAMS - It is very traumatic.

Dr BRODRIBB - Even for people who are willing parties to help the couple.

Dr WILLIAMS - Which is why excellent scanning at 19 weeks and the ability to make decisions at that time is much better for families - a 19-weeker will not breathe. It is probably important to say that not all 22-weekers will breathe either. It is really the absolute extreme of viability at 22-23 weeks.

Ms FORREST - One of the other things is that if you make a decision to attempt resuscitation at 22-24 weeks, it means a mother gets no time with the baby - no time to cuddle and be involved. We have seen photos of this tiny little baby with all the specialists around it - it is a big decision for the parents; do you make the most of that short time you may have? Unfortunately, we seem to trivialise this into being an easy decision for mothers.

Dr WILLIAMS - Some of the foetal anomalies that parents may be offered termination for - for example a hypoplastic left heart, where the left ventricle, which supplies blood to the body, is not formed. There is surgery offered for those infants who are live born now. It is multi-stage surgery. The survival rates have gone up in my time in paediatrics from less than 10 per cent to around 50 per cent. If the parents choose to go through with that pregnancy, and many do, the infant is immediately taken away and is in intensive care. It is a tough time for these parents regardless of what course they choose to take. Severe disability is a very hard row.

Dr BRODRIBB - The difference with that is that with ultrasound and assessment it is an ongoing dialogue. It is not as though one minute they had a healthy baby and the next they have a baby with a major anomaly. One of the good things about antenatal foetal assessment is that we can prepare mothers for the possibility they are going to have a difficult time. That doesn't take away the absolute horror of the whole situation, but at least it's not as bad as it used to be. I think that is one of the major advances we have had. That includes when the termination occurs for a major foetal anomaly - the parents are prepared. They have often seen a paediatrician, particularly after 20 weeks, and have had a chance to talk about it, come to terms with it and hold their baby afterwards. Whereas 20 or 30 years ago the baby was whisked away the minute it was born and the woman didn't understand what the baby was like and thought she had had a monster. I believe it is a much more humane way of managing it and people come to terms with it very well.

CHAIR - In terms of your submission, you make it very clear there ought to be some consideration in this bill to address that potential conflict between abortion, induction and homicide. Michael Stokes, from a legal perspective, has challenged this committee about that. It would seem it is not an easy proposition. Where you suggest the legislation should cover foeticide prior to induction, would I be right in suggesting it is already covered because that would be a termination?

Dr WILLIAMS - It would be good if it were clear that it were already covered. I believe there is debate amongst practitioners as to whether it is covered by the legislation or the proposed legislation.

CHAIR - But prior to induction, isn't that a termination and therefore covered? But you are suggesting that it is not clear amongst the medical profession. There is some concern -

Dr BRODRIBB - It is a very different act to terminate a life. If we terminate a human pregnancy and as a result of terminating a pregnancy then the life will be terminated as part of that process. If we consciously and deliberately terminate that life before, the issues are complex.

CHAIR - Before the birth?

Dr BRODRIBB - Yes.

CHAIR - Then you go on to say to clarify the relationship between abortion and homicide, because if we do have a live birth, which is earlier in that same paragraph, and again Michael Stokes addressed his mind to that, because on looking at section 153 of the Criminal Code, it would suggest that by omission as much as by an act that live child isn't given every opportunity, then there could be some prosecution for homicide. Quite complex.

Ms FORREST - When you look in clause 3 of the bill, in the interpretation section, it might -

Dr WILLIAMS - Which section, sorry?

Ms FORREST - Section 3, Interpretation. We look at the meaning of 'terminate' it means:

> To discontinue pregnancy so as not to progress to birth by using instrument of a combination of instruments which is a surgical induction, or using a drug or a combination of drugs.

When I read that I just think about the drugs we use to effectively bring on the labour or whatever it is we are doing; it would not cover giving potassium to the foetus, would it?

Dr BRODRIBB - Because doing that would not terminate a pregnancy.

Dr WILLIAMS - I wonder whether that should say 'progress to live birth'. I don't know why I didn't see that when I read it every other time.

Ms FORREST - This is the problem, and we have had long discussions about this too. I thought it shouldn't even be there and we should take the whole thing out. The example I put is if you have a woman who desperately wants a vaginal birth - she has had two or three vaginal births previously - has a breech baby, the obstetrician is reluctant and encourages her not to birth vaginally but have a caesarean, as happens, and she feels that she was coerced perhaps later on, she has some complications from the caesarean, comes back and says, 'I didn't have the consent of two doctors, so my foetus was terminated by caesarean, by the use of instruments,' I suppose that was going to catch these up.

But when we looked at it further and we had some advice from the department and the legal brains behind this - the medical side is one thing, the legal side is the other - and having a medical background, but not much legal focus on it now, the challenge is there.

If you leave it there it means we are not talking about those sorts of births. Once you put in 'live birth' - that is one of the things I thought maybe it should be something along those lines, or the term 'viable,' which is another contentious issue too - what happens to those ones as you have talked about that are born live? There is no intention of keeping them alive; you are just palliating those ones because they have some condition like trisomy 18 or something like that.

Dr BRODRIBB - I think you could take out the words 'so that it does not progress to birth'. Termination means to discontinue a pregnancy, whatever gestation.

Ms FORREST - So does an induction of labour and a selective caesarean also terminates a pregnancy. How do we not get those caught up in it? That is the question.

Dr WILLIAMS - I do not think you do if you follow Jamie's suggestion of deleting that part of that.

Ms FORREST - I thought that originally, but after advice from the department.

Dr BRODRIBB - The termination of pregnancy might very well be at 28 weeks, and that is an induction of labour, so I do not think that is an issue. We are terminating a pregnancy by drugs at that stage. To say that it does not progress to birth, but it will progress to birth.

Mr MULDER - The clarification seems if we have the word 'termination' and this is about a termination of a pregnancy and I think - I am as good as everyone else - every now and then the conversation seems to be the termination of the life of the foetus, but it is not what it is about - it is the termination of a pregnancy we are talking about. That is where this live birth issue starts to -

Ms FORREST - I have looked after women at 28 weeks who have had terminations or spontaneous labour at that stage and their babies are born, it is a birth. The argument was that if you left it in there and there was a challenge at any point, you could go the *Macquarie Dictionary* and it says 'brought forth into independent being or life, from or as from the womb: the baby was born; the idea was born'. It was talking about independent life.

Dr WILLIAMS - That's the *Macquarie* though.

Ms FORREST - That's what the courts go to, apparently, so I am told.

Dr BRODRIBB - That's an induction of labour at 28 weeks; usually a 28-weeker is not independent life. They need full facilities in intensive care.

Ms FORREST - It's not?

Dr BRODRIBB - If you were to induce a 28-weeker, say vaginally, for severe pre-eclampsia, the mother's life is in danger, that would be a termination of the pregnancy. That baby can't go to independent life at 28 weeks. It would need active medical support.

Dr WILLIAMS - It all comes down to definitions of definitions.

Ms FORREST - Absolutely.

Dr BRODRIBB - It will address an issue that we will talk about a little later in terms of that so-called late termination.

Dr WILLIAMS - Our next point was, unfortunately, also about definitions and this has been tidied up a little bit as the act has been improved. It was regarding the definition of a woman as a female of any age and a woman's consent is a major part of this. In part 4 of the act we have point 4, that the pregnancy of a woman who is not more than 16 weeks pregnant may be terminated by a medical practitioner with the woman's consent. The next part, with the woman's consent, had two medical practitioners for people over 16 weeks of pregnancy.

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

Ms FORREST - Why doesn't that come under the Guardianship Administration Act currently?

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

Ms FORREST - How do we deal with it in regard to any medical procedure?

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

We have spoken about how traumatic this can be for mothers. For people with altered capacity that is even more so. We would like the parliament to be aware of that when this legislation is debated.

The last point was the point we have already discussed about notifying all terminations of pregnancy so we can collect better public health data on congenital anomalies and knowing why we are having terminations and the foetal reasons for the late ones.

Ms FORREST - Can I take you back to the previous point? This is not just an issue for termination of pregnancy in minors who lack capacity, it is an issue for minors accessing any medical care or any decisions -

Dr WILLIAMS - Minors who don't have an active guardian, yes.

Ms FORREST - This is bigger than this bill.

Dr WILLIAMS - It's huge.

Ms FORREST - I wonder whether it needs to be addressed in a whole range of areas, not just this. A minor lacking capacity, without a guardian, needs contraception. A minor lacking capacity, without a guardian, needs an emergency medical procedure.

Dr WILLIAMS - It's probably outside of the remit of this committee but capacity can vary depending on the consequences of the action proposed. Contraception is far less of an issue because there is lower risk of complications than a surgical procedure or a termination of pregnancy, or admission under an involuntary mental health act - there are ranges of capacities involved.

Ms FORREST - Let's say, they need their appendix out, that's a serious medical procedure -

Dr WILLIAMS - It is an issue, Ruth. Yes, but for having an appendix out we know that the option is really major - there isn't a choice A or choice B for the young person so it's easier to have that -

Ms FORREST - You still need a guardian though, you still need a framework. How do you deal with that now?

Dr WILLIAMS - It is a different issue.

CHAIR - It is a different issue. It is way outside our remit but it does raise an important matter which the committee will, I suspect, report upon and draw attention to but for the purposes of this committee -

Dr WILLIAMS - That would be great, thank you.

Ms FORREST - I am just trying to clarify that it's not confined entirely to this issue, it's much bigger.

Dr WILLIAMS - Much. We just wanted to point out to you that that is an issue with this bill as well potentially for some, a very small group.

Mr MULDER - Can I suggest, Chair, given the complexity of this, although it's nice to seek points of clarification on the way through they invariably end up in long-ranging debates. Perhaps we should let the submission go through and then -

CHAIR - She is just about finished.

Dr WILLIAMS - That was my last point, Tony. The very last point was to thank you for the opportunity to make a submission and speak to it because we think the issues are pretty big and complex, even for us who are specialists in this field and it's nice to be able to present the medical side of things to you. Thank you.

Dr BRODRIBB - I'd like to speak to a couple of points from the obstetric point of view. One of the issues of termination of pregnancy - and most of them are done as surgical procedures with the cervix being opened - is that once you get a pregnancy beyond 10 weeks and dilating the cervix is that there is a risk of damage to that cervix and the development of a condition that has an unfortunate term called 'cervical incompetence', and that can result in a subsequent pregnancy in a woman spontaneously rupturing membranes and giving birth immediately quickly because the cervix has opened up painlessly and it occurs at about 18 or 19 weeks. In reviewing the perinatal deaths that we have had, a substantial number of very early 20-24-week stillbirths that have occurred have occurred as a result of this condition of cervical incompetence.

There are ways to minimise that problem by pre-treating the cervix with a group of drugs we call prostaglandins and they soften the cervix and reduce the risk of that happening. The concern I have is in regard to part 2 at number 4, which is the gestation at which a medical practitioner might terminate the pregnancy. Given that we know that cervical incompetence is a known complication beyond 10 weeks, it would seem sensible that, certainly from 11 or 12 weeks on, if a termination is going to be undertaken that should be reviewed by two medical practitioners, one of whom should have training in obstetrics and gynaecology so that that woman can be advised appropriately about what risks exist and also to advise about the pre-treatment of the cervix before the procedure is undertaken.

The more terminations the woman has - tragically there are a significant number of terminations that occur that are repeat terminations and there are substantial medical risks that exist associated with recurrent terminations of pregnancy. One is the cervical incompetence and loss of the baby at 18-20 weeks. There are also conditions of clinical significance later in the pregnancy called placenta praevia and placenta accrete. Those involve the placenta sitting in the wrong part of the uterus down over the cervix, which can be associated with bleeding and then there is a caesarean section and they are not necessarily a simple procedure to deal with. It is not a simple process once you start talking about (1) multiple terminations and (2) terminations over the period of 10-12 weeks.

One of the suggestions initially was that we should recommend that up until maybe 12 weeks that a single practitioner might be able to consent the woman in the way that a ordinary procedure can be done. From the period of 12 weeks through to what we might loosely call viability for the moment, it's very important that a woman is counselled appropriately by someone who has training in obstetrics and gynaecology, particularly as the pregnancy advances. The complications and risks increase dramatically and then you start to put potentially the life of the woman at risk.

I have had one woman I have had to do a hysterectomy on at the Royal Hobart Hospital who underwent a termination process medically, ruptured her uterus and needed an emergency hysterectomy and she never went on to have another child as a result of this pregnancy. They are uncommon but they are important.

Once viability occurs, given the problems that have occurred in Victoria in regard to the Royal Women's Hospital some years ago with late terminations, it really raises the issue of community sensibility and more than just the couple are involved when you are talking about terminating a pregnancy at 24, 26 or 28 weeks when there is no intention for that child to live.

In Victoria, I think, these are referred to a combined committee which has legal, ethical, medical and nursing representatives and it is reviewed, and that way the community can be reassured that these are being done for very valid reasons. It is unusual for, and would be very unusual, for any doctor to recommend a termination for anything but valid reasons but these things don't happen without considerable public uproar and what happened at the Royal Women's Hospital destroyed careers and destroyed a whole lot of things and created a lot of difficulty, but out of that came the recommendation that all such terminations go to a combined committee and I think there was a certain merit in considering that sort of thing. It is not common, but we are terminating pregnancies for more reasons now beyond 20 weeks, as I said at the beginning of the submission, because we are identifying abnormalities later with the way that foetal assessment is being done.

Ms FORREST - The outcome of that is that there are fewer stillbirths or neonatal deaths from those malformations because the pregnancies are terminated earlier?

Dr BRODRIBB - They would normally have been previously picked up at 17 to 18 weeks and the termination would have happened at 19 weeks. They would never have appeared on the statistics, but now they do and increasingly so, and very much noticed in the assessment of the 2011 data, which there has been some discussion about. Because that is where assessment is done at the Royal and that is where it is done out in private and we are getting terminations being done for valid reasons but, nonetheless, that has not moved and it has changed our perinatal mortality. If we took out those terminations that were done before 20 weeks, we would have a perinatal mortality that the country would be envious of. It is pretty good anyway.

That was one thing I wanted to say. The other one I wanted to talk about was the requirement of a practitioner to terminate on order and in here I can't find it.

Dr WILLIAMS - I think it has been removed from the revised bill. We were sent two bills.

Dr BRODRIBB - Has it? Good, because I only had this one, so there is no requirement to make a doctor terminate a pregnancy -

Ms FORREST - Only in an emergency. Yes, it is there.

Dr BRODRIBB - Okay, I do want to talk to it. There are people who have a fervent belief that termination should never be undertaken and there are doctors and obstetricians who have that view. As I said in one of our teleconferences when we talked about this at the council, to force a doctor who has a deep conscientious objection to terminating, for whatever reason, is to have a doctor who is an impaired practitioner performing the operation.

Impairment doesn't have to be someone who has a broken arm, a drug problem or a major depressant psychological problem; anyone performing something against their deep seated beliefs is operating under incredible duress; similarly with the nurse, the chance for error to occur increases exponentially and if an error or a bad outcome were to occur that would impact upon those people for the rest of their lives. Using the category of impaired practitioner, category 3 and 4 has the potential to create an impaired practitioner.

Ms FORREST - Can I put an example to you there? It's a bit easier at the Royal because there are a few more of you there. Up in the north west who presents with an acute ectopic, you know how tight things are up there at times as far as obstetricians go, one's away, the only one that is there has a conscious objection, the woman needs to go to theatre now.

Dr BRODRIBB - I would be very frightened to have someone put a laparoscope to my tummy who was an impaired practitioner.

Ms FORREST - I would too, David, but you can't do anything about it really.

Dr BRODRIBB - People have put laparoscopes into the aorta. It has happened here within the last year or so. A laparoscopy is not a benign process; people die and someone whose hand is shaking, whose emotions are high, is not the person to be handling the sort of procedure to do that. It may be a general surgeon that can open that tummy.

Dr WILLIAMS - With a ruptured ectopic, the fate is sealed already for that pregnancy. I don't think most of our fervently anti-abortion or anti-termination doctors would have a problem that is not termination that's a pregnancy that will never make it.

Ms FORREST - I am saying if someone had really fervent, deep seated objection to that, for some of them, they would probably see that as ending the pregnancy. It hasn't already ruptured, it is on the point of rupture; the baby is still potentially alive at that stage. These are rare circumstances we're talking about and this is a rare circumstance as well - ectopic is not that rare, but the circumstance we are talking about is.

Dr BRODRIBB - Would you like the person operating on you with a ruptured ectopic, whose hand was shaking? I think you have to ask yourself the question.

Ms FORREST - No. My question is, what do you do in those circumstances?

Dr BRODRIBB - A general surgeon can do a laparotomy, there's no reason why that can't occur.

Ms FORREST - That is true.

Dr BRODRIBB - All they have to do is -

Ms FORREST - As far as saving the tube, those sort of things that a skilled practitioner can do, you give up that for the sake of having a general surgeon - it's a catch-22 in some ways, isn't it?

Dr BRODRIBB - It is but it is not going to be common because you are going to have people who are going to be there within the hospital. I just think this is so prescriptive that in the situation you are going to have an impaired practitioner to perform. Would you want someone with a blood alcohol of 0.08 operating on you? We now say that people shouldn't work continuously for long periods of time because it is the equivalent of operating under raised blood alcohol.

Ms FORREST - How does that relate to this bit?

Dr BRODRIBB - The emotional stress will impair the practitioner. These have to be thought about; we are now thinking about how people perform in their day-to-day activities in terms of quality of the work that they do and there are a number of things that will impair that. One of the views will be being forced legally to do something against their wishes and immediately you have a person whose mind is not on the job.

CHAIR – I am wondering, given that both Michelle and Jamie are practitioners, we might want to go to questions about the conscientious objection with them. We are out of time, to be fair to our further witnesses today. We might want to invite you back.

Dr WILLIAMS - Dr Brodribb has already come in on his holidays today.

Dr GOODWIN - I had a question that was related to the early point that was made.

CHAIR - I did too, on the things that Jamie has just raised. There probably are a number of questions flowing from what Jamie has just indicated to us and when we review the transcript, we might have a number of questions. I want to be fair to other people we have booked in for today.

Mr VALENTINE - It could be September when you come back, so would that be a difference for you?

Dr BRODRIBB - I've got five weeks off.

Mr MULDER - You will have plenty of time to prepare for a rigorous cross-examination.

Dr GOODWIN - You have proposed a different structure in terms of the gestation period. I was interested in the frequency of those complications that you mentioned around the cervical incompetence and the other ones, if it would be possible to get an idea of that.

Dr BRODRIBB - We've got that.

CHAIR - Thank you for your time. It has been most instructive and by our last comments you will gauge that there is a fair bit more in this, and we appreciate your time so far.

DR WILIAMS - Thank you very much.

THE WITNESSES WITHDREW.

PUBLIC

Dr BETH MULLIGAN, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Dr Mulligan, thank you for giving your time and also for your submission. You are protected by parliamentary privilege while giving evidence to the committee. Nothing you say in here can be challenged or actionable by anybody because of that protection, but you don't have that protection outside of here. If you are invited to or choose to make comments about your views as to the matter, we suggest you exercise some caution because you do not have that protection of privilege outside of here. If you wish to speak to your submission - we have found that has been a productive process - we have had the opportunity to digest the content of your submission but it may be for the public record that you want to draw out some matters from that submission.

Dr MULLIGAN - Thank you all very much for allowing me the opportunity to come to speak to you. I felt it was part of my role to be an advocate for my patients in this matter, and for my colleagues. An opportunity to talk to my submission, even though it is only relatively simple and short, is quite valuable for me.

I am not a lawyer, an obstetrician or a paediatrician; I am a general practitioner, but I have spent quite a lot of time working with patients who have had to make these decisions and supporting colleagues who have had to deal with this kind of problem. I think, fairly simply, and I have tried to distil in my own mind this legislation because I think it is fairly confusing about this legislation - I am preaching to the converted, I'm sure. I have tried to break it down into just the four issues I see as being the major issues for my patients in particular.

I really feel that for this process and procedure to invoke criminal sanctions is inappropriate. As far as I am aware, and I am not a lawyer, as I said, this is one of the only medical procedures that can invoke criminal sanctions and I really feel that it needs to be decriminalised.

From the point of view of both the patients and the clinicians involved in this, people need to have a sense that they are not doing anything criminal by undertaking terminations or by undergoing a termination themselves. I think that sense has certainly impacted on the clinical people. Clinicians themselves have been very reluctant to engage in this process, which has made it difficult in more isolated places - not that Launceston is isolated, I am not saying that - but where we have had to rely on people coming into an area to undertake terminations, where the public system is basically saying, 'This looks too risky for us.' That creates a problem in itself.

One of the transcripts I read suggested that private terminations were easily accessible in a timely manner. One of the things I would like to convey to you is that is not necessarily the case. In fact, I am sure someone may have explained this to you. Our termination clinics in Launceston, for example, are run by a private practitioner who comes from Melbourne. Any time he needs to have a break, or if he is unwell or whatever and that clinic cannot be offered, it creates a real problem for the people in our region. What do we do in terms of being able to give timely access to women in this situation?

Ms FORREST - It is a very relevant point, Chair. We heard Dr Brodribb previously talk about the risk after 10 or 12 weeks increasing for the women. If you deny access even by a week or two -

Dr MULLIGAN - Absolutely.

Ms FORREST - Is it your experience that it can be just a week or two that pushes over that time?

Dr MULLIGAN - Absolutely. If someone presents to me, say, at seven weeks - and I think it also really important to impress upon the committee how difficult it is for women to walk in the door and to say to me, 'I'm pregnant. This is an unwanted pregnancy and I need to terminate it.' Sometimes I think we forget about that actual process of how difficult that is. If they present, say at seven weeks, if we need to get a scan, if we need to determine the gestational age - we might assume it is seven weeks but we need to know - and if that then their dates are right that translates to 10 weeks, so at this stage we are already down to a two-week wait. If the next termination clinic is not available to them we are looking at a very tight time frame; we are looking at maybe 12 weeks - just being able to get them in or if that clinic is not operating for that week they will then have to travel. They will either have to come here, so that is from Launceston to Hobart, or they will have to go to Melbourne. The timing of it can be very tight and there is no option.

Another example might be - an example that I have had - is a failed medical termination. By the time they have presented after a failed medical termination they could be well and truly over that 12-week period.

Mr VALENTINE - That is RU486 you are talking about?

Dr MULLIGAN - The medical terminations that are done on the north-west coast at this stage. The timing is important simply from the point of view of not having accessible service in a public space. I have seen over a long time now the public space becoming more concerned about this rather than less concerned, and I guess that has also been timed with the fact that the private clinics have been offered now; they were not offered originally and initially so that has opened up that early availability anyway. But the fact that these are not available to women at that later stage and also that they are not available in a public space means that we obviously need to decriminalise it.

I don't know the legalities of that - the detailed legal argument of that - but I think as a general principle that is what I firmly believe needs to happen.

CHAIR - I think we can move to the next point because that is one of the contentious issues and there are all sorts of legal propositions around that.

Dr MULLIGAN - Yes.

CHAIR - Can we just take that as your concern as a medical practitioner that that is a barrier?

Dr MULLIGAN - Yes.

Dr GOODWIN - You mentioned, Dr Mulligan, that the public system has become more concerned over time. What do you attribute that to?

Dr MULLIGAN - I think, as doctors, we are all very concerned about our professional behaviour. We are very concerned that anything that is considered to be outside our professional code or certainly our legal obligations, people are not prepared to undertake that at any risk, it is just too compromising to your ongoing professional survival to undertake anything that represents that sort of risk.

Ms FORREST - Have you been in Launceston long?

Dr MULLIGAN - Yes, I have been there now for about 20 years.

Ms FORREST - I was just looking for a bit of an historical perspective because there was a time when terminations were carried out in the public system -

Dr MULLIGAN - Yes, there was.

Ms FORREST - in the south that we have heard about, but what was the situation in Launceston or in the northern area there, and if there was a change, why was the change?

Dr MULLIGAN - It was an extremely complex process, Ruth. It required the completion of about a three-page form. It was a significantly delaying process and it absolutely delayed what you were able to offer. It had to go through the Director of Medical Services at that time and -

Ms FORREST - This is for any termination in the public system?

Dr MULLIGAN - Yes, this was for any termination in the public system. This is my memory of it, so that may not be entirely accurate. My memory of it was that it was a very clumsy and slow process. It required two doctors' signatures, which I think from memory were two doctors over and above the doctor who was referring. The change came when the gynaecological centres services opened up and the pressure was off the public system. It was much easier then for the public system to say, 'No, we're not entering into that realm of activity'. There was definitely a reluctance on the part of the consultants who have to undertake the procedure to do that. I believe that was around that whole sense of the legality of it.

The issue of the conscientious objection I find quite interesting. I am not really sure whether it is something that needs to be legislated for. Doctors are very much driven by professional code. If, for example, I am unable or unwilling to provide a service to a patient, the minute that patient walks into my room and talks to me about an issue, or the minute I enter into any contract of care - the minute I say, 'I am a doctor' and someone interprets me to say, 'I can therefore care for you', I have entered into a duty of care - I am obliged by my professional code to say, 'I can't provide that service but I will ensure that someone will provide it for you'.

It is not just a case of saying, 'I can't provide that service. Go away and find somebody else'. That is not adequate or appropriate. Therefore, if there is any reason I don't do the right thing by my professional code, the consequences to me are brought back to me by

my professional organisations. They don't need to be brought back by some sort of legal obligation because I have my professional obligation that is predicated by my professional code of behaviour. The whole issue of conscientious objection, I find, may be unnecessary in this legislation.

Ms FORREST - I hear what you are saying, but we also hear when a woman approaches a doctor to say she has an unwanted pregnancy the doctor is obstructive, even though they have the duty of care. I would argue it is a legal framework because of the national health regulation under which you operate is the arm of the law that can come over the top if necessary. If a woman is presenting to a GP who may not take the same approach as you, if he is reluctant to refer or say, 'I can't help you but you can go the Family Planning Clinic or another doctor', the only person who can start an action is the woman herself. We have a woman who has an unwanted pregnancy - and you talked about the challenge of walking through the door in the first place - and to be left with the clock ticking and thinking, 'Where do I go now?' without some sort of 'I can't help you, but ...'. It is in the medical code, I absolutely agree, but someone has to take an action. I have argued myself that we don't need this here - it should be happening anyway, what is the big deal? I can see both sides of the argument, but having it there perhaps strengthens that when there are people who currently operate under the medical code and have all the requirements you talked about but they are still not doing it.

Dr MULLIGAN - I take your point but I would say that could be the same in any situation where a patient is disempowered. It's not necessarily specific to this situation and therefore, should we legislate in all cases?

Ms FORREST - We heard some stories about people being denied access to vasectomy. That's not time-sensitive, although it still takes a while to become infertile after you've had your vasectomy anyway.

Dr MULLIGAN - What you are talking about is much more a generic problem, which is about the therapeutic relationship between the doctor and patient and the power relationships that exist in that situation. They can be used or abused so I don't think that's specific to this problem. We see this quite commonly in therapeutic relationships - particularly with young people and I deal a lot with young people - where they get a raw deal from a doctor. Not necessarily because they are go in for a termination, but a doctor won't treat them for things or give them things or whatever. That's a very different situation that needs addressing in a different way.

Ms FORREST - With the very time-sensitive nature of this, if you wanted some newfangled treatment for your acne, for example, obviously it's a huge issue for some young people and the doctor says, 'No, I'm not going to prescribe that', whilst it can have a significant effect on that person and it's not time-sensitive as such - is this perhaps why this is different, because of the time-sensitive nature of it?

Dr MULLIGAN - Certainly that's a real issue. I'm not sure whether the legal overpowering of this would make a difference here anyway.

Ms FORREST - Point taken.

Mr MULDER - On this issue and it also relates to the previous one, given the nature of this, your professional codes of conduct, your medical procedures and we have had a discussion about whether we need to have this business about conscientious objection referral, why do we need any legal provisions around the whole question of terminating pregnancies if they are such personal, medical things? Why would we move down the path of having legal requirements which result in hugely bureaucratic form which deter people from going down the path? Do we need this in the criminal law at all?

Dr MULLIGAN - Do we need what in the criminal law? Sorry, I'm not sure that I understand.

Dr MULLIGAN - Consented termination of pregnancies.

Dr MULLIGAN - Do we need it in the criminal code? I think the whole point of this legislation is that we take it out of the criminal code, isn't it?

Dr MULLIGAN - But I am saying that even the need for consent and things like that, should we -

Dr MULLIGAN - You could never take away the issue of consent.

Mr MULDER - Out of criminal law?

Dr MULLIGAN - It would be totally inappropriate to take away the issue of consent.

Mr MULDER - There is a general requirement for consent under the law but do we need a specific requirement of consent for this procedure?

Dr MULLIGAN - I'm not sure I understand the question.

Mr VALENTINE - Why is it any different?

Mr MULDER - You already need consent. If you perform an operation without consent, you fall foul of the law.

Dr MULLIGAN - Absolutely, and rightly so.

Mr MULDER - Why do we need a special provision for termination of pregnancy? There is a general provision for conducting a medical procedure without consent. Why do we need a special provision for conducting a termination without the need for consent?

Dr MULLIGAN - What I said in my submission is that provided the consent procedure is undertaken appropriately, you don't need to seek it within a criminal framework. If I want to do anything with a patient, apart from the standard things of history, examination or such things, if I want to do anything invasive or procedural with a patient, I absolutely have to obtain their consent.

Mr MULDER - No, I am not questioning that; I am just asking what is so special about a termination that requires it to have a special consent requirement -

CHAIR - A special law, whether it be this or a criminal law.

Mr MULDER - Yes, when there is a general law that covers it anyway.

Dr MULLIGAN - Termination is a very sensitive and value-laden procedure. People don't interpret terminations in the same way as they interpret other procedures. If they come in, for example, to have an Implanon or a Mirena inserted -

Ms FORREST - Which are contraceptive devices.

Dr MULLIGAN - Sorry, which are contraceptive devices.

Mr MULDER - Thank you for the clarification.

Dr MULLIGAN - Sorry. They don't carry with them the same value-laden judgment that a woman walking in saying 'I need a termination' is - she is bringing with her that whole sense of 'I'm going to be judged for this, I'm going to be criticised for this. I potentially may be refused treatment for this. Someone else is going to be taking the decision out of my hands, potentially.' That is a very different situation from other more simplistic, more straightforward and more direct routine procedures.

Mr MULDER - So this is an issue about the community's values, not necessarily those of the treating medical practitioner?

Dr MULLIGAN - This is hugely about community values, this whole perception of termination and what it means, and how it's managed.

Mr MULDER - Why do you think that is? Why do you think this is particularly value-laden, that this procedure is, in the minds of the community at least, not just another medical procedure?

Dr MULLIGAN - What are you asking me?

Mr MULDER - I am asking you why you think the community thinks this is not just another medical procedure.

Dr MULLIGAN - That's probably fairly well established historically - as you undoubtedly have identified, there is a lot of controversy, a lot of community division, a lot of polarisation about this kind of issue, which I'm sure you have already been able to identify from the groups who have presented here.

CHAIR - Okay, we will keep moving with your contribution, Beth, please.

Dr MULLIGAN - The counselling requirement - as I have indicated in my submission, I think that probably, generally speaking, people who are seeing a termination can be broadly categorised into those people who are very clear about what they want to happen and those people who are very unsure about whether or not to proceed.

For those who are very clear, I think being forced into a counselling situation is something that is unnecessary and reduces the timeliness issue again. Those who are

unclear and those who are uncertain - and again it becomes a matter of clinical judgment - should be offered an opportunity to talk through their concerns. This is quite apart from the consent issue, but their concerns about the termination process itself, the implications one way or the other, whichever way they jump with it. So certainly in some situations I think counselling is very important and in other situations I don't think it should be. I don't think it should be mandated, basically. It is a clinical decision that you make when you see a patient about how much information you feel they need to be able to make an informed decision.

Ms FORREST - Beth, with regard to that, when you get a woman come to you can you describe the process you undertake? You fill the role of a doctor and a counsellor probably at times but the counsellors who are only counsellors can't do both and when a woman presents to you, you could go through what happens, but how many women would - and you wouldn't know the exact answer to this, of course - go straight to a counselling service rather than to go their doctor first to get the pregnancy confirmed? People do a lot of home pregnancy tests and most people rely on those but a lot still go to the doctors for confirmation - I am not sure why we still do that but we still do, but anyway -

Dr MULLIGAN - Yes, to get a second pregnancy test done.

Ms FORREST - Yes, that is right, and you get to pay a bit more money. Can you explain how it works with you and how many women would not go to their doctor but go to another service first as their first point of call?

Dr MULLIGAN - I probably can't answer that, Ruth, because I obviously only see the people who come to me, so I don't have a sense of how many people would go to see a counselling service who haven't presented to me or haven't presented to a service like ours, so I probably can't answer that question. But if a patient presents to me and says, 'I'm pregnant and I really don't think I want to keep the pregnancy', we go through a fairly careful process of their circumstances, supports and their understanding of what would happen if they keep the pregnancy or if they don't keep the pregnancy, and their understanding that either way has lifelong implications. If they proceed with the pregnancy that is a lifelong child that they have and if they decide to go down the other track, that is a part of their history that will always be part of their history and it will always impact if they proceed to termination.

I am fairly careful about trying to ascertain how certain they are about this, also bearing in mind that when and if they do proceed to termination, to a clinic, that they will get another opportunity to talk through this and they can stop the process right up until the time when they get gestation. They still have that choice and I try to engage another appointment with them if there is time to make sure that they have that support.

Ms FORREST - These would be the ones who book the single appointment?

Dr MULLIGAN - Yes, 'I've just come into confirm my pregnancy'.

Ms FORREST - And then drop the bomb on you.

CHAIR - On that matter then, Beth, you have gone down that path of suggesting to make counselling mandatory, if this bill succeeds it no longer will be. It is currently a requirement.

Dr MULLIGAN - And I don't think it should be mandatory.

CHAIR - And it is not. If this bill succeeds it won't be, so that will clearly set that fear of yours to the side.

Dr MULLIGAN - That is really good; and the other thing is that you cannot force someone to accept counselling, they just won't turn up.

CHAIR - That will be covered if the bill succeeds.

Dr MULLIGAN - Absolutely.

Mr VALENTINE - It is interesting, isn't it, what counselling means? Some people have varying opinions.

Dr MULLIGAN - Absolutely, yes.

Mr VALENTINE - Helping someone to think something through rather than advising them.

Dr MULLIGAN - Yes, and if counselling were still to be mandatory, one of the big concerns is that people are then told what to do inappropriately, but if the counselling is appropriate then it allows the person to think through the issues. If the counselling is not done so appropriately there is the very real risk that they can be basically [inaudible] and feel themselves being told what to do.

Mr VALENTINE - Mr Chairman, can I ask a question with regard to the term 'referring' in that regard?

CHAIR - Yes, certainly.

Mr VALENTINE - In terms of that term 'refer', what is your understanding of that, where it talks about a doctor referring on?

Dr MULLIGAN - A referral is quite a formal process for a doctor.

Mr VALENTINE - But not necessarily for a counsellor, perhaps?

Dr MULLIGAN - I am not really sure how a counsellor would interpret the word 'referral.'

Mr VALENTINE - Is it the right term?

Dr MULLIGAN - It needs to be used carefully, the word 'referral,' because as a GP I can only refer technically -

Mr VALENTINE - By a form.

Dr MULLIGAN - Yes, that is right and I cannot refer patients to another GP, for example. I can advise that they go and see another GP, but I cannot refer a patient in that situation. The term 'referral' probably has been applied fairly loosely historically, and if the term is to be put into any sort of legislative framework it will need to be defined.

Mr VALENTINE - A definition.

Dr MULLIGAN - Yes.

Mr VALENTINE - Is there another term you can think of that might cover it?

Dr MULLIGAN - Advice to attend, directive.

CHAIR - We can move on to access zones, I think.

Ms FORREST - Are you aware of what Rob was asking about the referrer. In between AMA in the Victorian document, I do not know if you remember or not -

Dr MULLIGAN - No.

Ms FORREST - In their report of the article on conscientious objection in their state, it concluded that

> 'the word 'referral' under the legislation is to be quite related to the Victorian legislation because at a minimum a practitioner seeing or directing a patient seeking an abortion to another practitioner who does not have a conscientious objection to abortion or otherwise facilitate access to that practitioner. In the panel's view, this duty will be discharged if the doctor provides the patient with a name of a non-objecting medical practitioner or health service, such as the established family planning centre or appropriate accredited abortion clinic.'

Their view was that all you need to do if the doctor has provided them with the contact details the woman does not walk around saying, 'Where do I go now?' She has some information that says, 'You can contact this doctor or this clinic,' and their duty would be discharged through that process. If that was the intention, would that be adequate for someone like yourself?

Dr MULLIGAN - It would not happen in our service because we manage it. But one of the things that I think is important is that the woman does not feel that she is just tossed off, in a way. I do not know that you could actually put this into a legislative framework at all but one of the things that would be quite helpful for women would be to facilitate that appointment, maybe make it for her or make the contact with the service for her - those sort of things, particularly for young women who are very disempowered. Some people hardly even know how to make an appointment.

Mr VALENTINE - Especially younger -

Dr MULLIGAN - Especially younger women.

Ms FORREST - Some doctors have said they have a conscientious objection but by making the appointment themselves rather than just providing the information there, they are complicit in access to a service where they may well have a termination. Some of these doctors feel very strongly if that is the case and so actively making the appointment, would that be an issue for them?

Dr MULLIGAN - All they are doing is they are making an appointment for that woman to go and talk to someone about their issue, they are not actually saying, 'This service.' They cannot predict what that service will do and that service still has to make its own decisions about what it can offer, so they are not determining the ultimate outcome of that referral.

Ms FORREST - Family Planning does not conduct terminations. If they refer them there, there is no way that they can have a termination there.

Dr MULLIGAN - No, exactly.

Mr VALENTINE - The client may not have made her mind up at that point.

Dr MULLIGAN -For some people, for some couples, it does take that extra thinking and opportunity to talk through issues to reach that decision. Even if a service were to offer a termination, they can still say, 'I am not going to take up that option'. Ultimately it is not the service that determines whether the patient has the termination, it is the patient who determines that. It is almost like you are taking away that ultimate patient decision by saying, 'Oh no, if I send them there they'll definitely get a termination'. Ultimately the patient has to make that decision.

CHAIR - Are you ready to move on to your next one - access zones?

Dr MULLIGAN - It is very difficult for most women - there are some who do not see there is any problem with this, who are very clear about what they want to do and may not feel intimidated by having to do this, but for other women for whom this decision is difficult, challenging and value-laden. Exposing them to a potential risk of public scrutiny and criticism is detrimental and quite negative. The clinics are very careful - women will come into one area and be seen, they will then proceed through and have their procedure and leave from another area. The clinics are very careful that women are not exposed to that kind of potential value judgment and criticism.

Mr VALENTINE - When women present at a clinic, is it a foregone conclusion that they are going there for a termination or may they be going there to get extra information?

Dr MULLIGAN - Yes. I tell women to talk to these people. It may be that the ultrasound done just prior to the procedure being done may indicate that it is inappropriate, for whatever reason, or they may decide right then and there that they are not going to do it. The aim of going there is to proceed - in more discrete buildings - they could be going there for any other reason. If there is a dedicated termination clinic which is a stand-alone building, clearly they are going there for that reason. In Launceston we have a centre where they could be going for any reason. They need to have a sense that when they are going to do this they are not going to be abused.

Mr VALENTINE - They want to be discreet.

Dr MULLIGAN - Yes. It is so difficult. One example is of a young woman who was so ashamed of what was happening that she couldn't go to a termination clinic. She proceeded right through her pregnancy without her parents even being aware. She had the baby, adopted it out, gave it up to the hospital then and there, and walked away and her parents didn't even know. That is the sort of value labelling that happens around these unwanted pregnancies.

Ms FORREST - But if she does it without support -

Dr MULLIGAN - She was only young, didn't want her parents to know and concealed the pregnancy all the way through. What impact does that have on her later on in her life when she knows that she cannot acknowledge that to anybody?

Dr GOODWIN - Are you aware of any incidents occurring at that clinic?

Dr MULLIGAN - No, I am not aware of anything. I have not had a patient say to me, 'Someone was standing outside when I went in there and they abused me.' But it is a fairly discreetly placed centre in Launceston and there is little fear as far as that is concerned. I know that it happens in other places and we need to protect women from that.

Dr GOODWIN - Do women express any fears to you about going there and about the possibility of that occurring?

Dr MULLIGAN - They always ask what happens and they are quite reassured by the fact that they will go in one door and out of another door and they will not see anybody else. Particularly in a small town, they might run into their next-door neighbour or something like that.

Ms FORREST - Even in a doctor's surgery, they worry about going in a small town.

Dr MULLIGAN - That is right. The other thing group that we need to be really mindful of is our refugee population now, because that has major ramifications for them if they have an unwanted pregnancy. They are not supposed to be sexually active. They have an unwanted pregnancy; how do they deal with it discreetly? It will become an increasing problem as our recently arrived humanitarian entrants increases.

CHAIR - You can move to your final point in your submission, Beth.

Dr MULLIGAN - This a general comment that we do need to keep our legislation consistent with current practice. It is a general point. I do not think we should politicise these things. They can be well placed within the medical framework. I do not think they need to sit within a criminal framework, as I have said before. We need to avoid stigmatising women. We need to acknowledge the difficulties they have if they are confronted with this kind of problem and we need to be fair and humane, and I do not envy your job at all because this is a really difficult problem.

CHAIR - We do not have anybody jumping out the blocks for questions. We have done reasonably as we have gone through your presentation, Beth.

Dr MULLIGAN - Can I raise one thing that was raised by the previous speaker?

CHAIR - You are quite welcome to this committee; however you choose.

Dr MULLIGAN - I was interested in the comment about the impaired permission. One of the issues that was raised was tubal pregnancy and whether or not that constituted a termination in the sense of, if I conscientiously object to terminating a pregnancy but I am forced to because a lady presents with a tubal pregnancy, which is a life threatening condition if it ruptures, am I going to be impaired forever? I do not know Jamie very well but I would challenge him on that. I would say that because, in that situation, the clinical situation in front of the clinician is saving the life of that mother. If you do not manage that clinical presentation appropriately, it is a true emergency and I suppose technically it is a termination of a pregnancy, but the process you are undertaking is to save the life of that mother. I would challenge the thought that even in someone who had a conscientious objection to termination, that situation would make them an impaired clinician.

Dr GOODWIN - That baby, correct me if I am wrong, would not be viable.

Ms FORREST - No, no, it is only 12 or 14 weeks anyway.

Dr MULLIGAN - No, it is under. It is somewhere between 7 and 10 weeks and it will rupture. If you can appreciate this pregnancy is not sitting in the uterus, it is sitting in the fallopian tube. A fallopian tube has a finite stretch to it, so as this little embryo grows it will rupture the tube. If that happens, that is a true medical emergency. That is a very different context and I think it is a false argument to say that that will result in a conscientious objector becoming an impaired clinician. I just want to make that point because I would argue that.

Ms FORREST - At that point the doctor is a making a decision based on the clinical presentation of a woman.

Dr MULLIGAN - Yes.

Ms FORREST - Whose life is in danger.

Dr GOODWIN - That is one circumstance, but are there any others? The one you mentioned was the heart attack situation, where you need to resuscitate.

Ms FORREST - Someone who has a cardiac arrest?

Dr GOODWIN - Yes, a cardiac arrest.

Ms FORREST - It does not necessarily kill the baby, though. It depends; if she does it in front of you, you might have a chance. It depends on where she does it.

Dr MULLIGAN - Sorry, I obviously missed that.

Dr GOODWIN - That is another circumstance, I suppose, but are there any others apart from ectopic pregnancy and heart attack where a doctor might be placed in that situation of having to save the woman's life, with the implication being that the pregnancy will be terminated.

Dr MULLIGAN - Severe trauma, car accident, something like that, assault.

Ms FORREST - It could be an undiagnosed cardiac condition or something like that the mother has that becomes apparent.

Dr MULLIGAN - Yes, I could think of heaps of different examples and there the focus is very much on the woman. I would be really interested to poll clinicians to see whether or not they would concede that to me, 'I'm terminating a pregnancy.'

Ms FORREST - Or, 'I am impaired in doing it because I have an objection.' That was more the question I was asking. Because they have an objection and ultimately the foetus is going to end at that point, would it impair them.

Dr GOODWIN - The Catholics in their guidelines they deal with this issue as well, don't they?

Dr MULLIGAN - Once the woman dies the baby dies. If the woman has been traumatised or had an accident, a heart attack, a stroke or whatever, if she dies so will the baby.

CHAIR - Therein lies our dilemma. A doctor giving his evidence and now you are giving your evidence.

Dr MULLIGAN - I am sorry, but I really felt that that was not a good example.

Ms FORREST - We need to be challenged.

CHAIR - Thanks very much, Beth.

Dr MULLIGAN - It was a bit opportunistic, but thank you very much and thank you for the opportunity to speak with you. Good luck with your deliberations.

THE WITNESS WITHDREW.

PUBLIC

Dr INGRID VAN DER MEI, PUBLIC HEALTH ASSOCIATION OF AUSTRALIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED AND **Mr MICHAEL MOORE**, PUBLIC HEALTH ASSOCIATION OF AUSTRALIA, WAS ALSO CALLED, BY TELEPHONE, AND EXAMINED.

CHAIR - Hello Michael, Paul Harriss, at Parliament House in Hobart. Thank you for taking our call. We have five of our committee members here today: Tony Mulder, Ruth Forrest, Vanessa Goodwin, Rob Valentine and myself. The process will be that we will swear in Ingrid in a few moments and by that process she is protected by parliamentary privilege by being here. You are probably aware that you do not get afforded that same protection of parliamentary privilege as Ingrid does.

Mr MOORE - I am quite comfortable about that.

CHAIR - Okay, that is fine. In terms of the process, do you need me to explain to you, Ingrid, the protection you have of parliamentary privilege? No? You are comfortable about all of that? We will get Ingrid to take the oath and then we will proceed, if you like.

CHAIR - Thank you both for being available and for your submissions. What we have been doing through the process of the committee is inviting the people who have been appearing before us and who have submissions, whether they be lengthy or not, to speak to that if there are matters that they want to specifically have on the public record, given that the proceedings of our committee are recorded and then transcribed, and that process allows us to put those transcripts on to the web so that it is a matter of public record, just as the proceedings of Parliament are. So, if you wanted to proceed, make some comments and draw specific matters out from your submission or build on it, then we are happy to go that path, whichever way you two would like to handle that in the first instance.

Dr VAN der MEI - I would like to start. Thank you for providing the opportunity to give our comments on this. I am the branch president of the Public Health Association and Michael is the CEO of the national office, so we are taking a public health perspective. Personally, I am an academic, not a medical doctor. We are very much an evidence-based organisation, so whatever we do, or the position statements, are drawn upon the evidence that we have and we believe that is the best way of getting more public health gain and arguing a good case for everything we do in public health.

From that perspective, we have looked at the terminations of pregnancy and it has been something that has been put forward by our special interest group, the Women's Health Special Interest Group, and they have been advocating for this issue for quite a while. We have a clear position statement on this and as a result we are really in favour of legalisation of terminations.

With the proposed bill, we are comfortable with the way it has set out. There is a good justification for doing this and the first thing is the protection of health professionals and their patients. At the moment there is uncertainty and fear both among doctors, but also for patients; there is uncertainty and stigma associated with it as well, so legalisation of this bill, shifting it to the Health Act and making it health legislation rather than criminal

legislation will reduce that fear and stigma. Abortion is the only medical service that is regulated under the Criminal Act and we believe that that is not the right thing to do.

The second issue is that it will influence the termination services. At the moment, termination services are inadequate in Tasmania. That we have to have fly-in, fly-out doctors is inappropriate; that the public health system is not providing terminations except for foetal abnormalities is unacceptable and it is not equitable because it is the women who need those public services, the women in rural health areas are the ones who need to be protected so, hopefully, this legislation will do that.

Lastly, the current laws are basically not in line with societal values and the survey from Family Planning Tasmania clearly indicated that.

In terms of the different legislation for 16 weeks, we are basically not in favour of any different legislation and 16 weeks is an arbitrary number. It was 24 before and we could have 18 or 14 or whatever. There is basically no justification for blacking out a particular number. It impedes the right of women to choose and it will lead to renewed controversy and reviewing when medical services might be different, so we are basically not in favour of having different legislation at a particular cut-off point.

There are a few other clauses in there that, hopefully, will improve services for women but we are not set in concrete about that. It will be great to have that in if that turns out to be so controversial that it threatens that the whole bill will not go through, then I would say it is more important to get this bill through than having those couple of additional clauses in terms of access zones, conscientious objection and the conscientious objection in relation to emergencies. I am happy to outline more about that, if you like. I will just leave it there for the moment and maybe ask Michael to add anything if he wishes.

Mr MOORE - Thank you very much and thank you, committee members, for giving us this opportunity. The only thing that I would like to make clear is that the Public Health Association is an organisation that does favour choice. The second element is that we see terminations as a medical procedure. There are already many protections in place in normal medical procedures that should cover this issue rather than as a criminal issue. That is the main driver behind why we welcome the legislation.

CHAIR - Thank you, Michael and Ingrid likewise. If there are any questions that we want to work through systematically in the submission because you do, in your submission, go in a chronological way, or maybe we just go with questions that people have. With regard to the conscientious objection or more particularly, the obligation to refer, in terms of the conscientious objection being held, I am going to your submission on page 7 where you quote from the Medical Board of Australia, good medical practice and the like. Members have had a look at those documents previously as well.

The wording in both that and the other document in which you state the AMA code of conduct - is it fair to say that that is less onerous than the wording in the bill because the wording in the bill requires referral, whereas the codes of practice, as you put the words there - decisions about the patient's access to medical needs - you shouldn't deny patients access? You are obliged to disclose but there is no obligation in those codes, as I understand, to refer - just disclosure of your conscientious objection - whereas he bill is

much stronger than that. There is a requirement to refer; the moment you have the conscientious objection, you are required to refer.

My question really is the codes of conduct go to those propositions but they don't impose any particular obligation on the medical practitioner.

Dr VAN DER MEI - We have outlined that. It is not explicitly stated but when you talk to GPs, and that's what I've done, what is your expectation? They clearly say that that is the expectation and it has been clear that some people have not done that; some doctors with a conscientious objection don't do what they are expected to do. This wording in the bill will hopefully assist.

CHAIR - Just to add to that, we've been provided with documents which set out disciplinary action being imposed upon doctors interstate - in Victoria, I think - for not referring under the codes. The boards held that it was a disregard for the patient's rights and obligations by not referring, so yes, as you say, it is implied in the codes but the bill suggests something stronger than that.

Mr MOORE - I think there might be an issue of legal interpretation in a way. The reality is that the legislation just makes it clearer. I would say - and I am not a lawyer - but the code, and you refer to particular cases in other states, effectively does require the same as the legislation. The legislation makes it much clearer.

Ms FORREST - On that point, good medical practice, the medical code of conduct for doctors in Australia from the Medical Board of Australia says under section 2, providing good care under the introduction in clinical practice, 'The care of your patient is your primary concern.' Providing good patient care includes 2.1.4, referring a patient to another practitioner when this is in the patient's best interests. There is an expectation there of referral. Further, it goes on that ensuring your personal views should not adversely effect the care of the patient and being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and any relevant colleagues of your objection and not using objection to impede access to treatment that are legal.

While it does not say, 'You must refer' in once sentence, it does imply that. Your contention as I hear it, Michael, is that you are saying that the legislation makes it very clear that is what that means. Is that a fair interpretation?

Mr MOORE - That is a fair interpretation of what I have said and I think the whole intention of the legislation is to make it really clear so that medical practitioners know what they ought or ought not do and where they do have room to move and they do not. That is one of the strengths of the legislation.

Ms FORREST - Another point in your submission where you talk about having the 16 week change of process for access to terminations which originally, I am sure you are aware, was 24 weeks and it was changed back in the lower House to 16. I think Ingrid said that will renew the controversy and misunderstanding that some people out there in the community have - that you cannot have a termination beyond 16 weeks. That is not the case but there is that perception out there.

We have had quite a bit of evidence from practitioners, particularly obstetricians and gynaecologists, who say that having a termination becomes a more risky procedure after about 12 weeks and certainly beyond 16 weeks and that the woman will always be cared for by a gynaecologist or obstetrician. From a public health point of view, which is your focus, is it important to have perhaps a more structured approach after a certain time, whether it be 16 weeks, 24 weeks or whatever, even though it may create some confusion?

Mr MOORE - Our perspective is that this is something that should be regulated within the normal medical procedures and processes that doctors abide by and making their medical judgment which is covered by a whole range of codes of conduct, rather than having this in the legislation. The fact that it can be changed from 16 to 24 weeks, illustrates that people outside of a particular circumstance, outside the medical profession, are not in a position to make that decision. We would say that there should not be a time in there. That said, we also would not consider it appropriate for the legislation to fall over on this amendment alone.

Ms FORREST - Are you saying it is best to have what you can in political sense? The other alternative is that you have a consensual model right through that facilitates what is good clinical practice. That would be big step for people to take to accept it, even though it is probably right. But in reality, after 16 weeks and I would say probably after 14 weeks, there is clinically always an indication to involve a specialist, and that would happen as a matter of practice, wouldn't it?

Mr MOORE - We think that we would have it as a matter of practice and that is why we would not put the time here in the legislation. That said, if this clause was going mean that the legislation did not go through, we would not approve of that. We would prefer it to be in rather than have the legislation fall over. But we do think it is just good medical practice.

Mr MULDER - You have made the provision that it's a medical procedure. If it is an ordinary medical procedure, why do we need legislation surrounding things like 'this procedure being conducted without consent' because that is already covered for other medical procedures - the conscientious provisions and things like that - why are we intruding on this area if, as you say, it is just another medical procedure?

Mr MOORE - Because it is currently in the criminal legislation, so legislation is necessary first and foremost to take it out of the criminal legislation. We would also contend it should be completely dealt with as a normal medical procedure. That is probably not acceptable politically - you have this legislation and this is better than having it dealt with as part of the criminal legislation.

Mr MULDER - Assuming we take the procedure out of the criminal law, which is what we are doing with this legislation, why do you think these other things are necessary to regulate a medical procedure when all other medical procedures are not regulated this way?

Mr MOORE - It is a political issue. You probably don't feel you can take it out of the criminal legislation without doing something else with this particular issue. We know there are significant portions of the community that consider this a completely separate

issue medically. The Public Health Association doesn't; we think it should be part of normal medical procedure. It is much more important to us to have this out of the criminal legislation than it is to have it set out as simply a medical procedure. This is a very good step forward. What do we think would be the very best system? The very best system of all would be to have no specific legislation around this medical procedure but to do it within the normal medical processes.

Mr MULDER - I think Ingrid made mention that the public health network supports legal terminations. Would you concede that we already have legal terminations?

Dr VAN DER MEI - It sits under the criminal code and it is legal under certain provisions.

Mr MOORE - Which also means that terminations can be illegal under the Criminal Code. Under the current code that means there are significant restrictions and the inability of certain sections of the community to access terminations when they require them.

Mr MULDER - You have also mentioned the fear amongst doctors of the stigma of performing an operation that might be illegal when in fact it is not. Where do those sorts of fears come from?

Dr VAN DER MEI - I have read some of the *Hansard* and it was clear that that fear amongst doctors was definitely there five years ago. Apparently someone was taken to the police. We had the issue in 2001 as well. I think it is absolutely clear that there is some fear amongst doctors. I don't understand why we have fly-in doctors; why are our own doctors not doing this? Fear.

Mr MULDER - I want to pursue the issue of the fear of doctors.

Dr VAN DER MEI - Yes, it is out there, otherwise those services would be there.

Mr MULDER - How well-founded is a fear when on one occasion the doctor was interviewed by the police? No charges, prosecutions or convictions arose, and it only ever happened once, so I wonder why that would create a fear in people's minds they were going to be prosecuted.

Dr VAN DER MEI - Because it sits in the Criminal Code and they are not as familiar with that as some of their own health code.

Mr MOORE - It is an important matter of principle here, rather than the issue of fear that really plays a role. The really important matter of principle is that we have a medical procedure that for historical reasons sits in the criminal code and it is not comfortable there, and it is an inappropriate place for it to be. I think that is the real principle upon which we are operating.

Mr MULDER - Isn't it a fact that any illegal medical procedure could be subject to the provisions of the Criminal Code, as is abortion at the moment?

Mr MOORE - This particular procedure has been singled out and what we are saying that it is inappropriate to have this particular procedure singled out in the Criminal Code. I think that is the fundamental issue.

Mr MULDER - I will just go back to my other point about if we are going to take this medical procedure out of the Criminal Code, shouldn't we also take all the issues like the illegality of the procedure out of the criminal code as well?

Mr MOORE - You are talking particularly about terminations?

Mr MULDER - The only thing is illegal at the moment - the only abortions or terminations, if you like, that are illegal are those performed without consent or outside some pretty general conditions. First of all, you can see that not all terminations are illegal, and it is only a narrow range of terminations, mainly around the issue of consent. I am just trying to tease out from you as to why, if we clarify the situation so it is beyond doubt and bearing in mind that there is nothing wrong under the new procedure with someone coming up and interviewing a doctor to see whether consent had been validly obtained if someone wants to make a complaint along those lines. I am not quite sure how changing any of this changes the fear of doctors being stigmatised by being interviewed by the police.

Dr VAN DER MEI - It will. Changing the whole legislation does a lot more. It is not narrowly focused. It will change the stand for the women completely and it will change it for the doctors as well, by taking it across.

Mr MOORE - May I make one little point. When legislation rests in the criminal code it focuses specifically on the termination or the abortion. What we really want is the medical practitioner to be looking at the whole situation, the whole woman's health, taking all that into account, which is part of the way that a medical practitioner would normally operate. Moving it out of the Criminal Code allows for a much more effective approach in a medical sense.

Mr MULDER - Let me put another suggestion to you. With this law as it stands, if it passes both Houses of parliament, next year someone performs a termination and then the question arises - someone goes to the police and says, 'I didn't consent,' thus making it an illegal termination, and that will be in the Criminal Code as an offence.

Mr MOORE - That would be exactly the same as if somebody went to the police and said, 'I had my appendix taken out and I didn't consent to it.'

Mr MULDER - Yes, I think that may have been a point I was making earlier. The point is that the police would interview that doctor. How is that different from the situation today, where the police would be investigating an allegation of an illegal termination, and that would be exactly the same under that scenario as the situation that caused the doctors to be concerned this time?

Dr VAN DER MEI - That particular scenario might be the same, but that does not mean that we shouldn't do this. Because there are so many other things that will be changing and will be much improved -

Mr MULDER - What I am getting at -

Dr VAN DER MEI - That is the bit that will be changing and will be much improved because that is the bit that remains in the Criminal Code, isn't it? The last little bit; there are two bits and I think we have addressed that in our submission, as well - that theoretically we would like everything removed but there are two bits that remain. One is that issue about the history of backyard abortions and this one and we feel comfortable with that.

Mr MULDER - That is what I am saying - that we are not removing illegal terminations from the Criminal Code; we are only changing what the legal terminations are.

Dr VAN DER MEI - Yes, changing that substantially.

Mr MULDER - Having done that, I am simply saying, how does that get doctors' fear from prosecution under the new legislation which they currently have under the current legislation? It says the same things could happen - that police could investigate an allegation of an illegal termination; I just wonder how you see this as a panacea to that problem.

Mr MOORE - I do not think we see this legislation as a panacea,

Mr MULDER - A solution, perhaps?

Mr MOORE - What it does is that it changes the tone around termination. Instead of identifying termination as a specific, separate medical procedure, it puts it back in the context of the woman's whole health as a health issue and therefore doctors feel more comfortable operating within the normal practice because it becomes part and parcel of their normal practice.

Mr MULDER - The other issue Ingrid raised was the service -

CHAIR - Just before you do, Ruth, had a question on that same issue, Tony, and then we will come to your other one.

Ms FORREST - I think you said, Ingrid, that it would be better if this legislation was not even in existence, if just it took the termination of pregnancy out of the criminal code and it became a normal medical procedure but for various reasons - political reasons, in other words - they are looking at piece of a legislation that does not quite go that far and puts it into the Health Act. Could it be a matter of clarity, perhaps, that those two provisions would remain in the criminal code?

When you have termination of pregnancy identified as a separate piece of health medicine, medical practice or medical service, which rightly or wrongly is the way we are proceeding here, but it is separated out that you do need that clarification in the Criminal Code to say that even though it is separate to other medical procedures because we have made a bill about it, we have an act here about termination pregnancy, we still need to make it very clear that even in spite of that, if it is done without consent or done by someone other than a medical practitioner, it is still illegal. This is the question that I think Tony was asking: why are we still leaving some in the criminal code and the rest of it is in the Health Act?

Mr MOORE - The reality is that any procedure that is done by a unqualified medical practitioner can of course be considered a criminal act; that is why it is that we see this simply as a medical procedure, and while we take the perspective on it that we do, we do see it, this legislation as a big improvement, not going quite as far as we would, but we feel that it is a big improvement.

Mr MULDER - The question of fly-in, fly-out services, which I think we have heard plenty of evidence of, are really only done in early stages of pregnancy without trying to get into specific number of weeks. How are they inadequate?

Dr VAN DER MEI - They are inadequate because, first, it is in the private system so the cost is higher; second, they can only be done before, I believe, 12 weeks because then it does not need the follow-up next day because those doctors will have flown back already, so those services can only be provided in the private system and only before 12 weeks. After 12 weeks women need to be flown to Melbourne to have a procedure; there is a significant cost associated with that and they are obstacles for women. That is why there are now certain services that help them out, to provide the funds to do that.

Mr MULDER - We have also heard evidence that in relation to the hospitals not performing these early terminations or only performing terminations in very limited roles and that seems to be some fear of stigmatisation but the fact is that hospitals did do them before, that we have clinics now doing these procedures here today and I wonder why pressure has not been put onto the public hospital networks to return this service to the people?

Dr VAN der MEI - I think we have discussed that issue.

Mr MOORE - That may be an administrative issue rather than for us an issue about the legislation.

Mr MULDER - Thank you. You also said that the current legislation which allows, as you have just said, it is only for administrative purposes that public hospitals don't do it, but which part of the current procedures is not in conformity with community values?

Dr VAN der MEI - Could you say that again, please?

Mr MULDER - The current law and practice in terms of terminations - you made a statement that that is not in conformity with community values. Specifically, what parts of the current law are not in tune with community values?

Mr MOORE - Maybe I can start. The most important of those, of course, is equity and access. The issue for people who are in lower socioeconomic circumstances where finances are a significant concern, where remoteness is a specific concern, are more vulnerable and the thinking, I think, has shifted quite considerably in the last 10 to 15 years about issues around what in public health we call the social determinants of health and that we should have much more equity in our systems.

Mr MULDER - That is an administrative thing and what we were talking about here was that the current legal situation is not in conformity with community values; equity and access is not necessarily a legal issue, it is more of an administrative issue, so I am just wondering which parts of the law -

Mr MOORE - Our contention would be that having the legislation within the criminal code is not within the current norms.

Mr VALENTINE - You deal in your submission with terminations associated with subsequent mental health issues and you go on to talk about the good quality research which takes into account psychiatric history, violence exposure, social support, et cetera and you reference a couple of studies and one - the 2009 review of all international literature - as well as the analysis of the Australian longitudinal study on women's health, and that is good information for us to have. I wonder whether those studies, or how well you know those studies, but whether those studies actually ever looked at the effect of on women carrying babies to full term and the subsequent problems and issues they might have faced. People who are against this are always pointing to the mental health issues that people have later on as a result of termination, but is there any balancing study done that looks at perhaps the negative side of women carrying babies to full term who may not have wanted those children and the problems and issues that they are confronted with?

Dr VAN der MEI - Not that I know of, but I am more than happy to ask some of my colleagues in this area to provide you with some information on that.

Mr VALENTINE - This talks about a longitudinal study of women, presumably not just about termination, perhaps. I wonder whether there is any balancing research that shows the effect on women who have had children, lower socioeconomic possibly, aren't able to afford them, problems and issues with the children further on, the stresses and strains that brings, and possible mental health issues as a result. I am interested to know if there is any study that looks at that.

Dr VAN DER MEI - It would be challenging to find those women who wanted a termination and did not end up having one and having that as a group to follow.

Mr VALENTINE - I know it would be challenging, but I am interested to know whether there is anything out there.

Mr MOORE - There is of course a very broad range of studies around issues such as post-natal depression among women who actually wanted their babies. To a certain extent they may confuse or confound some of the issues you have asked about. Ingrid has agreed that we will try to find some studies to understand the question you are asking.

Mr VALENTINE - I won't be holding my breath because it is not likely. There may be, and I would be interested to know if there is. You say the current laws are not in line with modern societal values; would you agree that probably the reason this is in a bill at the moment is because societal values haven't been totally resolved and we have a section of society that is railing against this sort of legislation? Isn't that an indication that probably societal values aren't quite as well resolved as we may think they are?

Dr VAN DER MEI - Yes, but the survey provided a good cross-section and gave good percentages of who is in favour and who is against. There will always be a small group out there, and they are very vocal, so it merely looks like it is a big percentage while in

fact it is a small percentage that is incredibly vocal and puts up a lot of resistance but that is more resistance in terms of the issue of whether somebody should have a termination. It is very different to the question we have in front of us here.

Mr VALENTINE - I should look at the reference, shouldn't I?

CHAIR - We've had lots of evidence, and it is competing evidence, I suppose - and you have provided good evidence to the effect that the best position would be that we didn't have legislation covering terminations because they are medical procedures and therefore your codes of conduct and the like would cover that - and yet we are re-enshrining in this legislation some of those codes of conduct provisions. I am trying to understand - and not just you two before us today, but others in the medical profession who have come before us, have indicated that the medical codes of conduct are robust and sufficient - we are hearing from both of you today, and other witnesses previously, that it is not a bad thing that we have these requirements in here, particularly the matter of referral we spoke about earlier. I will come to clause 5 in the bill in a moment. Why is it that you're suggesting to the committee today that it is a good idea to make it clear in our law that referral is required and yet your codes of conduct go in that direction? Why do we need to put that into our law if the codes are sufficiently robust? We are talking about this being a new health law rather than a criminal law.

Dr VAN DER MEI - The codes of conduct can simply deal with it, but I think we have evidence to suggest that it is not quite good enough. It is clarification, It is saying in terminology what is really expected from people because there are some people who do not quite do that and women are adversely affected by that.

Mr MOORE - While we see this it is a medical procedure, we know that there is small percentage of the population that sees it very differently and that is why it is that, in the end, you have the legislation like this in the first place and why that clarification then ought to be built into such legislation if you are going to have it.

CHAIR - Okay. I will not labour the point. I think there is some inconsistency there. I then go to the matter in your submission on page 6 and this is the differentiation between terminations up to 16 weeks and post 16 weeks and your suggestion that we could amend clause 5(1) in the bill by deleting certain words, so that it would then read, 'the pregnancy of a woman may be terminated by a medical practitioner with that second opinion,' taking out any reference to 16 weeks in that process. Some in the medical profession have contended that it is crazy to require the opinion of two doctors. You are suggesting here that that be strengthened, that notion of requiring the opinion of two doctors because you are suggesting taking out any reference to 16 weeks so that all terminations -

Mr MULDER - With respect, Chair, I do not think anyone said it was crazy, but I think they might have said it was unnecessary.

CHAIR - My words.

Mr MOORE - The intended impact, when you read what we are saying, is that there should be no provision within 16 weeks and you are drawing that to our attention - that the

impact of that would mean that you will always need two doctors, is probably an inadequacy in the preparation of that amendment.

CHAIR - Are you saying, then, Michael, that you would not see it necessary for the two-doctor provision at any stage?

Mr MOORE - That would normally be a decision that a doctor would make under these codes. In their normal practice, if they have any doubt or they believe it is appropriate to have a second opinion, that is when they should be seeking a second opinion, rather than having it dictated in legislation, was the intention of what we were trying to get across here.

CHAIR - Thank you. To another area - and I am relying on your submission again - still on page 6, right at the very top, where you go to some media comment that terminations would be allowed at 38 and 39 weeks for socioeconomic reasons and then you say that is an ungrounded proposition as reported in the media because, under the codes of conduct, doctors would not allow a termination for those social or economic reasons. If it is a legal interpretation I would not expect you to provide an answer. Yet clause 5 of our bill makes it quite clear that when the doctors are assessing the risk which they seek to mitigate by terminating, they are required to take into consideration four matters: physical, psychological, economic and social. It does not preclude them from taking into consideration a whole range of other things, but they are required to take those four things into consideration, two of which are social and economic.

Dr VAN DER MEI - They are important but the insinuation of the comments in the media was that you only do it for that reason. We are talking about a holistic perspective and a doctor will take that holistic perspective. But when you are talking about 38 and 39 weeks, it will not happen. It will be picked up earlier and I am talking about severe abnormalities and those issues.

CHAIR - That has clarified that, thanks, Ingrid.

Ms FORREST - I don't think you have commented specifically on the issue of conscientious objection - there is a little bit here, yes. We have had a range of views expressed around this - that it shouldn't need to be there, it doesn't better clarify it - but one of the big concerns has been around the word 'refer'. In the medical sense 'refer' can mean as a GP refers to another specialist or someone else for ongoing consideration of a condition. As I understand it, when you refer someone you do not say, 'To do this' because that is telling the specialist how to suck eggs and we don't do that because they don't like it. When you refer someone on you are referring for them to take over the care of that patient with that particular condition, but some doctors are concerned that by doing that they could be complicit in procuring a termination of pregnancy.

We also have from the Victorian AMA, out of their journal, a comment that simply giving the woman information about where she can go, like the Family Planning Clinic or to another doctor, is adequate. You do not actually have to say 'For termination of pregnancy.' You can say, 'Go and get some more information here.' The word 'refer' from our public health sense and how does that sit? is it a big issue or are we making a mountain out of a molehill, as some might suggest?

Dr VAN DER MEI - We discussed that issue amongst some GPs on how they feel about it and how they interpret the word 'refer'. Yes, you have that formal sense of referring, but there is also the freer sense of referring, directing, the other terminology, 'effectively refer,' has been used. From our perspective that will all work; you just need to ensure it works for the health professionals who need to do it. The other issue of Family Planning Tasmania has been mentioned; it is not a health professional but a service. Yes, we would feel comfortable to add that in if that would be a minor amendment. All of those options are appropriate.

Ms FORREST - Some doctors who have a conscientious objection who appreciate and understand - the ones I have spoken to - that there is a need for a safe, accessible service for a termination of pregnancy because some of them will need it, as well as will choose it, but some will need it and the concern was that they wanted to be able to ensure that the woman gets the most appropriate care, but that 'refer' is the issue. It has been something that is bandied around, but you do not think the word 'refer' is a problem?

Dr VAN DER MEI - I can see it is an issue for those doctors, but if we can get around that then that would be fantastic.

Ms FORREST - You said 'effectively refer' or 'provide an effective referral,' or whatever the words might be; how would that change it? Do you think that would change it in the minds of doctors?

Dr VAN DER MEI - I think the best way is to ask the doctors themselves - the doctors who have conscientious objection but would still like to do the right thing. I do not think we have an answer for that.

Mr MOORE - One assumes that what the doctors would like to do is where they cannot provide care that is of satisfaction to the patient that their referral is that, 'This patient has a concern about her pregnancy and I have now referred her for treatment by you.' It may well be that the person who is sending is someone who is prepared to do a termination, though under the particular circumstances, considers in the overall health of the patient that it is not a suitable procedure to conduct.

Mr VALENTINE - About the number of weeks - you were saying before that it would be better if there weren't an arbitrary number of weeks put in the bill because a woman should have the right to choose. I am trying to understand. A minute ago you were saying that ay 38 or 39 weeks it would never happen, but if a woman chose to have an abortion at that point for some reason, for her own mental state or whatever, are you saying it would be right for her to choose 38 weeks?

Dr GOODWIN - You mean 28, don't you?

Mr MOORE - Medical procedures are never done in isolation of somebody just choosing it; even if I'm waiting to have a prostate out, the doctor won't just do it because I want it done because I happen to have a high PSA. The decision is made in conjunction with the medical practitioner; he takes into account a whole range of things and that would be the same as any normal medical procedure - the same as the issue that the medical practitioner would take into account at 38 weeks would be very different to those taken into account at six or seven weeks or 16 weeks.

Mr VALENTINE - Fair enough. I guess what I am trying to find out is at what point does the woman's right to choose stop and the doctor's opinion takes over.

Mr MOORE - The doctor is always part of the decision making. A doctor would not carry out any procedure if they think it is not in the interest of their patient.

Mr VALENTINE - You wouldn't say that 24 weeks is feasible?

Mr MOORE - We don't put a date on it; we think it is conducted as part and parcel of normal medical procedure.

Mr VALENTINE - I can't understand the two -

Dr VAN DER MEI - Why would you need to put a number on it? Why would it suddenly stop and start?

Mr VALENTINE - You are saying it's the woman's right to choose. I am just trying to find at what point the woman's right to choose is overridden by what might be -

Dr VAN DER MEI - The doctor needs to perform, so if the doctor does not want to perform, the woman can try to choose but it goes together and that is normal medical practice. If you go to someone and say, 'I want my hand chopped off,' - you can't isolate the two, I guess.

Mr VALENTINE - No, I understand. Having a certain number of weeks in there is quite defining for a woman to be able to choose up to that point. If it were 24 weeks, it's a longer time for the woman to have more information because of the scans and everything that's available. From the 20-week scans she has a few weeks to make that decision whether she wants to go ahead with it.

Dr VAN DER MEI - You always have the same process; it is a different process. If you need two signatures, you are increasing the hurdle.

Mr VALENTINE - Do you think two signatures is reasonable or do you think there should one?

Dr VAN DER MEI - We do not believe the two signatures are needed.

Mr VALENTINE - So it should be the woman and her doctor?

Dr VAN DER MEI - Yes.

Mr VALENTINE - At any time through the whole process?

Dr VAN DER MEI - As it is with any medical procedure.

Mr MOORE - The medical practitioner in normal procedures may decide that from their own perspective that they want a second opinion, particularly, for example, from an obstetrician, and that would be the logical process but that is normal medical procedure.

Dr VAN DER MEI - Again, you have the review boards as well when you get to later terminations - the diagnostics, how certain are they about particular foetal abnormality, all of those issues - that is where other doctors are being brought in and that is beautiful medical practice.

Mr VALENTINE - You can see where I am coming from; in terms of the woman's right to choose, it is her body, it is something that has happened within her, as opposed to the doctors needing to consult and provide an opinion, at what point I would have thought that 24 weeks perhaps is a more viable thing than having nothing or 16.

Dr VAN DER MEI - We would prefer 24 weeks over 16 weeks and we would prefer nothing over 24 weeks.

Mr VALENTINE - Okay, thank you.

Ms FORREST - I would like to follow that up. Even at 36 weeks or 38 weeks if a woman demands an induction, which happens often enough, there still has to be an informed consent provided before the procedure can proceed, so that a obstetrician at that point might say that it is not in the best interests of the mother or the baby to induce a labour at that time so that is the sort of thing you are talking about, isn't it, that there would be informed consent just with a termination at whatever stage it occurs after 16 weeks there needs to be two doctors who agree?

Dr VAN der MEI - Yes.

Ms FORREST - Whereas in any other procedure it is only ever one and when you are considering what is the best interests of both, particularly when you get to that stage, the mother and -

Dr VAN der MEI - I believe it is the only medical procedure that requires two signatures.

Ms FORREST - They used to require for vasectomies both the man and the woman to sign the consent form but we got over that a while ago.

CHAIR - Ingrid and Michael, thank you very much for you time. We have gone over time; I wasn't looking at my agenda, so we had better conclude it there. Thanks very much.

Mr MOORE - Thank you for the opportunity.

CHAIR - Thank you for your time, Michael.

THE WITNESSES WITHDREW.

PUBLIC

Ms MARY ANNE RYAN, TASMANIAN WOMEN LAWYERS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Before you make the declaration are you familiar with the protection of parliamentary privilege which is afforded you by being here or would you like me to explain that to you?

Ms RYAN - No, that is fine.

CHAIR - We have your submission and we invite you to speak to it because it may well be important that there are matters that you want to specifically draw out for the public record and that they will be on *Hansard* and thereby on the website as well for public reference, if that is required.

Ms RYAN - I first of all want to point out, and I know you are all aware but for the matter of the record, I am here as a committee member of the Tasmanian Women Lawyers. I am a past president of that organisation and I am a past president of the Australian Women Lawyers. At present, I am a committee member of the Tasmanian Women Lawyers. The committee decided that they wanted to make a submission right from the beginning so they made a submission to the government in preparation for the lower House and we have made a submission to the Council now that it has reached that stage.

I wrote this and it was settled by the whole committee. The president, Bridget Rheinberger, would like to have been here but unfortunately she is not available. I understand that you have had other members of our organisation give evidence in different capacities.

I consider that the submission we have made is fairly comprehensive and it gives a summary of our opinion as to the bill and its provisions. I did have the benefit of listening to the previous witness - I am not sure who that was - and it was quite interesting. Who was that?

CHAIR - The Public Health Association of Australia.

Ms RYAN - It was Ingrid, was it?

CHAIR - Yes.

Ms RYAN - I thought at the very end she was very succinct in answering Mr Valentine's questions and we feel the same way as she does. We feel that it is important that this bill passes and if to pass it, it included an amendment that put a limit of certain weeks of gestation, then we were prepared to support that if that was the only way you were going to get the bill.

Our organisation agrees with Ingrid and her organisation; our first most preferred position was that there be no gestation limit. If it had to be 20 weeks, we would prefer that. At the moment it is 16 weeks and we are content to accept that, although our preference would be that you brought it back to none.

Mr VALENTINE - To be further out?

Ms RYAN - Yes.

Ms FORREST - Or not in there at all?

Ms RYAN - Our preferred position is that it is not there at all. We don't believe it is necessary. However, like everything, we are a pragmatic group of women and we see the big picture is that the bill is passed and we were prepared to compromise on the question of weeks of gestation.

Mr VALENTINE - I have a question on the signatures. Would you be happy to see just the doctor and the woman as opposed to two signatures?

Ms RYAN - It makes absolute sense to us. We feel with an administrative burden it is not necessary. It would be costly and would be a burden socially and economically on the patient.

Mr MULDER - We have heard a fair bit of evidence from doctors and others involved in this procedure to date with the current law. Given that particularly early terminations are occurring in this state and that there have been no prosecutions, so far as I am aware for terminations, how ill-founded is the oft-stated fear of prosecution for what are legal terminations today?

Ms RYAN - I think people take the laws very seriously, despite the hoo-ha in the press when crimes are committed. The general public takes the commission of a crime very seriously.

Mr MULDER - My point, though, from a lawyer's perspective, is how real is that fear, given that there have been no prosecutions for activity that is occurring?

Ms RYAN - I don't feel qualified to answer that question. I do not see how I can speak for the genuineness of other people's fears. I think it is unreasonable to expect me to, Mr Mulder.

Mr MULDER - I am not demanding.

Ms RYAN - That is all right. I must have misinterpreted your look, that is all

Mr MULDER - It was a look of disappointment that I was not going to be able to pursue that line of questioning with you. If you were a doctor, would you have a fear in those circumstances?

Ms RYAN - Yes, I would.

Mr MULDER - Why?

Ms RYAN - Because if I were committing a crime I would be scared and concerned about being charged with a crime. Is that what you are asking me?

Mr MULDER - No - the fact is that you are not committing a crime. There are people conducting those procedures in Tasmania today and they aren't being prosecuted under the current law. The issue I am trying to pursue is why does almost an entire profession consider they are at risk of prosecution for what are legal operations when some members of that profession are conducting them because they are lawful? It is not the fact that, 'Am I committing a crime and am I going to be prosecuted?', it is, 'If my activity is lawful, why do I hold a fear of prosecution?'

Ms RYAN - I will first of all say that my observation of consultation with the medical profession is that they are very vocal about how laws would affect the practice of their profession, so I would expect them to be mindful of that. Second, I don't feel qualified to speak for the medical profession.

Dr GOODWIN - I want to ask about the conscientious objection aspect of the bill. We have had a bit of debate over the meaning of the word 'refer'. There is a well-understood meaning so far as the medical profession is concerned and perhaps a different understanding for the purposes of this bill - we were drawing on the situation in Victoria where the AMA issues guidelines which suggested that to 'refer' in that circumstance is merely to give the patient the name of another doctor or even perhaps a brochure about Family Planning or something like that. Do you have an understanding or an idea of what the term 'refer' means or should mean in the context of this legislation?

Ms RYAN - I see it meaning - and I assumed it would mean the example you first gave. That is how I would practice as a lawyer. If I was unable to help someone or one of my clients needed something other than or more connected to their problem I would refer them to someone where they could get help; I would not necessarily to engage that person. It is really to give information that is decent, bulky information, where they can get their questions answered, but that is about it.

Dr GOODWIN - Not necessarily a written letter of referral as in the medical specialist understanding?

Ms RYAN - Honestly, that has never occurred to me until you told me people are talking like that. I would think if this was - not that I base this on any knowledge of what the government plans if the bill is passed - but I would have thought the people running the Family Planning Clinic would provide brochures to every GP to make those brochures available and that is how I would see that most practically working. It is not a referral in which you would write a detailed history and things of that nature and transfer treatment of the patient. I would be very surprised if the courts interpreted it as the same thing.

Ms FORREST - Just on that point, it just occurred to me- and we had a GP here earlier - and often women come to the GP as often their first point of call with a pregnancy, wanted or unwanted, and they usually only book a single appointment and then they drop the clanger that they want to discuss termination. Doctors' books are very full, so it could be that someone without a conscientious objection could say, 'We only have 15 minutes - or however long a consultation might be - I don't have time to discuss that fully with you today, but - '

Ms RYAN - That is totally conceivable.

Ms FORREST - So they could.

Dr GOODWIN - Maybe just another one on that conscientious objection issue. One of the points - and I think you made this in your submission - the guidelines that the medical profession have already provide for that situation where there is a conscientious objection and suggests they should act in a certain way, this legislation reinforces that, but the question I have is why is it necessary to put it in the legislation when it is already covered by the guidelines?

Ms RYAN - One of the reasons that it is important is that the health consumer understands their rights, their obligations and those of their treating professional. I do not believe that health consumers know that now. If for a health procedure there is a law governing that, then I think it is appropriate that that also includes reference to the rights and obligations of everyone involved.

CHAIR - I am just trying to decide, Mary Anne; there are questions that have been running around in my mind and the committee's, and I am trying to decide whether it is a matter which I ought to reasonably raise in the debate when we are in the chamber or raise it with you now.

Ms RYAN - I am here now. If you want to ask me something, please go ahead.

CHAIR - It goes to this area, I think - the proposition of moving this from one legal jurisdiction to another, if you like. We are aware that there have been health boards and whatever they are, disciplinary boards, that call doctors to account because of breaches of the Abortion Act in Victoria - section 8 in that act, which is similar to a couple of provisions of this bill.

Ms RYAN - In what way?

CHAIR - In the referral process particularly, and the requirement in Victoria and what will be a requirement here to refer. It seems to me that with any sanctions being considered by and imposed by the medical boards, the disciplinary councils, what would be a process for some legal action to be taken against somebody for a breach of this, if it becomes law? If a doctor did not refer, it is a breach of our law; who would proceed against that doctor in terms of the breach?

Ms RYAN - I assume the Department of Health Board.

CHAIR - There is no sanction in there in terms of a penalty for not having referred. It was originally, I think.

Ms RYAN - I think there is a public interest. If this state has gone to the trouble of drawing up this bill, holding many consultations - this is yet another and will probably be the last - then the Department of Health needs to follow through on what gets into that bill, regardless of whether a colleague may refer that doctor who is said to be in breach to his professional organisation, or perhaps his patient would. But the Department of Health also has an obligation, in my opinion.

CHAIR - I am wonder what sanctions they could then seek to have levelled at the medical practitioner for that breach.

Ms RYAN - They could make a complaint of their own volition to the department

CHAIR - With what outcome, I wonder?

Ms RYAN - I could not predict. It depends how strong were the case that it was a breach.

CHAIR - If medical boards consider, as they have in Victoria, they can strike off and do disciplinary things -

Ms RYAN - What is wrong with that though, if someone breaches - to be honest, I am subject to the same controls in my profession and the overwhelming majority of us practice very protectively. The last thing we want is a complaint against us. Not only is it dangerous for us professionally and our ability to continue practice, but also for our ability to support ourselves, something as basic as that. But in addition to that, being the subject of a disciplinary complaint is enormously stressful. Any sensible practitioner, no matter what their area of practice, would practise protectively and take advice about that law if they did not understand the position.

CHAIR - That takes me down the path which we have had put to us by some in the health profession, that in an ideal world we do not even need this law because terminations are a medical procedure. The medical codes of practice imposed on medical practitioners - a high level of conduct expectation; if that is not complied with, then the medical boards will act against the medical professional and strike them off.

Ms RYAN - I would caution you about using words like 'striking off.' In the first instance, I cannot see that is the best sanction, removing a practising certificate

CHAIR - Whatever the words, whatever disciplinary action they seek to bring.

Ms RYAN - You do not want to get involved in beating things up greater than they need to be.

CHAIR - No. Disciplinary action will be brought regardless of this law. I am wondering why we need this law.

Ms RYAN - We need this law because certain people seek to regulate reproduction.

CHAIR - Certain people. Who are they?

Ms RYAN - It is part of the criminal code at the moment and I am not meaning people personally seek to regulate it, but our society is regulating it at the moment. That is the position, isn't it?

CHAIR - This re-enshrines society's expectation - would that be what you are contending?

Ms RYAN - That the bill re-enshrines society's expectation?

CHAIR - Yes, because, as you said, society is expecting what we are doing at the moment.

Ms RYAN - The fact that it exists and is not entirely being repealed. The fact that those provisions in the criminal code are not being entirely repealed without any replacement is a function of this state trying to reach a compromise.

CHAIR - I do not see anybody else lined up for questions. Mary Anne, thank you very much.

Ms FORREST - A couple of finer points that have been raised on a political perspective. I do not know if you have ready any of the transcripts from the previous witnesses or anything but the interpretation of 'terminate' is to create a bit of concern in that it says 'terminate' means to discontinue a pregnancy so that it does not progress to birth by surgical or medical means, basically. There was some concern that having 'to birth' there creates a confusion including births that resulted in or terminations that result in the child that maybe born live, we are talking about the infrequent number of later term terminations which are generally conducted for, usually, gross foetal abnormality but some of those babies potentially will be born live after 22 or 23 weeks.

Ms RYAN - Is that a question of do we need to define 'birth?'

Ms FORREST - Well, that sounds very problematic in itself and I think the department suggested that if a court were looking at this, if it stays as it stands in the bill and the court were trying to decide whether if this related to a birth at a later stage being terminated by elective cesarean section, for example, or induction of labour or even a termination at a stage beyond 28 to 30 weeks, which happens rarely but on occasion, this could create a problem. Michael Stokes addressed his mind to this in saying that this could bring in homicide provisions and things like that. We have had a lot of evidence around that,

Ms RYAN - To be honest, I cannot see that happening.

Ms FORREST - Because a child born alive has a protection of the law anyway?

Ms RYAN - Yes.

Ms FORREST - So, having it as it is not a problem, do you think, with 'to birth' there? Because we were told the online *Macquarie Dictionary* is what is used by the courts to determine and being a lawyer you would know more about that than I do, but that talked about -

Ms RYAN - It would be the first port of call if there were a need to define in the court.

Ms FORREST - That talks about bringing forth independently alive.

Ms RYAN - Is that the definition in the *Macquarie Dictionary?*

Ms FORREST - Yes, the online *Macquarie Dictionary.* Dr Brodribb said earlier that even a 28-weeker whose pregnancy was terminated for a maternal condition, such as

pre-eclampsia where the mother's life is clearly at risk, but that baby does not have independence because it needs to be cared for, basically. Do you see a problem there?

Ms RYAN - No. I think Dr Brodribb's analogy is precisely what we are getting at, is it not? I cannot see somebody being charged with homicide when they went to perform a legal procedure that was going to result -

Ms FORREST - Provided it is done with consent by a medical practitioner.

Ms RYAN - Yes.

Ms FORREST - Thank you.

CHAIR - Thank you very much, Mary Anne.

Ms RYAN - Thank you.

THE WITNESS WITHDREW.