PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON TUESDAY, 30 JULY 2013

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 INQUIRY

Ms TERESE HENNING, SENIOR LECTURER, UTAS, AND **Ms AUDREY MILLS**, PRINCIPAL, DOBSON MITCHELL & ALLPORT, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Good morning. I'm sure we don't need to inform you about parliamentary privilege. You are well aware of processes attached to a parliamentary committee.

Ms HENNING - The submission that I am speaking to is one that Professor Warner and I both wrote a little while ago. That was in response to some points that had been made by Michael Stokes and a number of other members of the Law faculty. We had been requested by the minister to provide advice about those points and that is basically what our response does.

We took the opportunity, however, to point out what the bill is doing, how it would work and how, if you do not have a clear understanding of the operation of the bill and what it is targeting, then it might be easy to see it as not working properly, but that is only if you have come at the bill from the wrong perspective. The purpose of the bill is to take the law in relation to terminations of pregnancy as far as possible out of the criminal calendar, so to decriminalise terminations of pregnancy except in very narrow circumstances. Those circumstances are where a termination is performed without the consent of the woman unless it is an emergency situation and the woman cannot give consent - that is not criminal either - and where a termination is not performed by a medical practitioner. They are the only two circumstances now which preserve the operation of the criminal law in relation to terminations of pregnancy. I am sure you understand all of this.

When you understand that and you can see that the point is to locate terminations of pregnancy in the health law, then a lot of the criticism that were provided by my colleagues disappear. That is the intent of the law; the bill quite patiently achieves that. It does it simply and elegantly. That means that a lot of the problems in relation to the criminal criticisms that have been provided by Michael Stokes disappear. They are no longer of concern because we are changing the model. I think the bill is appropriate in doing that.

First of all, it means that a woman can never be prosecuted under the criminal law for terminating a pregnancy, so that is taking the prosecution of women for terminating pregnancies out of the criminal law. That cannot now occur. Where medical practitioners are concerned, they would only be able to be prosecuted if they performed a termination without consent and it was not an emergency situation where the woman could not consent. However, medical practitioners will still be subject to professional controls under the health law, so it is not open slather for terminations of pregnancy. The community is still pronouncing the standards it requires medical practitioners to have in terminating pregnancies. Up to 16 weeks, as you know, termination of pregnancy can occur with consent. After that, parliament has imposed certain standards on the termination of pregnancy, requiring confirmation of its necessity by two medical practitioners.

Ms FORREST - Michael Stokes was saying that there is no connection in this bill with the requirements under the medical codes under the regulatory of framework that AHPRA oversee. Are you are saying the opposite here? Can you explain how that actually exists?

Ms HENNING - The point Michael is making is that if a doctor does not adhere to the standard set down in the health bill, they will not be able to be prosecuted by the criminal law. That is certainly the case, because this is not a criminal model which we are imposing, but they will be subject to rigorous health standards, professional standards, so of course they will be able to be dealt with by their professional bodies. That is not a soft option.

Ms FORREST - The bill does not specifically say that so how do we know that?

Ms MILLS - You go to how the operation of AHPRA and look at their legislation requirements. It is set up under specific legislation. The code of conduct is a code which AHPRA applies. In the introduction to that it says that the standards which they apply will interpret the standards which were applicable to doctors in accordance with the code and with any other legislation that applies.

Mr VALENTINE - Do you know which legislation that is set up under?

Ms MILLS - It is the Health Practitioner Regulation National Law (Tasmania) Act 2010. It doesn't need a specific mention in the legislation because AHPRA is aware that they are subject to whatever laws parliament passes as well as their own codes.

Ms FORREST - That relate to the practice of any medical practitioner in any setting?

Ms MILLS - Exactly.

Ms HENNING - The other objections to the bill that have been raised relate to difficulties in some of the interpretive provisions, particularly in relation to the definition of terminations of pregnancy. The argument around that has been that

because a termination of pregnancy is defined as the discontinuance of a pregnancy in such a way that it does not proceed to birth - and the problematic words appear to be 'to birth' - then that may expose doctors more than they currently are to charges of murder or manslaughter if they perform a late-term pregnancy by inducing a birth, and the foetus survives that procedure. I will make two points about that. We do not believe that is a concern because we think doctors would be protected by the defence in section 51 of the Criminal Code, which is the defence relating to surgical operations. We think that doctors would be protected by that provision. Nevertheless, if it is a concern there is a very simple remedy - simply delete the words 'to birth'.

The third point is if a viable child is born as a result of this procedure then we see no problem with the law of murder and manslaughter applying if the doctors do not take measures to assist that child to continue to live. We do not see why the law should apply any differently in this situation than it would in any other where a child is born and doctors are required to assist the child to keep living. This is going to be an extraordinarily rare situation. It is almost one of those situations where we are not really engaged with reality when we worry about it as being a problem.

Ms FORREST - Having worked in the area, the majority of terminations that have occurred after about 24 weeks certainly are for gross foetal abnormality where the baby may be born alive but is not expected to live beyond a short period. You see less of that now with more thorough diagnostic scans at 18 weeks. Because a lot of terminations, particularly those later terminations, involve medical termination, sometimes surgical as well but always medical initially, section 51 would not provide that protection if it is a medical termination in entirety. You basically said you believe it needs to be there by an amendment to the interpretation section, but because a lot of terminations are medical not surgical, then it is important to have that in there to ensure that all terminations carried out in those circumstances would be covered.

Ms HENNING - You are talking about the new section in section 51?

Ms FORREST - Yes.

Ms HENNING - That is a slightly different issue. Professor Warner was more of the point that the new amendment to section 51 was probably not necessary, but the point you make is correct - that it would safeguard that situation. It is there as a double insurance, if you like. Also, it maintains a consistency in relation to consent across the legislation. Because terminations are lawful if performed with consent, then an amendment to section 51 to preserve that consistency in relation to that defence is also not a bad idea - we don't think entirely necessary but if you can prevent argument on an issue by enacting legislation, good.

Ms FORREST - Particularly when you have a woman usually facing a very difficult choice at that time.

Ms HENNING - Yes.

CHAIR - Just on that issue, because that was going to be my first question anyway, Terese, your submission suggests that the new section 14 paragraph (b) is not required. You have just addressed that.

Ms HENNING - But I agree. I think that it isn't a bad idea to include it for insurance purposes, to maintain consistency across the code in relation to terminations so that we ensure that the focus is on, and remains on, consent, which is the intent of the legislation.

CHAIR - Yes, because the observation I was going make and seek your response was that in my words - I have written that - the clause is an attempt to free up the process so that a defence is not bound in unreasonable proof.

Ms HENNING - I think that is another way of looking at the issue as well and it's a legitimate way of looking at it. I think the legislative intent is, as the honourable member suggests, to provide insurance that the defence does cover medical procedures and not simply surgical procedures, and that you have that consistency across the code in approach, maintaining the focus on consent.

CHAIR - Thanks. If you want to continue building your position, that will be fine.

Ms HENNING - I don't want to become too repetitive and I don't want to take too much time because we'll run short. One of the other problems that was raised by my colleague was that there shouldn't be a differential in our approach to requirements to refer for doctors and for counsellors, that that is discriminatory. Antidiscrimination principles are not absolute in their operation.

Where discrimination is justified then it may occur, so if you have a solid basis or reasonable grounds for adopting what appears to be a discriminatory approach, then that is legitimate in human rights terms. In this case the argument is that doctors are covered by a professional organisation and therefore this requirement in the legislation is not needed. For counsellors, on the other hand, there is no professional organisation which deals with them and their misconduct and therefore this is a requirement that we need to impose in law. That means that in this instance some form of discrimination is necessary and it's only a minor form of discrimination in fact because it doesn't require counsellors to actually participate in any kind of termination - they wouldn't anyway. It simply requires them to refer on to somebody who can provide the information that they are not willing to provide. It's a very low-level duty that we are imposing on them.

As far as access to access zones are concerned, and we are now dealing here with the situation where we are trying to protect women who are accessing a facility to obtain a termination and we want to protect them from harassment, from abuse, from

intimidation when they are attending these facilities, we say that the current provisions in the Police Offences Act don't go far enough and that we do need specific - and we have set out why clearly in our paper - protection for these women. I'm sure you have heard from women and from organisations who have dealt with women who have been harassed and intimidated when they have attempted to access facilities, and it is not something that they deal with easily after the event. It makes an event - and decisions which are incredibly hard and often very painful to make - far, far worse and way more difficult to live with.

Let's face it, the point of the protest action outside these facilities is to try to prevent women from accessing them, is to try to prevent women from feeling safe in accessing those services. That is the point and people should not be able to behave in that pointed, intimidatory fashion and this legislation prevents that from happening. It does not prevent protests from occurring, it simply constrains their location. The High Court is not going to overturn that. It's on all fours with its earlier decision in the Adelaide case. That would be on all fours. Factually it might be slightly different - it doesn't matter. The courts are dealing all the time with slightly different fact cases, they apply the same principles and exactly the same principles would apply here. That's very clear. I do not think that there would any constitutional difficulties with this law.

CHAIR - We might proceed with questions first, Terese, and then we will come back.

I thought it particularly important in your submission, Terese, where you address the matter of regulation by health law rather than criminal law. You set out, in my judgment at least, really concisely the application of sections 149 and 152. You go on to say that, clearly, the proposed sections 4 and 5 in no way exempt any medical practitioner from the effects of sections 149 and 152, whereas in Michael Stokes's proposition, consensual terminations performed by a doctor which don't comply with sections 4 and 5 ought to be criminalised. You say there is that connection automatically anyway and that is a powerful component of what you are suggesting.

Ms HENNING - Exactly. The criminal law will still apply in its general sense, as it applies to all surgical operations, any surgical operations. What we are doing is the reverse of what Michael is suggesting. In this bill, parliament is bringing terminations of pregnancy into line with all other surgical operations. It's no longer going to be a special, criminal surgical operation; it's going to be covered by the general provisions relating to medical practice and surgical operations, so it still is governed by the criminal law in that general sense.

Mrs HISCUTT - Do you reckon clauses 4 and 5 should remain in the bill?

Ms HENNING - Yes. I would make very few changes to the bill. The only one that I would suggest for insurance would be to lop off 'to birth' from the definition of 'terminate'. Otherwise, I think it can stand. I think it will work very well.

Ms FORREST - When I read that, Terese, I look at it and say, 'terminate means to discontinue a pregnancy'. Stop there and then put 'by ... using an instrument' and we don't even need 'so that it does not progress' - that is superfluous, in my view as well. Do you have an opinion on that?

Ms HENNING - I suppose you could do that. Some people would be concerned. I am sure the reason why the words 'to birth' are in there is that people are worried that then it's going to be too wide. The definition of 'terminate a pregnancy' would cover things like caesarean section more generally. I don't think it matters really because termination of a pregnancy by performing a caesarean section, where it is necessary to save the life of the child, is not going to be a problem, it never would be a problem. It's going to be protected by section 51 in any event, as it is now.

Ms FORREST - Yes. The question is, what is a birth?

Ms HENNING - Yes, that's right, what is a birth? If you can lop it out, if you have any difficult issues and they can be dealt with simply and elegantly, do it.

Ms FORREST - In my experience, there would only be a very few cases where you would conduct a caesarean to terminate a pregnancy.

Ms HENNING - No, but I'm just talking about generally.

Ms FORREST - Yes, to bring to the end a pregnancy.

Mr VALENTINE - You mean a normal caesarean, so to speak?

Ms HENNING - Yes, women would be caught by the criminal law and that would be absurd. Well, it's not going to be because in any event it is covered by section 51, if push comes to shove, but it's not going to.

Ms FORREST - But there could be a case where you have a grade 4 placenta praevia, where the baby has anencephaly -

Ms HENNING - Yes.

Ms FORREST - or trisomy 18 or whatever it is, and to allow that woman to try to birth vaginally puts her life in immense danger.

Ms HENNING - Exactly.

Ms FORREST - So there may be times when a caesarean would be done.

Ms HENNING - Yes, yes.

Ms FORREST - But you try to avoid, but at grade 4 placenta praevia you can't.

CHAIR - Leonie, while we are on this matter?

Mrs HISCUTT - What particularly worries me is late-term abortions of healthy foetuses. In your opinion, is there any way that we can put into this bill - as minimal is it is, because doctors don't usually just do that - whereby these late-term abortions of defined 'normal' children without any defects can be terminated from the mother, live, and taken away for adoption or something like that? I'm just trying to protect these children that are just not wanted in late term.

Ms HENNING - Doesn't the law already deal with that situation?

Mrs HISCUTT - Yes.

Ms HENNING - If a child is not wanted by the mother, then -

Mrs HISCUTT - And she wants to get rid of it at an earlier stage and not proceed through to the nine months, can a birth be induced and the child taken away? You don't think that can fit in there?

Ms HENNING - Are you suggesting that a woman should be required in those circumstances to carry that child -

Mrs HISCUTT - No, no, this is what I'm saying. If a late-term expulsion of a baby - not an abortion because abortion means death - can she get rid of that baby at an earlier stage and the baby be taken away live? I mean, either way the mother is negated of the responsibility of the child. I'm just trying to see how - as rare a case as it may be, if you have a healthy child that is not wanted anymore, we can preserve that child either by caesarean section or induced labour and then take it away for adoption?

Ms HENNING - I don't think I'm really grasping the question.

Ms FORREST - Can I make the suggestion that this could be a question for an obstetrician, to ask them maybe -

Mrs HISCUTT - Okay.

Ms FORREST - Rather than it being a legal thing? Only because -

Ms HENNING - Yes, I think that that is probably more a medical question.

Ms FORREST - The number of women who request early induction because they're sick of being pregnant or whatever -

Mrs HISCUTT - Or don't want the child any more.

Ms FORREST - Doctors won't do it, generally.

Mrs HISCUTT - No.

Ms FORREST - But it's a question for an obstetrician I think, rather than lawyers.

Mrs HISCUTT - But at the minute, getting rid of the 'to birth' part might eliminate that problem. I'm just concerned.

Ms HENNING - No, I'm sorry, I just -

Mrs HISCUTT - No, it might not be the right question for you.

Ms HENNING - Yes, possibly that's the case.

CHAIR - I would like some clarification, Therese, on page 3 of your submission, where you address your mind to the proposed section 178E, right at the top of that page, at the bottom of the paragraph you talk about if in fact failure to inform would vitiate consent under section 178E, and so on. I don't grasp exactly what that goes to, if you wouldn't mind clarifying please.

Ms HENNING - Yes. We are talking here about surgical operations in general. Doctors will only perform a surgical operation with the consent of the patient. If consent is going to be problematic in relation to terminations, it's equally going to be problematic in relation to all surgical operations, so that is the point that I'm making there.

CHAIR - Okay.

Ms HENNING - So this is not an issue that's confined to terminations of pregnancy.

CHAIR - At the very early part of your submission you indicated that the current section 164 presents major barriers to accessing safe terminations.

Ms HENNING - Audrey can probably talk a bit more about this than I can, but the evidence that has come our way is that section is that section 164 is not an easy provision for doctors to work with. They are not confident that following its mandate would necessarily protect them from prosecution. That makes them wary of performing terminations and makes it very difficult for women in Tasmania to obtain terminations. We know women are required to travel interstate to obtain a termination because it is difficult to obtain them here. That is very often down to the fact that section 164 is a difficult section. It is a well-intention provision but a difficult provision.

CHAIR - Do you have any anecdotal evidence as to what component - I have read it many times, 2001 and well as this current process, it makes it quite clear you are not guilty of a crime provided you comply with the other provisions set out in section 164 and, having once complied, why is it then that medical practitioners are concerned about exposure to prosecution?

Ms MILLS - Members might be aware or will during the course of briefings become aware of a survey that was conducted amongst doctors within Tasmania. That indicated a very high level of concern. Unlike lawyers and people who deal with the law regularly, they don't necessarily see it as something which, provided they follow the steps, provides them with the protection they think they should have. The fact it is still in the Criminal Code means for many there must be a risk. 'If I slip up on one tiny aspect here, I can still be in a criminal court'. The fact that it sits in the Criminal Code, their starting point is, 'I am concerned about being involved in any procedure that has a risk to me, even if I do the right thing, that I might for some reason end up in the criminal court'. I believe that is probably the basis of their apprehension, and that means, 'I would prefer not to be involved in that area'. That is the practice in Tasmania, doctors just don't want to be involved because they believe there is some risk to being in this area.

Ms FORREST - They seem to be more confident under the ARPRA process because they are more familiar with that.

Ms MILLS - Absolutely. That is the process that applies to every other procedure they do.

Mr MULDER - It is not your question to answer but it beggars belief that here we have highly-skilled professionals who have had abortions performed under these regulations and under the provisions of the Criminal Code in this state for years, according to one of the abortionists something like 1 000 or more a year, yet here we have another group of professionals saying, 'No, no, there is a risk associated here'. If there was such a risk, why on earth haven't we prosecuted the others who are doing abortions in this state? It beggars belief that we would have these highly-skilled professional people with major degrees who retreat from doing abortions. All they are doing is leaving the field open to colleagues from interstate who come down here and perform them for them. I do not see the point you are making has any real validity.

Ms MILLS - No, but unfortunately that is the reality.

Ms HENNING - And the evidence is there.

Mr MULDER - That is fine, but has it stopped abortions being conducted in this state? No.

Ms HENNING - But it does require women to go interstate to obtain abortions on occasions, and that is the point. They do not have access on an equal basis and do not feel they have access to medical procedures they can obtain interstate.

Mr MULDER - So you're saying they are forced to go interstate, but there are abortion clinics running here, and they are running part-time because of a lack of demand.

Ms FORREST - But only to 12 weeks. After that they have no choice.

Ms HENNING - Because the legislation imposes hurdles that concern doctors. It takes it out of their normal process of operation. It attaches the criminal law to a procedure.

Mrs HISCUTT - So the doctor is not aware of -

Ms HENNING - So the doctors are nervous about it. As Audrey has said, they are not lawyers, so they are loath to engage in anything that places them at risk of a serious criminal sanction.

Mr MULDER - Where does the 12 weeks some in, because the current legislation makes no reference at all to periods of time.

Ms MILLS - It is just a provision that the providers of that service impose on themselves, having regard to the particular and limited facilities that they have.

Mr MULDER - We are really only talking about later-term abortions needing to go interstate?

Ms MILLS - The other reality is that for women living in the north of the state on the west coast and north-west, or even north-east, arranging all of this is a real hurdle in itself because the facilities are not available. There aren't providers in that area of the state that are available to do these procedures.

Mrs HISCUTT - How will this bill help that?

Ms MILLS - One would hope by doctors realising that this procedure is to be judged as any other medical procedures which they undertake under the processes they are very familiar with, and that it is no longer subject to a criminal sanction. They will then realise that the risk, albeit perhaps not valid, they perceive is taken away.

CHAIR - As a dumb individual, looking at section 164 it is very clear there is a broad exemption from prosecution to doctors having a say. The woman has given consent and the medical practitioner takes into account any matter which he may consider relevant. You could argue that it is even a broader exemption than being proposed.

Mr VALENTINE - I notice in the submissions that you do not deal with the number of weeks - 16 or 20 or 24; is there a reason for that? You do not feel that you are able to address that as a lawyer?

Ms HENNING - No, that was not addressed. Our submission, Professor Warner's and mine, was in response to Michael Stokes' addition and that was not touched on, so we did not address that either.

Mr VALENTINE - Do you have an opinion?

Ms HENNING - We certainly have an opinion and it is based on what doctors have said. It is preferable, we would say, to extend the period for terminations by consent to 22 weeks, rather than to have it at 16 weeks. One of the reasons we say that is because if you do extend it out to 22 weeks - and this isn't the medical reason but it is our view - then you are not placing women under such pressure to make a hasty decision. You are giving them more time to reflect. That is one of the reasons why we say to extend it out to 22 weeks. I think that doctors' position would be, and I hope I am not verballing them, that if you extend termination by consent to 22 weeks then again you are additionally protecting them from being dealt with by the law, imposing what they would consider to be unreasonable constraints on the doctor/patient relationship. Thereafter they can see that perhaps other controls may be valid.

Mr VALENTINE - Is the 22 weeks about the fact that the kidneys do not form until 20 and those sorts of things?

Ms HENNING - Do not ask me about those issues. I am just talking about what we have been advised.

Mr VALENTINE - I was just wondering why 22 weeks, that is all, as opposed to 20.

Ms HENNING - That is the medical view by doctors, so in light of what they say we take that view, but we have the other reason as well. We would prefer women to have that reflective time.

Ms FORREST - You are probably aware there is a fairly extensive diagnostic scan done at 18-19 weeks generally, and that 22 weeks, you and the medical profession are suggesting, would give time to make a decision based on the outcome of that.

Ms HENNING - Exactly, based on that scan.

Ms FORREST - Some people have a foetal abnormality that is quite severe, but choose not to terminate.

Ms HENNING - Quite.

Mr VALENTINE - In relation to protest, how do you see this as being different to someone protesting at an environmental protest - Ta Ann, for instance? People have the freedom to protest, but here it is being restricted in a certain way.

Ms HENNING - Yes, because it is targeting individuals and because it is targeting vulnerable individuals. It has a particular aim of intimidating them from obtaining a lawfully available procedure. As we say, protesting per se is not prevented, just its location.

Ms MILLS - I have addressed what I saw as two issues that appear to have arisen in relation to the bill and my concern that they were being misrepresented in terms of various views that were being presented. It is clear that health law is not an area that all lawyers practise in and it is not one of the mainstream areas. It is an area that I practise in, so I am very familiar with AHPRA and the workings of AHPRA because I have represented a number of doctors involved in that process. I was concerned there were some people of the view that by decriminalising terminations we were leaving it unregulated. That is really not the case.

The procedures set up for the regulation of doctors and their practise under that national law, which came into place in 2010 and complementary legislation has been passed in every state, is that AHPRA deals with any complaint that is made to it. It has a very detailed process to investigate and deal with the complaint. It goes through a number of stages in its investigation, seeking responses from the doctor, having it peer reviewed, then tribunal hearings if necessary. At the end of the day there are very significant sanctions which can be placed on doctors as a result of a breach which results in a prosecution. Those sanctions can be anything from a requirement to do retraining, all the way up to suspension of practise, practise with conditions imposed, or to not practising at all. Unlike the criminal law it actually gives a range of sanctions which are much more particularised to the matter and can take into account exactly what has occurred.

I am certainly of the view that in terms of regulation for doctors this is a much more preferable system, one that relates to every other procedure except this one at the moment. AHPRA is required, when considering standards which apply to a certain procedure, to take into account the law - this bill, if passed, would be the law used - and then take into account the code that exists in relation to their conduct.

I have specifically referred to conscientious objection, because I am aware that is a contentious issue, and the relevant principles that APRA would take into account in relation to conscientious objection. My view is that doctors are currently under an obligation, where they have a conscientious objection, to refer to another practitioner who they are aware does not have that same conscientious objection. Therefore, requiring them to do so in the bill is really confirming and making very clear that obligation which is part of their current obligations.

I make the point that not to refer in some cases will result in harm. A woman may well go past a point in the pregnancy and a doctor would say, 'I am sorry; we cannot do a termination in these circumstances', or it may cause physical harm depending on the complications that then can occur later in the pregnancy. Those circumstances are obviously not going to be the norm, but it is important that if someone is seeking a treatment which is legal that they are not impeded in doing so, and to impede is against the code of practice, by the standards that have been set for doctors.

CHAIR - Audrey, you make it very clear there that failure to refer amounts to impeding; is that a matter which has actually been applied or tested by AHPRA when they have been required to consider whether a doctor has impeded, and that failing to refer amounts to impeding?

Ms MILLS - I am not aware of any reported cases that deal with this section or this particular provision. Many of the matters that AHPRA deal with are not reported. Not all of their decisions are reported and it may be a question for AHPRA who I understand may be appearing or may be providing you some information. I am not aware of any reported decisions in respect to this.

CHAIR - I wanted to ask you about that because that then suggests, as you have set it out there, it is your opinion -

Ms MILLS - That is my opinion, yes.

CHAIR - of the position of the code that a doctor shall not impede. That, it might be argued or contended, is a passive component whereas the bill is quite an active, prescriptive requirement, that the practitioner 'must' refer.

Ms MILLS - Yes, some people could argue that. My view would be that if there is any doubt about this then the bill should clarify it. The bill should make it clear what is the requirement. If parliament has said that this procedure is legal but someone has a conscientious objection then I would have thought, that it is a community expectation that a doctor in those circumstances would refer to someone or a service - Family Planning or something like that - that would be able to provide the information that the person needs.

Remember that we are talking about not necessarily a referral which will result in the procedure; it is referral to a medical practitioner who will then have to discuss whether in fact this is the right option for you. There has been much emphasis on informed consent in the last 10-15 years for medical practitioners; they are now very aware, because they have been sued numerous times for other procedures, that if they don't carefully go through informed consent outlining all the options and outlining all the risks, that they won't have informed consent and that they could be liable to civil legal action and of course it is confirmed in the codes that apply to them. Referral in these circumstances may not necessarily result in the procedure being undertaken but it does result in at least the woman being given information about what are the risks,

what are her options which then enable her to make a decision, and a decision which the doctor is part of, too. In some circumstances they might not be prepared to do the procedure.

Mr VALENTINE - Is it in fact something where a doctor could simply pass across a pamphlet which has all of the information about the services that are available et cetera; would that be considered to be sufficient, do you think -

Ms MILLS - Yes, think it would provided it had a name and address on it.

Mr VALENTINE - or would it have to be a more active referral to say that it is these services within that need to be considered?

Ms MILLS - Referrals to family planning services, I would have thought would be perfectly appropriate, provided the pamphlet has the address and the telephone number of the family planning service.

Mr VALENTINE - So the doctor in a sense is not saying, 'This is where you go to have your termination'?

Ms FORREST - Family Planning don't provide terminations.

Mr VALENTINE - That's the important aspect.

Mrs HISCUTT - So the practitioner must refer to another medical practitioner? The 'must' bit might lead to doctor shopping where if one doctor doesn't give me what I want you must refer me until I finally find a doctor who may think that a termination is appropriate in this case even though maybe 10 before haven't.

So if we were to replace something like 'must refer' by something like what you have here, or 'may refer', or 'may' or 'must give a list of appropriate places to go' - I see this 'the practitioner must refer the woman' as 'If I can't get what I need off doctor 1 they must refer me to doctor 2 and I can keep going until I finally get a doctor I want' - is that - ?

Ms MILLS - The referral in the bill, subsection (2), refers to 'must refer the woman to another medical practitioner who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations'. The reality is, this will be played out by doctors referring to services like a planning service. But the provision itself means that the doctor who is referring needs to be at least of the view that the doctor at Family Planning or whatever other services referred to, doesn't have the same conscientious objection. I doubt that you would get that problem

Ms HENNING - Also, the section is dealing with where doctors have a conscientious objection to performing the termination, not a medical objection.

Ms MILLS - Not that they say this is not appropriate.

Mrs HISCUTT - Yes. We discussed that yesterday, that some doctors may object to some terminations but not to others.

Ms HENNING - But we are still dealing with a conscientious objection in this section, not a medical objection.

Ms MILLS - A doctor might still have a medical objection but this section doesn't apply to medical objections, it only applies to conscientious objections, your conscience saying, 'I do not believe in this procedure in any circumstances'.

Ms FORREST - I pick up Leonie's point about saying you have to refer to another doctor. Could it be amended to say, 'the practitioner must refer a woman to another medical practitioner or service who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations'?

Mrs HISCUTT - Yes, that sounds a lot better. That is a good point. A lot of constituents who talk to me object to the economic and social circumstances; they see that as being a lifestyle selection. To get around that or to make that more comfortable, in section 164(3), it already says, 'the medical practitioners may take account of any matter'. What would be wrong with taking out 'economic and social circumstances' and just adding, 'or any other matter the doctor deems necessary'?

Ms HENNING - I suppose that the new section is aimed at clarity and at -

Mrs HISCUTT - It doesn't sit well with a lot of constituents.

Ms HENNING - Yes. It's aimed at clarity and ensuring that doctors do understand that included in 'any other matter' is any other relevant circumstances in the case, that they are not constrained.

Mrs HISCUTT - I can't think of anything that would be outside these ones that are stated. If you going to state every circumstance, someone will come up with something that's not there at some stage. Why couldn't you just have those words, 'or any other circumstances'?

CHAIR - Subsection (2) is not exclusive, it just requires certain things to be taken into consideration. It doesn't exclude you from taking the broadest possible range.

Ms MILLS - These are the essential ones.

CHAIR - Yes.

Ms HENNING - The answer to the members' constituency is that these things have already been taken into account, so this isn't effecting a change.

Mrs HISCUTT - This is like educating doctors that they are already safe under these procedures. It's there and anyone who sees it will see that as lifestyle abortions. I'm trying to get that out of it by using the words 'or any other circumstances'. Is it education? We could educate doctors that section 164 covers them. Why does that have to be there if you put 'or any other circumstances', other than clarity?

Ms HENNING - If you want to but clarity is always an object of law-making to ensure that it is as clear as possible and doesn't leave -

Mrs HISCUTT - And 'any other matters' doesn't cover that?

Ms HENNING - It may do but this adds that extra degree of certainty for doctors. It's an expression that broadens out. It still allows them to take into account any other circumstances as well. It's not a marked diversion from the current position. It's a matter of clarification and certainty, and where you can introduce clarity and certainty, it is a good idea to do it.

Mrs HISCUTT - It was suggested that the 'must' be taken out and use 'may', which I think is a little bit soft.

Ms MILLS - That's a change. That means, I can decide whether I will refer or I won't refer.

Mrs HISCUTT - But if you leave 'must' in and just have 'any other circumstances' including psychological and physical or medical and leave the social and economic out, do you have strong objections to that?

Ms HENNING - That is a matter for you but as I say, in doing that you are making it all less clear than before.

CHAIR - Unless there is a really pressing question, we will call a halt to that. Audrey and Therese, thank you very much.

Ms HENNING - Thank you.

Ms MILLS - Pleasure.

THE WITNESSES WITHDREW.

PUBLIC

Ms BRIDGET MATHEWSON, COUNSELLOR AND OFFICE CO-ORDINATOR, AND **Ms PNINA CLARK**, SENIOR COUNSELLOR, PREGNANCY COUNSELLING AND SUPPORT TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - We are more than happy to have you speak to your submission or if there are any matters that you wanted to expand upon and then we will have questions for you.

Ms CLARK - Thank you, I wonder if it will be all right if I were to read a few pages that we have prepared to substantiate our submission.

CHAIR - Yes, that's fine, if you think that is needed to expand upon or clarify components of your submission, that is perfectly reasonable.

Ms CLARK - Yes, we do. Firstly, we would like to thank you for inviting us, to have this opportunity and our concerns are with section 7 of the amended proposed bill and in particular, section 7(3) which deals with exclusion of counsellors with a conscientious objection to abortion. We are concerned about section 7(3) because of the adverse impact it would have on our counselling service to our clients; on our clients themselves, to whom we have a legal obligation of duty of care, and for the continued existence of our agency. Our agency has served the greater Hobart community since 1975, which is almost 40 years. There have been a lot of social changes in that time but we have continued to be contacted by, and be of service to, women and men who have problems regarding the pregnancy. Our office keeps a comprehensive record of statistics and the figures show that we have continued to be of service up to this time.

Should the current bill under inquiry become law, we would have to close our counselling service because we are a life pregnancy counselling agency and, as such, our counsellors hold a conscientious objection to referring directly to an abortion provider or indirectly to another counsellor who will do so. I want to stress that having a conscientious objection does not affect the professionalism or efficacy of our service to anyone considering an abortion.

At Pregnancy Counselling and Support Tasmania, our counselling is client-centred and ensures the counsellors' personal views do not enter the counselling process. A code of ethics is signed - but every pregnancy counselling and support does that - where they agree that counsellors at all time respect a client's right to autonomy and self-determination. Counsellors never engage in the giving of false information or information that is designed to shock or manipulate a client. A client's right to make their own decision is always to be respected.

At Pregnancy Counselling and Support we do not give advice. Our counsellors do counselling and this is a process. It takes into account the many issues that may be of concern to the woman. The only time we advise is when the woman has issues

that are of a medical or legal nature. In these instances we do advise her to consult with a qualified and registered practitioner in these fields. Our counsellors do not have medical or legal training. The suggestion to seek the advice of those who are so trained is part of our duty of care to our clients. We consider that the abortion procedure is a medical issue and needs a qualified and registered medical practitioner's advice.

The majority of women who approach us for counselling about a crisis pregnancy are women who are conflicted and ambivalent about their pregnancy. In these instances, the counselling process explores the woman's social, economic and emotional life. It helps her to resolve her crisis as she herself decides. We help her to make her own decision. Should a woman decide that abortion is her preferred course of action, we don't abandon her but keep her counselling available to her both before and after the abortion procedure. Of course there are women who have abortions for other than social, economic or emotional reasons. For example, a woman faced with an ectoptic pregnancy. This may cause a woman distress and she may need to speak to a counsellor and we would be there for her.

Our counsellors counsel women with a range of concerns around pregnancy, not just pregnancy options. These include relationship issues, financial or material concerns, physical and emotional support, and issues around self-esteem and body image. Statistics for the past year show that 47 per cent of all client contacts were for counselling, and of these contacts the primary reason for counselling given was: abortion seeking and decision counselling clients, 17.2 per cent; post-abortion clients, 13.8 per cent; other counselling was 69 per cent. It is just under half of our clients, but a big minority are for counselling.

Under section 7(3) a woman may choose to consult with an abortion provider, but will be denied the choice to consult with us also. I would like to just tell you two instances, which have been de-identified. I have had two clients who called our service for counselling just recently. One was a teenager and the other a 30-year old woman. Both had consulted abortion providers prior to calling our service. The teenager wanted to know what support she could expect from us if she were to continue with her pregnancy, because her reason for wanting an abortion was lack of support. The other client wanted to talk about her situation, which was quite complex. Both women had obtained the abortion provider's phone number as well as our phone number from the internet. To us this indicates that women who are seeking an abortion have no difficulty in contacting an abortion clinic if they have access to the internet or a phone book, and therefore this is no justification for the exclusion clause of section 7(3).

Were exclusion clause section 7(3) to be enacted these women would not have been able to speak with me, after they had spoken to the abortion providers. They would have been denied this choice. Under section 7(3) they would be able to access only those counsellors who had no conscientious objection to abortion. These same

counsellors could be ones employed by an abortion clinic who, under section 7(3), are not obliged to counsel a woman in pregnancy options other than abortion.

Post-abortion counselling is another service that we offer to women. Part of the counselling process for these clients is allowing them the freedom to tell of their experience without fear of judgment or minimising the impact that abortion has had on their lives. There are women who, in sharing their experiences and grief after an abortion, have told us of feelings of not being properly informed of what would happen during and immediately after the abortion procedure. They tell us that they did not understand the impact it would have on their lives, that they were not informed of any potential side effects of abortion or the dangers of the procedure, that they felt they were not counselled before the abortion; they were merely asked if they were sure of their decision and the reasons for wanting their pregnancy terminated. These were then marked off a checklist.

If you consider that an abortion procedure is a medical issue, our current practice in keeping with our duty of care is to suggest that a woman who is seeking an abortion makes an appointment with a qualified medical practitioner of her choice. Such a practitioner is able to provide her with a medical assessment of her personal health situation, give her medical facts on abortion procedures, as well as any side effects and dangers, facilitating an informed consent. With section 7(3) being enacted, this process will no longer be in place. Counsellors will be required to refer women seeking abortions to other counsellors who may or may not uphold a similar standard of care for our clients as we do. So our counsellors would not be able to say, 'This requires a medical opinion'. We will have to just refer them to other counsellors and we don't know what their standards are. This is a concern for our duty of care to our clients.

Section 7(3) of the bill does not stipulate that counsellors should have no bias other than against abortion. All that is required of a counsellor is that he or she has no objection to abortion. There is no requirement other than this in this bill. There is no requirement that counselling given to a woman seeking pregnancy options advice should deal with the woman's issues within the woman's personal and unique life context and not the counsellor's worldview. Section 7(3) will not only deny women access to our service if they are considering pregnancy options but also prevent many women from benefiting from our counselling service on other pregnancy-related issues. Almost half of our client base will be lost. This, in turn, would result in a service loss that the Tasmanian Government has until now considered worthwhile funding.

In its current form our funding agreement requires that one of the outcomes to be pursued for consumers is the mental and physical health and wellbeing of women who make choices in relation to pregnancy. Should we cease to do counselling for pregnancy options, we would not be fulfilling the terms of our agreement. Any changes to our funding agreement would need to be negotiated with the Department

of Health and Human Services, which will then decide if they are willing to continue to fund us if one of the key consumer outcomes is no longer being provided.

Implementation of section 73 would also result in another part of our service to the people of Tasmania being lost. This is our after-hours phone counselling. The government funding only covers our office for four hours a day, from 10 a.m. to 2 p.m. on weekdays. For the benefit of our clients, we also provide an after-hours crisis phone line which is staffed by volunteers. This service is with the agency of an interstate pregnancy organisation. As an interstate agency it is covered by its own state laws with regard to abortion. Under section 7(3) we would probably no longer be able to provide this after-hours service to Tasmanian women. Having to cut these two services would not only mean that we will be negotiating from a place of non-compliance with the department's objectives but it would also mean the removal of a major part of what presently constitutes our service, a service which our clients expect of us.

Without government funding, Pregnancy Counselling and Support Tasmania will close, with two employees losing their jobs. Our clients - the women, their partners and families who suffer distress or hardship of various sorts due to pregnancy or pregnancy loss - will no longer have access to the support and services we provide and which have been, till now, their right to choose.

CHAIR - May I firstly test a concern I have here. If a woman decides she wants an abortion, we do not abandon her, and in your submission you say that counsellor training does not include training in medical and so on. That suggests to me that your counselling is neutral.

Ms CLARK - Absolutely. It is client-centred.

CHAIR - That being the case, how is it that you contend further in your submission that the bill would force you to overstep your area of expertise, if your counselling is neutral. I want to link that to something else you said to the effect that if a woman has consulted an abortion clinic first she would not have had the freedom to come to your counselling service. I do not see the connection. Just because a woman has consulted an abortion clinic first does not preclude her in any way in coming to you. Even if this bill became law, it does not preclude because your counselling service is neutral. She might have gone to an abortion clinic; they may have given her all sorts of options about a medical procedure or a surgical procedure to terminate the pregnancy. She is in no way prohibited or fettered in coming to you if 7(3) became operational.

Ms CLARK - The reason we say that is because we will no longer be able to counsel such a woman. We do have a conscientious objection. The bill does not say anybody who has a conscientious objection will counsel according to these conscientious objections. The bill does not say that someone who is neutral in their counselling. The bill is talking about our personal conscientious objections to

abortion, which does not come into the counselling process that is outside. When we are there with a client, we are there with the woman in her world view, not in ours, otherwise we would be no help to her.

Ms MATHEWSON - To clarify, as we have a conscientious objection we will no longer be able to counsel. We have to keep that in mind when we are counselling. So if she comes to us and says, these are my problems, and we are in a counselling process, and then she does ask for a referral, we need to give it to her because this is what is stipulated. We can either give it directly or indirectly.

Ms FORREST - If she has asked for a referral why would you not give it to her?

Ms MATHEWSON - Because we have a conscientious objection. If she asks for a referral to an abortion provider, by this bill we have to give it to her.

Mrs HISCUTT - You just said you were neutral.

Ms MATHEWSON - We are neutral but this bill does not take that into account.

Ms FORREST - You just said if a woman asked for a referral, so why would you not? If she has asked for a referral, you are denying her request if you don't provide it.

Ms CLARK - There are a couple of other issues that come into this besides conscientious objection. We also do post-abortion counselling. We want the woman to feel comfortable to come to us if she needs to after the abortion. We mentioned that, should we be part of the abortion process. How would you feel going back if you had problems to someone who was part of the process? We want to be available.

Mr MULDER - You are saying your counselling is neutral, yet I also heard you quite clearly say that you don't give advice, so your counselling really is listening, talking through the options but not advising one or the other - just explaining the consequences of each of those options?

Ms CLARK - Not necessarily.

Mr MULDER - No, because that would be giving advice.

Ms CLARK - Yes. The bill is too general and does not specify what counselling is. The people who made this rule do not know what a counsellor does.

Mr MULDER - If a woman comes to you and she is of a mind to have an abortion, you don't give her advice not to have it? You simply talk through the issues and listen, but give no advice?

Ms MATHEWSON - We listen and give no advice. We ask her how she would feel about it. We ask, 'How do you think that's going to affect your life?'. We get her to think so that at the end of the counselling process the decision she has come to fits in with everything else in her life. She is going to think about her relationship, and social and economic situation.

Mr MULDER - If she tells you after all that she has decided she wishes to have an abortion, what is your response to that?

Ms MATHEWSON - We don't give referrals for abortions.

Mr MULDER - What is your response to her - not to give her a referral? She doesn't need one; she just has to look in the yellow pages and find it.

Ms MATHEWSON - We explain to her that we don't give referrals for abortion and we explain the reason why.

Ms CLARK - We have had counselling sessions which have ended with the woman saying, 'I think I am going to have an abortion'. We wish her well; it is her choice and her life, and in no way indicate that we are against her decision.

Mr VALENTINE - You don't try to dissuade her?

Ms CLARK - No. This is a misconception and we are quite cross about it.

Ms MATHEWSON - We do not have to live with her decision; she does. What we think is best for her may be the total [inaudible].

Mr MULDER - Part of the problem we face is that counselling is now mandated in the current legislation and that mandatory counselling will continue into the new bill. Is that the problem?

Ms MATHEWSON - No, the problem is that we have a conscientious objection; we are a life-affirming agency. When faced with somebody who, for whatever reason, asks for a referral for an abortion, we do not give it.

Ms CLARK - This bill says we can't counsel. This bill would cut us out completely, not because of how we counsel but because of who we are outside the counselling arena.

Ms MATHEWSON - Because we have a conscientious objection. That is the reason we won't be able to counsel. If that crops up within a counselling process, that she wants a referral -

Mr MULDER - I am wondering why the whole referral things gets in here. Anyone referring anyone else is referring them to someone with the expertise to perform the operation they require.

Ms MATHEWSON - Which is why we will refer to a doctor. We will suggest she speaks to the doctor, find out about the procedures, the side effects and the dangers so she can make an informed decision.

Mr MULDER - So you will refer her to a medical practitioner?

Ms MATHEWSON - Yes, of her choice. This does not specify a medical practitioner; it is asking us to refer to another counsellor.

Mr MULDER - When you talk about referring her to an abortion clinic, that is not even contemplated in this legislation; it is only referring to another counsellor.

Ms MATHEWSON - Yes, who may be employed.

Mr MULDER - Yes, but it is to another counsellor; it is not to a medical practitioner.

Ms MATHEWSON - We have no conscientious objection to asking her to seek the advice of a medical practitioner, who will then do an assessment of her health and talk to her about -

Mr MULDER - What if that medical practitioner is a person known to perform abortions?

Ms CLARK - We do not refer directly to any particular doctor. We ask her to choose her own.

Mr MULDER - But if she chooses someone who you know is going to recommend abortion?

Ms MATHEWSON - We don't know who she is going to speak to. We just suggest she speaks to her doctor or a doctor she knows. That is the only specification. We have developed a list of questions she can discuss with the doctor to facilitate her informed consent. We let her know we are here for her if she runs into any difficulties, if she wants to discuss things further or if she needs us after.

Mr MULDER - I have some trouble with how people who are conscientious objectors to termination can provide neutral counselling.

Ms CLARK - We are trained. I have two postgraduate degrees in counselling. I am the counsellor trainer and supervisor of our counsellors.

Mr MULDER - I want to get back to the professional standards and things of the counselling service but that is a little off the topic, and I suspect by the body language that some others might want to pursue that same issue about referral and advice.

CHAIR - Let's go to Ruth for the moment because it is a question that I raised to start that given the neutrality of your counselling and before that, I did link it to another component of your submission where you suggest that by this obligation to refer, if the bill succeeds, you suggest here that you would be obliged to refer to one who may not uphold a similar standard of care for your clients as you do. To some extent, is that not a subjective judgment? You have got a level of care which you know within your organisation is sound but in the end, regardless of your counselling or anybody else's counselling, the decision to terminate or not will be the woman's so because you have a conscientious objection, what is the damage then in referring to some other organisation? Because it is not an abortion clinic, as Tony has indicated, it is another counsellor who will sit and listen and we presume be neutral, and the woman will then make her decision. What is the damage in such a further referral?

Ms MATHEWSON - The damage in this case for us, for what we have seen, by women who have gone directly and received what was supposed to be counselling at an abortion clinic, is by what Pnina was just stating then, where they feel they weren't informed, where they were shocked and horrified by what happened because they didn't feel that they were informed. We deal with feelings and emotions, and this is how she felt. She felt like she didn't know what was going on, she felt she wasn't informed of side effects and dangers. The counselling process that she received within the clinics is described to us as: 'Well, are you sure and what is your reason?' and it was just tick, tick and that was the end. It wasn't about working out whatever decision or even discussing it previously. If these counsellors are counselling within an abortion clinic and this sort of thing is happening as we are hearing, then we hold a question in our minds about the kind of counselling they receive in there, and then we question whether or not they uphold the same standard of duty of care to their clients as what we do.

CHAIR - But I come back to the neutrality of your counselling that you would not promote a discussion about the side effects or anything else because that's for her to determine in consultation with the medical practitioner.

Ms MATHEWSON - We will if she says, 'Do you know?' and we can discuss these sorts of things but we suggest that she ask somebody who is trained, somebody who knows what the side effects and the dangers are. As our code of ethics states, we are not counselling and giving information to shock or dissuade somebody from a certain course; we are simply finding a place where she feels comfortable and strong enough to make an informed consent and if she wants to further explore the option of abortion, then she should do so with the guidance of a doctor who can give her a medical assessment rather than us just pushing her off to another counsellor who may or may not uphold that care for her.

CHAIR - How do you make that judgment as to whether they may or may not uphold that standard of care?

Ms MATHEWSON - At the moment we don't need to because we are not obliged to refer to another counsellor but when it comes to deciding whether or not we are going to refer to another counsellor, it would really be up to whether or not this bill passes. At the moment we don't need to refer her to another counsellor because she receives counselling from us. Medical advice and assistance, she receives from her doctor.

Ms FORREST - Do you have copy of your code of ethics with you?

Ms MATHEWSON - Yes.

Ms FORREST - Would you be happy to table that so that we could have a look at that? That would be helpful to see what your framework of practice is.

Ms MATHEWSON - Yes. As you will notice, it is put out by Pregnancy Health Australia, who we are an affiliated member of, and this is why we feel quite comfortable with the counselling that our clients receive after-hours because they sign the same code of ethics.

Ms FORREST - Without reading through that now but I will at a later time, when a woman who is pregnant comes to you and maybe she is sure what she wants to do or maybe she is not, do you provide information about the support available to pregnant women, particular the young, single woman, for example?

Ms MATHEWSON - Yes.

Ms FORREST - What sort of information do you provide for them?

Ms MATHEWSON - We provide referrals to support services. It is part of what we do.

Ms FORREST - What sort of support services?

Ms MATHEWSON - There are early support services such as PYPS for young pregnant teens and Good Beginnings. We provide physical assistance, home help and things like that if she needs help in the home. Some of our services we provide ourselves and then others, we will link them in with other support services, home programs. Also through Gateway, if we feel she may need the help of other services, rather than just one singular service, we will link her in with Gateway.

Ms FORREST - Do you provide information about adoption?

Ms MATHEWSON - Yes.

Ms FORREST - What do you provide?

Ms MATHEWSON - We would give her referrals to that but we will also go through the counselling process with that as well and how she feels about it.

Ms FORREST - Does she need to ask for that or do you provide that as one of the options?

Ms MATHEWSON - If somebody says, 'What are my options?', we say, there is abortion, there is keeping the baby, and there is adoption and we will talk with her about that.

Ms FORREST - Do you give information about abortion?

Ms MATHEWSON - Not information as in the kind information that a doctor would give, but we would discuss how it's going to affect her life.

Ms FORREST - But you are giving them the contact details for the various other support for pregnant women? You are giving her information of how to contact the adoption agency?

Ms MATHEWSON - Yes.

Ms FORREST - But you don't give her any information about how to contact someone who would provide information about the risks and benefits of abortion?

Ms MATHEWSON - We suggest that she sees her GP and who better to see her than her own GP who can make a medical assessment, have the medical files there.

Ms FORREST - How many women come to you who haven't been to a GP already?

Ms MATHEWSON - I don't have that percentage.

Ms FORREST - A ballpark? Most women go to a GP to have their pregnancy confirmed.

Ms MATHEWSON - They do pregnancy tests.

Ms CLARK - And they were sent a [inaudible]. A lot of our clients have gone to the chemist or the supermarket.

Ms FORREST - A lot of people do that but most of them will have it confirmed by the doctor.

Ms CLARK - No, I wouldn't say most.

Ms MATHEWSON - I would say probably more people would come in, having taken a home pregnancy test than who would come to us after going to a doctor for a

pregnancy test because it's the first line of confirmation for them. They will then go off to a doctor and see the doctor and have everything properly confirmed. But that home pregnancy test is probably more likely the confirmation that they get.

Ms FORREST - If you are saying, if you want to consider abortion, you should go to a doctor, then how is that not referring them under the requirements of this provision?

Ms CLARK - It is a counsellor.

Ms FORREST - We talked about this with the previous ones, with the doctors. If it is to another counsellor or other service, which may be a doctor, maybe Family Planning or maybe some other service, even an abortion clinic, not just to a counsellor, would that relieve the problems here?

Ms CLARK - We can't counsel them, that is the problem.

Ms FORREST - No. I am asking you, if this was changed to 'the counsellor must refer the woman to another counsellor or other service', because what you saying is that you do refer to doctors.

Ms MATHEWSON - We do refer. We suggest that she seek the advice of a doctor. We are not saying you can get an abortion from a doctor.

Ms FORREST - No, you are referring to someone who may or may not have a conscientious objection and it is up to the next person in the line to say yes they do or they don't. You said that you do not recommend a particular doctor and that you allow them to make that choice. They may well choose a doctor who is quite happy to discuss a termination with them.

Ms CLARK - So are we.

Ms FORREST - Let me read this section to you, as it could be amended:

> If a woman seeks a pregnancy options advice from a counsellor -

such as yourselves -

> and the counsellor has a conscientious objection to terminations -

which is you -

> the counsellor must refer the woman to another counsellor or other service who the first-mentioned counsellor -

that is yourselves -

reasonably believes does not have a conscientious objection to terminations.

Ms CLARK - But we are not allowed to counsel in the first instance. Our problem with it all is that we were told that if we had a conscientious objection to abortion we cannot be pregnancy options counsellors.

Ms FORREST - This bill does not do that. This bill says that if someone comes to you -

Mr MULDER - Seeking advice.

Ms FORREST - Yes - seeking pregnancy options advice, so I have come to you with an unwanted pregnancy - not just unplanned but unwanted pregnancy. I have seen on the ad pregnancy counselling and support, so my mind tells me that you will talk to me about all my options; that is what I will read from the title of your organisation, so I seek your advice. When I turn up I say, 'Look, I want to consider all my options, including termination', and you tell me you have a conscientious objection to that.

Ms CLARK - No, we don't.

Ms MATHEWSON - We would counsel a woman on all of her options. For us to counsel is not for us to advise. It is not for us to say, okay here are three options and here are three advices. It is for us to, within her unique life perspective, go through how this is going to affect her life. It is the same as if we counsel on adoption. For us to change that we must refer the woman to another counsellor or service who the first-mentioned counsellor reasonably believes does not have a conscientious objection, is for us to indirectly refer. We would have to be sure that the person who we are sending her to, whether that is a service or a doctor, does not have an objection to abortion.

Ms FORREST - Reasonably believes, that is the test.

Ms MATHEWSON - We could give a list of people, but we would have to be reasonably sure that they are going to get that referral from the next person.

Ms FORREST - Not a referral, but that they can get the information and support they are seeking.

Ms CLARK - We do give information and support as counsellors.

Ms FORREST - Going back to the point of my unwanted pregnancy, I want to discuss all my options and you want to talk about how I feel about various options and how it might affect my life. Then I say, 'Okay, can you give me some information about continuing the pregnancy, the support that is available to me? Can you give me some information about how to contact the adoption agency? Can you give me some information about how to access a termination?'.

Ms MATHEWSON - Adoption is not a medical matter, abortion is, so we are not going to refer for a medical matter.

Ms FORREST - But you just said you would suggest they see a doctor.

Ms MATHEWSON - We would.

Ms CLARK - Because it is a medical matter to discuss with a doctor of their choice.

Ms CLARK - She may have other issues physically that we would not be aware of.

Ms MATHEWSON - As you said, for us to refer we would have to be reasonably sure that the person who we are referring to does not have an objection to abortion, but because we also do post-abortive counselling we also would then become part of the referral process. We have given her the number. In dealing with post-abortion counselling we are dealing with grief and the stages of grief that we go through and quite often blame and anger are part of that. She is looking at probably one of the only services in Tasmania specifically designed to give post-abortion counselling and she is saying, 'Well they sent me there', then she is not going to come back to us, which may lead to depression and all of these other things that she has no support for. So we cannot become part of the referral process, even indirectly. We can suggest that she seeks further information from the care of her own doctor.

Mr MULDER - The point that is being made, though, is that if you have counsellors and one of the options that she wishes to get information on is termination, you then give her the information or you suggest to her that she goes and seeks advice from her doctor. Her doctor then goes through and either does the operation or refers her on to the abortion clinic. She then comes back post the abortion and seeks post-abortion counselling. Haven't you then cut yourself out of that because you are part of the process that -

Ms CLARK - Yes.

Mr MULDER - Because she went to the doctor?

Ms CLARK - Yes.

Mr MULDER - So in other words anyone who has come to you cannot get post-abortion counselling?

Ms CLARK - They may choose not to come back to us.

Ms FORREST - Why can't they come back?

Mr MULDER - Well, she said they will not feel -

Ms CLARK - I'm sorry, we've misunderstood the question.

Mr MULDER - You said that they wouldn't - post-abortion - if you were part of the referral process -

Ms MATHEWSON - Yes, there is a very good chance that they would not.

Ms CLARK - We didn't refer to a particular doctor. We ask her to choose her own doctor. They will not come back to us, 'You told me to go to this doctor. This doctor caused me this pain'.

Ms MATHEWSON - Yes.

Ms CLARK - A women who has pain afterwards is looking for someone else to blame, not herself, at that time. She will get through that, but at that time this is one of those stages that when giving blame we look for anybody to point the finger at, because it's too much.

Ms MATHEWSON - It's too much to bear.

Mr MULDER - You don't have to be a pregnant woman to go through that.

Ms FORREST - That happens after miscarriage too.

Ms CLARK - Absolutely.

Ms MATHEWSON - It does.

Ms CLARK - And we do see women with other pregnancy losses.

Ms MATHEWSON - And we deal with post-abortion -

Mr MULDER - I'm just exploring that issue about how they distance themselves from the chain of events of which they're clearly part.

Ms MATHEWSON - Yes, we do post-abortion counselling like we do counselling for miscarriage. To us they're one and the same thing because the people who seek our help afterwards are not the people who are fine with it. For the majority of people, they deal with it and they go through things and they're fine, but in saying that, 'Okay, go to this person', and we have a pretty good understanding that this person is either going to refer directly or do it themselves or whatever, we are then part of that referral process and we're going to shut the door on her, not because we've shut the door but because she's not going to feel comfortable coming back to us. That is another reason why we have a conscientious objection to this.

Ms FORREST - You mentioned that a lot of the women you were hearing from said they were not informed of the risks or the complications that could occur et cetera.

Ms MATHEWSON - Some of the women.

Ms FORREST - So with those women, do you not suggest they contact AHPRA? It's about informed consent. What I'm hearing you say is that these women didn't provide an informed consent. What do you do about that?

Ms MATHEWSON - In going through the counselling process we're hoping that they're going to come back, and a lot of them don't. A lot will come in a few times and then they need to deal with it themselves, or come in once and get it off their shoulders because they feel like no-one else is listening and then they go.

Ms FORREST - Are you mandatory reporters?

Ms MATHEWSON - Yes.

Ms CLARK - Could you please clarify what AHPRA stands for?

Ms FORREST - AHPRA's the regulation body where a patient of any sort, from any service, has a complaint, particularly in the area of informed consent, because AHPRA's very clear about informed consent, is a patient didn't provide informed consent they should be referred -

Ms MATHEWSON - We reported it through our service reports to the Department of Health, and I spoke to somebody there as well, so they have received our concerns on that. Pretty well, there is nothing we can do about that.

Ms FORREST - So the woman could make a claim herself to AHPRA. She can make a representation.

Ms MATHEWSON - Yes, she could, but whether or not she would want to come out and do that in an area where -

Ms FORREST - She's come to you as counsellors.

Ms MATHEWSON - Yes, as counsellors, but whether or not she wants to take that further and deal with the conflicting emotions that having the abortion has brought up, we could offer that as an option.

Ms FORREST - So as mandatory reports, which you are -

Ms CLARK - Well, we are held in underneath, especially with regards to the Children and young Persons Act, yes.

Ms FORREST - I'm not sure how far that extends.

Mr VALENTINE - I'm just wondering whether you've looked at 7(3) and thought to yourself, 'Well, if we change this little bit, this is the way we would be protected'. Have you done that? Rather than just deleting the section have you looked at how that might be changed to satisfy what you're trying to communicate here today?

Ms CLARK - No.

Mr VALENTINE - Is it the fact that -

Ms MATHEWSON - I would change it to 'the counsellor must refer the woman to a qualified medical practitioner'.

Ms CLARK - Which is what we do.

Ms FORREST - This is all counselling services, though, we have to consider, not just yours.

Ms MATHEWSON - Yes, but if we were to change this we would suggest the woman be sent to somebody who can give her a medical assessment.

Mr VALENTINE - If a woman seeks pregnancy options advice from a counsellor concerning, or including, termination and the counsellor has a conscientious objection to termination, is that going to satisfy the issue you have?

Ms CLARK - We do counsel on that. She can come to us for counselling about termination.

Mr VALENTINE - I think I hear what your concern is, that you are being put into a box with a lot of other counsellors.

Ms MATHEWSON - Our concern in black and white is that we are counsellors, we don't give advice and we don't direct her in any such way.

Mr VALENTINE - But you do have conscientious objection.

Ms MATHEWSON - We do have conscientious objection, which does not influence us in our counselling process. The only way that influences us is the fact we don't refer for abortion.

Ms FORREST - You said you don't give information either.

Ms MATHEWSON - We will give information but we will counsel on it. We are not going to sit down with diagrams of little babies and shock and horrify. That is not

who we are, we are counsellors. If the woman wants to find out more than we can tell her, she goes to a doctor.

Ms CLARK - I believe there is also a problem that 'counselling' is not defined. It is very general.

Mr MULDER - I can be a counsellor if I tell you I am, under the law.

Ms CLARK - Yes.

Mr VALENTINE - Is there a problem with that definition of 'counsellor' under clause 7(1)?

Ms CLARK - What does a counsellor do? Not necessarily what does 'counselling' mean? What is the meaning of 'counselling'? It is not giving advice. Who is a counsellor? A counsellor is someone to ask who counsels. Legal counsel will give advice; a psychological counsellor will give counselling, not advice. In different contexts this term has a meaning.

Mr MULDER - The bill talks about counselling as persons seeking advice from a counsellor, which is the interesting point when you're saying you don't give it. If you look at the words, 'If a woman seeks pregnancy options advice from a counsellor', it seems to me if you don't give advice, it doesn't apply to you.

Ms CLARK - As long as we have that clarified. I have shown this to someone who is no longer practising and she said, 'No, you can't counsel because according to this you have a conscientious objection'. It's not at the end of the counselling process that you have to refer, here it doesn't say that, or if you cannot counsel, full stop. Perhaps if we had legal advice that this was not so, we might be more comfortable.

CHAIR - Can I suggest we won't go down that path as to the legal application. Tony has raised a very salient point in regard to the wording of the act and as legislators we can take serious account of that.

Mr MULDER - And your understanding of the role of a counsellor.

CHAIR - Pnina and Bridget, thank you very much for your submission and precise information to us. We appreciate that. It may be you need to seek some advice about the matter that Tony raised as to the legal applicability and sanctions that might impose upon you.

Ms CLARK - Yes. Thank you very much for your attention.

THE WITNESSES WITHDREW.

PUBLIC

Dr CRAIG WHITE, CHIEF MEDICAL OFFICER, AND **Miss CHERIE STEWART**, LEGAL POLICY OFFICER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thanks, Craig and Cherie for being in front of the committee today. Craig, you would be well aware of the protection of parliamentary privilege but Cherie might not be as to what happens in a committee such as this so it is important I explain that to you. While in this process you are protected by the principle of parliamentary privilege and so any evidence you give here cannot be actionable by anybody else, but we would suggest that you exercise caution if you wish to, or are invited to, speak to the media outside this process in the things you might say notwithstanding that they would be connected to and appropriate to the submission you will make. Outside of here people might decide to take action against you if they feel aggrieved and feel they have a case. That said, would you please each individually take the oath and then we will proceed.

You may wish to speak to your submission. We have allocated 45 minutes and we may need to get you back and if that is the case, we are flexible about that.

Dr WHITE - We may be out in 20 minutes, who knows, it depends where we go.

I would like to make a few opening remarks and then I thought dialogue is probably more useful to you so you can focus on any areas of concern to you.

Thank you for the opportunity to address the committee on this important matter. You will have received the department's submission signed by the secretary. I'm here today as the chief medical officer. I'm a registered medical practitioner and also, as it happens, an AMA member but I'm not here specifically in either of those capacities; it is as chief medical officer from the department.

The submission with a covering letter signed by the secretary Matthew Daly states in that letter that the Department of Health and Human Services supports the bill in its entirety and considers it will improve the health and wellbeing of Tasmanian women by reframing terminations in a health, not a criminal, context, reducing impediments to service delivery in Tasmania and addressing access and equity issues caused by current law. That's a sort of overarching statement of position.

Then the structure of the submission is intended to help you see specifically where we thought the issues were and there is a table immediately after the letter that sets out five areas of concern. The first three really go to the issue of criminality linked because of the construction of the current legislation of terminations. We have called those three headings: 'Access to terminations is governed by criminal law', 'Current laws are not evidence-based' and 'Criminal law is linked to a service delivery'. The fourth area there is called 'Limited services means limited choices for

women', particularly those in vulnerable circumstances and the fifth area of concern was that protesters are currently allowed to intimidate, harass and shame women accessing health services. They are on pages 2, 3, 4, 5 and 6 and there is one issue on each.

The way we have set it out is to have the issue followed by the consequences of that issue and how it could be different. We have tried to make it easy for the committee to look at that. The last part of our submission goes to specifically the terms of reference of this committee in that it goes through the draft legislation on a clause-by-clause basis.

Our view is that the outcome of the proposed changes is that decriminalisation will reduce stigma for women and their treating doctors. Stigma is never good for people; it's always bad for them. I think you had submissions on that yesterday from Darren Carr. There can be improved equity for the Tasmanian women who most need it through better access to termination services. When I say 'better access', I mean in that circumstance a bit of a package of ways that access is improved because over time you would anticipate that the public sector might well respond. About a third of our households in Tasmania rely on the government for support, many of them in rural and remote circumstances. They have to find money in the current situation. They have to be able to get away from their own community, often find other doctors to help them out and that includes a lot of waiting. I think it's easy to see for a lot of Tasmanian women that is a pretty intimidating set of barriers and obstacles to achieve what is a recognised important dimension of good reproductive health.

The last comment that I make in opening is to reference - and we might provide the committee with copies of these later - three AMA policy documents. In Reproductive Health and Reproductive Technology 1998 - revised 2005, they say that it is important that there is an absence of stigma associated with reproductive health, including terminations. There is a position statement on health outcome equity, which I think is relevant and there is a third one which is about the ability of pregnant women to make decisions, which I think is relevant and important in consideration of the changes as well, and also the AMA Code of Ethics, the first of which says that the interest of the patients must come first.

That's a bit of a high-level summary of everything that is in our submission and I'd be happy to move into discussion if that is all right with you.

Mr VALENTINE - In your part 2 you say that after 16 weeks some additional criteria remain that may be seen as hurdles to access. Can you explain those sorts of hurdles that you see there and are you suggesting there should be no limit, if you are able to do that? I realise that it is a departmental submission.

Dr WHITE - There has been, as you are well aware, considerable debate about whether there even should be a threshold like that, and if there should be one, where it should

lie. We have taken a view that 16 weeks is a bit of a middle-ground approach. It's not as short as some would like and it's not as long as others would argue. You would probably have had some submissions from others, particularly obstetricians and gynaecologists about that. We thought that it was a pragmatic position to take at 16 weeks.

When we are referring to barriers beyond that, it's because you move then into the same model as you have now where you need to find two doctors who will support you. There isn't any other area of clinical practice or provision of healthcare services where such a scenario applies.

So the hurdles are practical ones, really, as well as anything which sets the process of termination apart from other clinical services will generate different perceptions and stigma about it.

Mr VALENTINE - It has been suggested by others that maybe it should be 22 weeks because you have the final scans or the 18-week scan that has been done. They are much more informed. The woman is more informed and indeed is able to make a more informed judgment.

Dr WHITE - I'm aware of that point of view. I'm not putting a case to extend to that. We have said 16 weeks is okay with us and I think I'm correct when I say that the main focus of this is to get the benefit for women in earlier stages of pregnancy. That's a greater priority than dealing with the later ones.

The later ones, even if it's 22 weeks, there are still going to be some hurdles and the numbers in that category - in that gap, 16-22 weeks - are going to be less than the numbers up to 16 weeks.

I guess I come back to saying it's a pragmatic cut-off. There is no law of physics, as such, that says 16 weeks is somehow different from 17 or 15. It is really a pragmatic assessment but it will get the benefit for the vast bulk of women where it is time-critical for them to make a decision and be able to act at the right time.

CHAIR - I want to pursue that matter for the moment. The 16-week versus any other time frame - Michelle O'Byrne, in her first draft, had 24 weeks and given that your submission indicates that you have provided a range of advice to her in formulating the bill and OPC, et cetera, what is the department's view about 24 weeks?

Dr WHITE - The 24-week position is based on that which was landed on in Victoria, which went through an exhaustive process of assessing the situation. So that was the basis of an original proposition that landed at 24 week.

That would certainly be acceptable to the department. We would have no exception at all, in fact we would support restoring the 24 weeks, but we would rather have it at 16 weeks than how it is at the moment, if that's the option.

Mrs HISCUTT - Just on that, Chair, would you say the 16 weeks has come about because of public pressure? Is that your reason? Why did you drop it to 16 weeks?

Dr WHITE - Cherie, do you want to comment on the process of consultation?

Miss STEWART - Again, I think it comes back to that sense of practicality about trying to get through legislation that would be an improvement on what we have.

Mrs HISCUTT - Do you think that 16 weeks came about because of public pressure?

Dr WHITE - I wouldn't call it 'pressure' because we don't feel pressured.

Mrs HISCUTT - So why did you drop it to 16 weeks?

Dr WHITE - Because our assessment was that that would have the benefit of lowering some resistance to the bill and it was seen as more important to decriminalise and to get the threshold to 16 weeks than to come in saying, 'We have to have everything or nothing', because we recognise that we live in the real world.

Mr VALENTINE - So it's the politics - the Lower House proves that.

Dr WHITE - Not that I am aware of, certainly none I have been involved with. You would have to talk to the minister about that.

Mr VALENTINE - That's fine, I understand you can't comment on it.

CHAIR - Yes, we could talk to the minister if she were prepared to come and talk to us. Ruth, on the same issue.

Ms FORREST - Do you believe there was perhaps a misunderstanding in the broader community, not to mention the public pressure, but termination of a pregnancy was actually illegal in this state, or if they got past that, they thought it was illegal after a certain point and things like that. There is still a perception out there that this 16 weeks, previously 24, was a point at which it became illegal after, and that is clearly not the case. Now it is legal and under this new legislation it is legal; it just changes where it sits.

Dr WHITE - Absolutely.

Ms FORREST - Do you think the 16 versus 24 weeks argument - and public or parliamentary or other pressure that might have come on - is a result of a misunderstanding of that?

Dr WHITE - I really do not have enough knowledge about discussions that took place to go to the heart of what you are rasing but I can say, based on reading the media and

listening to people on the radio and so on, that there is a lot of misunderstanding and indeed misinformation about what this is about, and this is something I think we struggle with more generally about trying to get the right messages out. That's why I thought it was such a positive thing that this committee has the term of reference to look at the proposed legislation which is looking at merely the changes and not revisiting something that was dealt with more than a decade ago - and we made that move then.

Ms FORREST - On the 16-week change of process, it has been argued particularly by the obstetricians, that it is unnecessary and there should be no cut-off or a change of process because as I understand it, usually after 14 or 15 and certainly after 16 weeks you would have the input of a obstetrician anyway and the procedure would be carried out in a medical facility that had the capacity to deal with that sort of birth.

Dr WHITE - If I apply a general principle of medicine, which is to ask if this would really change the outcome, I am not at all sure the outcome would be different whether it is one or two doctors, for the reasons you describe, that by that second half of pregnancy it is very likely women will be consulting an obstetrician-gynaecologist and I cannot imagine anyone other than and an obstetrician-gynaecologist even contemplating any sort of procedure involving termination at that stage. In terms of whether it will make a difference whether it is one or two doctors after 16 weeks, probably not. I think it is very unlikely that it will make any change, but if that gives people a sense of reassurance in the context of all of the proposed legislative changes, we are moving forward.

Ms FORREST - I do appreciate your comments that it is the only medical procedure requiring two doctors so you can have it, which is odd in a way. As you would be well aware, the detailed diagnostic scan done at 18 weeks generally is for the purpose of detecting significant foetal abnormality particularly, as well as other factors of course. Do you think that having the 16 weeks there, that means that the process changes at that point and becomes more difficult and there are more requirements and expectations - and particularly women from rural communities don't have easy access to that second health professional as easily because there may only be one doctor in town or whatever - will mean there will be push to push those scans back earlier with the risk of making poor decisions.? The contention that was put earlier today was that at 22 weeks or even 20 weeks, but it is still pushing it a bit, you are forcing them to make decisions very quickly without all the information, so if it was even 22 weeks -

Dr WHITE - It gives a little bit of space.

Ms FORREST - Yes, to have some time to reflect on the findings of the diagnostic ultrasound before having to make a decision where an unfortunate anomaly exists for the baby.

Dr WHITE - To be clear, my view is that 24 weeks would be better than 16. Sixteen weeks is acceptable and better than where we are now but 24 weeks would be better, for the reasons you outlined. It gives women a bit of scope to consider scan findings or other information that is provided to them, bearing in mind that the late-term pregnancies are the ones that almost invariably involve some sort of severe foetal abnormality or condition incompatible with life or a severe threat to the health of one or the other. These are not decisions that women take lightly and I believe it is important they have enough time to make it in the way they need and get the support and information they want. If they are from a non-urban setting, that all takes longer.

Mr MULDER - The current law makes no distinction at any stage of the pregnancy. Terminations for the mental and medical health of the child or the mother are the only considerations. Why was it felt necessary now to introduce a mid-term cut-off? Why do we need this particular period of time?

Dr WHITE - You are asking why wouldn't we suggest that it is just one doctor at any stage? I think it is a pragmatic move. We were not seeking to do anything that was able to be alleged to be radical. All we were proposing is something that was consistent with the outcomes in our jurisdictions, which seemed to be working well, and settled on a period of 24 weeks, but we've already discussed 16 versus 24.

Mr MULDER - Is there a greater risk to the medical or mental condition of the mother or the child in late-term abortions than early-term abortions?

Dr WHITE - It is very difficult to generalise because these are not things that women undertake lightly; we know that. Any risks need to be weighed up against the alternative. We know there are risks associated with continuing to term and of unwanted children; there is quite a lot of literature on that. There is also a lot of experience we have had, even in Australia, with the downsides of adoption. The recent work on forced adoptions shows that adoptions are not the perfect solution for everyone either. Whilst there are risks with any clinical procedure, they need to be assessed against the alternatives, which are that a woman proceeds to term, delivers a child and looks after it as an unwanted child, and there are some research studies that show that children in that situation have lower cognitive skills than others and some other research that shows it is not good for the mother or the child. There is also the adoption pathway, which doesn't work for everybody. It has its pitfalls as well.

Mr MULDER - We won't go into the questions about the rights of the unborn child, but with the abortions that are occurring in the state at the moment the clinics that are providing them are saying they do not do late-term abortions. That shifts around the 12-14-16-week mark. I am wondering how this legislation solves that problem.

Dr WHITE - Which problem?

Mr MULDER - The problem of not having the option of late-term abortions in this state.

Dr WHITE - My understanding is there are a very small number of late-term abortions which have been done in the last however many years in the presence of severe foetal abnormality; they are very rare. I don't think anyone foresees a situation where a provider of early-term terminations in a private setting will also become an appropriate clinical setting for a later-term abortion. It is a larger procedure and needs to be done in an appropriate setting, which is usually a hospital.

Mr MULDER - How many Tasmanian women, when you talk about the need to go to Melbourne or other places, are currently going to the mainland for a late-term abortion because that option is not here?

Dr WHITE - We have no way of knowing those numbers.

Mrs HISCUTT - There may be none.

Miss STEWART - We have qualitative evidence from the service providers to say it is happening for early gestations; I don't know about late gestations.

Dr WHITE - We do not know the numbers.

Miss STEWART - Certainly in Tasmania already those services are available in the public sector if there is severe foetal abnormality or the woman's health is at risk, so if they meet that criteria currently in the Criminal Code, so it is not quite true to say -

Mr MULDER - So the problem of women leaving Tasmania to access abortions in Melbourne in either early or late term just does not seem to be -

Miss STEWART - No, late term. Early term, we definitely do. We have the service providers. I am not sure if you are calling any here to give evidence because they are the ones who are directly dealing with the women. They have been telling us we are sending women off to the mainland. We have been accessing funding to be able to do that, so it is actually occurring.

Mr MULDER - It seems to me that one of the reasons being put forward is to avoid the necessity for Tasmanian women to have to go to Melbourne to access abortion. Yet what I am hearing from you and from the providers is that early-term abortions are readily available in this state; there is no need to travel to Melbourne to get them unless you wish to. The other point I hear is that late-term abortions are extremely rare, in abnormalities, and the public health system is already delivering them. What does that do to the argument about Tasmanian women having to leave the state to access abortion?

Dr WHITE - I think that is a fair summary for women who have the sort of access to income, freedom and support that most of our families and friends would have, but we know a lot of women in Tasmania are not in those circumstances.

Mr MULDER - Those who are not in those circumstances have access to the abortion clinics?

Dr WHITE - Not unless they can find $300 cash -

Mr MULDER - $300 cash?

Dr WHITE - Yes, and that is just for the procedure. They also have the transport costs, accommodation if they are coming from the west coast, so it really adds up.

Mr MULDER - So this is about trying to give the public health system the level of confidence to be able to perform abortions inside the public health system free of charge with Medicare rebates?

Dr WHITE - Yes.

Mr MULDER - The real issue there is providing access to cost-free abortions because the impediment is the cost.

Dr WHITE - Not only. It is removing disadvantage. Remember also decriminalisation and reducing the stigma for the health professionals for being involved in terminations in Tasmania - I think almost uniquely in jurisdictions. I had a difficult experience back in the early 1990s that have made people very wary here and I think until the law changed no amount of educational reassurance from people like me is going to change their view. It is a combination of things that will free up the public sector to consider what their responsibilities are, so it has the added benefit -

Mr MULDER - It is important to realise this is about freeing up the public sector to provide these services, not freeing up services per se.

Dr WHITE - No. The evidence from other jurisdictions is that they have not seen a significant change in the number of terminations carried out. We do not anticipate anything different in Tasmania. The numbers may go up a bit but I suspect that will be because of better access in Tasmania rather than having to go interstate.

Miss STEWART - The public health system may not be the service delivery system that comes to the fore in the new world of decriminalisation. It may enable other providers, instead of extending, they might come in and say, 'We can now come in and provide this service', so a brand new service provider. For instance Marie Stopes International might look at coming here. It is not just about changing this law is so that the public health system can suddenly accommodate more. It is about removing the decriminalisation aspect, which is a very significant deterrent to doctors not wanting to be -

Dr WHITE - Nurses too.

Miss STEWART - Exactly. It is about removing that as a deterrent and that will then free up the space for innovative ideas and new providers to come in, if needed.

Mr MULDER - But in terms of the capacity to deliver that service, early-term terminations, it is already here. We have three service providers in the state who do private clinics, and will tell you that they have a capacity to do more because they are only down here one or two days a week. All this does is perhaps remove a few legal scruples of a few additional practitioners. It is not a question of demand versus supply.

Dr WHITE - We are not trying to change the number of terminations. We are trying to make the pathway a little bit easier for women who are making a difficult decision to be able to have a medical procedure carried out, and also to have their care providers, the doctors and nurses looking after them, a bit less distracted by worrying about a threat of criminal prosecution.

Mr MULDER - That is my point. The only real impediment there is the fact that access to those terminations is available from doctors who do not seem to have those concerns for early-term abortions. Yet the public health system already is catering for the rare but essential late-term abortions. It seems to me that we are running around here solving a problem that does not exist.

Miss STEWART - Looking at it from the demand and supply perspective may not be the best way of looking at it simply because the exact numbers are not known. I recall in the Legislative Council briefing one of the service providers indicated that she cannot know the people who are not coming to her. Basically it is not about demand and supply as such, because there is very strong research from the World Health Organisation that shows that almost no matter what your laws are, women will still continue to seek termination. The question then is, knowing that is going to be the case, knowing that our termination laws do not affect the rates, how best do we then want to treat women who are trying to access?

Mr MULDER - I do not have issues with those but you keep trotting out these arguments like there will be no more abortions. Who at the moment is not getting an abortion who would have wanted one?

Miss STEWART - To clarify that, the number of women having terminations will not increase through this bill. The number of women having terminations in Tasmania is likely to.

Dr WHITE - It may well increase, but it is not as simple as reducing it to will there be more or less. We are also concerned from a health perspective with the experience of the women going through it, as well as what it is like for the providers. From the fact that there are so few providers in Tasmania, there are people who are prepared to take the risk. We are saying that we do not think it should be necessary for them to

be risk-taking, exposing themselves to an allegation of doing something wrong which brings into play the criminal justice system, for a medical procedure. It needs to be looked at in that context, not merely can women get it now. Yes, they can but I could get a beautiful new watch by breaking the jewellery store window and putting my hand through but there are implications and consequences of that.

Mr MULDER - That is not a very good analogy unless there are people in there who are getting watches that way already without retribution.

Dr WHITE - Well, I was hearing about the world's biggest-ever jewel heist, so I think that is why it was in my head, $135 million worth. It really is more than just will there be more or less and what they can do now, it is about the experience of people that we think is important, making such a decision as undergoing a termination.

Mrs HISCUTT - To clarify a few points, you were talking about the abortion provider who came to us last time and said things like, 'You don't know what you don't know'. She also categorically said there was no waiting list; there was no patient who came to see her who she was not able to service. You talk about the remote areas. If this bill goes through, does that mean a person in Queenstown will be able to have an abortion in the Queenstown Hospital with the local surgeon at the cost of Medicare? Do I understand that as when you are saying 'able to help remote people'? You keep saying it is going to help remote people, but how is it going to help remote people?

Dr WHITE - The changes to practice are likely to happen over time, as the information percolates through. There may be some early adopters; I don't know the doctors in Queenstown so I couldn't say but certainly -

Mrs HISCUTT - But legally speaking, this is what would happen?

Dr WHITE - If from a clinical practice perspective, provided you have someone who has appropriate skills to undertake the procedure and do the anaesthetic and perform safe resuscitation in a properly licensed setting like a hospital, yes, it could happen, but I don't anticipate that the landscape will change overnight.

Mrs HISCUTT - Yes, but when you keep talking about helping remote people, is this an example of how it will help remote people?

Dr WHITE - The way that it can help remote people is having to access one less doctor. It may over time be possible that that person can access services in Burnie, which they can't currently do, rather than having to go to Launceston, Hobart or Melbourne. The provider who was here I think also said that sometimes women have to wait a couple of weeks. I suppose when they ring to make up an appointment we don't know how many more say, 'I can't wait two weeks, I'll pawn my watch' - there's that watch again - 'that expensive watch and take myself to Melbourne.'

Mrs HISCUTT - Is the general aim of the bill that in time a person in Queenstown could access an abortion in that hospital under the proper procedures?

Dr WHITE - Proper clinical frameworks.

Mrs HISCUTT - In that hospital with a doctor under Medicare? Is the aim to make it easier for these remote people? Is this the aim?

Dr WHITE - In the new governance of the health system in Tasmania the providers are now separate organisations and the department has the role of system manager. The department would go through a process of looking at need for services, where they should be provided, and building it into any purchasing frameworks. That is from a DHHS point of view. A private practitioner could certainly do everything you say, absolutely, and I think it is pretty evident at this stage of your discussions to know that it is more likely to happen under the proposed new legal framework than under the current one. That's why we're saying it's a good thing to decriminalise it.

Ms FORREST - On that point, using Leonie's example of the Queenstown services where they do not have an obstetrician - they have a visiting obstetrician down there - but with medical progress in this area and putting RU486 on the PBS, there may be opportunities for women in more remote areas - not just in Tasmania, but Australia generally - to be able to be provided with that very early in the pregnancy so they don't have a need to leave the area, and that would be a benefit and a much safer approach than having to have the surgical procedure.

Dr WHITE - With the option of medical termination, which is becoming more available, albeit with its own hurdles and barriers in place to ensure safety, that is one of the ways terminations will be more available across the state, wherever you are.

Ms FORREST - To clarify what I heard you say - and please correct me if I am wrong - it seems as though you were saying this wasn't the purpose of the bill but a potential benefit and consequence of removing it from the Criminal Code. In my youth working in the area, we used to do terminations in the public hospital system.

Dr WHITE - They did when I trained, too.

Ms FORREST - But even at that time the medical staff involved were sometimes vilified by other staff who either held a conscientious objection or because they thought they were doing the wrong thing because they didn't believe it was appropriate because it was in the Criminal Code. Speaking to some of the doctors involved back then, some who have since retired, they are very supportive of this because they see it will enable it to happen in the public system, as it did before, with much greater respect for the staff involved but also for the women. Do you see that happening?

Dr WHITE - I believe that is consistent. I don't think anyone wants to limit people's private views or how they see things. In a professional setting I think it's absolutely

paramount that the needs of patients are met and all professionals have a responsibility in regard to how that happens.

Ms FORREST - If there was to be a late-term termination - it is very rare, but it could be a baby that didn't have a gross foetal abnormality - that would have to be undertaken in a maternity unit, so it wouldn't only be the doctor who would have to be happy with it, you would have to have staff to support it.

Dr WHITE - You can't do it on your own. It's teamwork, as you know, in any clinical setting, so you'd need nurses and midwives who feel comfortable about it. It's a really big thing because you even have to work out which hospital you're going to put someone in because you can't expect them to come back from a procedure like that and be in a bed next to a woman who's just had a baby and is happy about it. You have to do all these things very sensitively. It isn't just the women who are upset, it is the staff, too, if it's not done well.

Mr MULDER - That raises an interesting point to me. We keep saying this is just another medical procedure but we know it's not. People have to feel more comfortable with it than they do with other medical procedures. This is a special kind of medical procedure and I think that point sometimes gets lost in people saying, 'It's just another medical procedure'. It's a special kind of medical procedure for a number of issues.

Dr WHITE - Consistent with my last comment, I beg to differ. I think it is just another medical procedure, it's just that different people have a range of views about it and tend to judge it in ways they don't judge other medical procedures. I don't think it's the procedure itself that is so different -

Mr MULDER - But there's the stigma that attaches to it, which is the taking of a life - that's the issue.

Dr WHITE - That's because of how people think about it.

CHAIR - I have a couple of indications from members lined up with questions, so I think we will have to have you back, Craig.

Ms WHITE - I am happy to come back.

CHAIR - Thank you.

THE WITNESSES WITHDREW.

PUBLIC

ROBIN BANKS, ANTI-DISCRIMINATION COMMISSIONER, OFFICE OF THE ANTI-DISCRIMINATION COMMISSION, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Robin, thanks very much for being here well and truly on time. We don't need to explain to you the matters of parliamentary privilege because you are well versed in that. Thank you very much for being prepared to jump into this timeslot, because it gives us an opportunity to keep progressing the matters rather than have a vacant spot for the day. We certainly have your submission and we are more than happy for you to speak to it for a limited time and then we will proceed to questions.

Ms BANKS - Thank you very much, Mr Chair, and to the committee for the opportunity to make a submission to the inquiry and also to have the additional time to put that in after my return and to provide evidence today.

Reform to the way in which pregnancy terminations are regulated is overdue in Tasmania. It is an issue that particularly impacts on women such as to disadvantage them and their access to adequate and appropriate healthcare. As such, it is a discriminatory impact but not one that is able to be addressed under the Antidiscrimination Act because of limits on the act.

In addition to having the effect of disadvantaging women, it particularly disadvantages women on low incomes, women from non-English-speaking backgrounds and those from more rural and remote areas. Again, those are not areas that can be readily addressed under antidiscrimination law because they don't fit within the scope of the law. Those disadvantages flow from the current significant barriers to the availability of pregnancy terminations locally and in the public health system. The fact that a person may need to go interstate or to access a private clinic certainly disadvantages women on low incomes and those who find it difficult to travel to the major urban areas.

The bill seeks to remove the potential of criminal prosecution of women and of medical practitioners but particularly of women who seek to have their pregnancy terminated and, for practitioners, those who perform terminations in accordance with the proposed law. The way in which the bill is drafted I think seeks to find an appropriate balance between two very important human rights: the right to enjoy the highest obtainable standards of physical and mental health and the right to freedom of thought, conscience and religion. In my view, the bill has achieved that balance. It's a fine line but I think it has achieved it.

The right to enjoy the highest obtainable standards of physical and mental health includes sexual and reproductive health and the Convention on the Elimination of All Forms of Discrimination Against Women, to which Australia is a party, recognises reproductive self-determination; that is, the right of women to be autonomous in decision-making that affects their own bodily integrity. Relevant

United Nations committees have held that restrictive abortion laws breach a number of human rights of women, including the right to life, because of the risk to women arising from unsafe abortion, and the right to equality.

The countervailing right, the right to freedom of thought, conscience and religion, requires that a person should not be subjected to coercion that would impair a person's freedom to have a particular belief. The freedom to manifest one's beliefs may, however, under international law, be subject to limits set out in law that are necessary to protect health and the fundamental rights and freedoms of others, including that right to health. The right to enjoy the highest obtainable standard of health is not subject to similar limits.

Through clause 6 the bill provides that a person who has a conscientious objection to terminations does not have a duty and is under no other legal requirement to participate in terminations, whether prior to or after six weeks of gestation, other than in a medical emergency. As such, the right to freedom of thought, conscience and religion to that extent is recognised and is only subject to a limit in respect of emergency medical care. What the bill does require is referral where a medical practitioner or a counsellor has a conscientious objection; that is, referral to another medical practitioner or counsellor who does not have that same conscientious objection to terminations.

This approach of requiring referral has been considered in other jurisdictions in terms of whether or not it cerates and unjustifiable or illegitimate limit on the right to freedom of thought, conscience or religion. The United Nations and other international bodies have consistently found that it is not sufficient in order to protect the right to health to simply criminalise abortion. It may also be necessary to place a duty on medical practitioners to facilitate access to accurate information about the termination of pregnancy. This does not mean having to provide that information themselves but has been found to include a duty to ensure that a pregnant woman is referred in a timely way to services that will provide the information and potentially services sought.

I note also that the bill has an effect on people engaging in public protest, and I did not address that in my submission but I briefly touch on it. It does affect people seeking to engage in protest about pregnancy termination and limits, through the bill, how and where such protests may be conducted. Clause 9 of the bill makes it an offence to engage in a prohibited behaviour within 150 metres of premises at which pregnancy terminations are provided. 'Prohibited behaviour' is defined quite extensively and includes, relevantly, harassing or intimidating another person, protesting in relation to terminations and recording a person attempting to access the premises.

While this provision has an impact on a person's freedom to manifest their views, it does so to the extent necessary to protect the right to the highest attainable standards of physical and mental health and also the right to privacy. There is quite significant

material available where the United Nations has considered what effect criminalising and other behaviour that makes a woman feel bad about seeking information or a termination has on mental and physical health and that is it an unnecessary infringement, but there is also consideration given to the right to privacy and the fact that filming a person attending a clinical hospital would be likely to be a breach of the right to privacy at international law.

The passage of this legislation, if it occurs, will remove a continuing and significant inequality for women in our community. The maintenance of the current situation has the effect of criminalising certain reproductive health decisions made by women and undermines women's decision-making autonomy in respect of their own reproductive health.

CHAIR - Thank you very much, Robin. The matters you address with regard to disadvantage in accessing terminations, do they go specifically to the current provision which requires the opinion of two doctors, whereas the proposed change is abortion on demand up to 16 weeks? Is that the only area of disadvantage which you see?

Ms BANKS - I don't think it is as narrowly constrained as that. I think it's the overall impact of accessing abortion being criminalised conduct at the moment. If you remove that and put it into the proposed framework I would anticipate - and it has been the case elsewhere - that there is greater willingness to provide information and the medical procedures at a broader range of healthcare providers, including public hospital and elsewhere. There is less need for a women then to go to a private clinic or interstate to access the same healthcare services. Criminalisation has a stifling effect. People are afraid of being prosecuted and there have been prosecutions, not so much here but interstate, where people had anticipated it wouldn't happen and then somebody was prosecuted which then makes everybody afraid. Even people who have been operating well within the law and the current restrictions become more fearful of the consequences of participating in terminations. So it's a broader impact than just the difference between the 16 weeks or not. The fact that it is within criminal law has a particular effect on people's behaviour.

Ms FORREST - Robin, I assume you are probably aware that on the north-west coast, the west coast and probably the north-east, you cannot access a termination at the local hospitals there currently under the public health system. There was an expectation when we talked to the department earlier today that this would reinstate - because we used to do them a number of years ago - that capacity for them to be conducted there making it more accessible. Is that another aspect?

Ms BANKS - Yes. My understanding is that that change occurred because of some agitation around the basis on which people were able to access terminations prior to the removal of that option and a concern that perhaps somebody would be prosecuted, even though they thought they were acting within the letter of the law. I

think it really is about ensuring that people understand they are not at risk of criminal prosecution as a result of it being removed from the Criminal Code in that way.

Ms FORREST - But under the health regulation that every other medical procedure is dealt with.

Ms BANKS - Yes, and that's where it belongs. It's a medical procedure and should sit within the scope of medical procedures.

Mr MULDER - The fact is that in the private sector abortion must be relatively freely available as there are a number of them happening, so why is our public hospital system not prepared to do what the private medical practices in the clinics are? What is the impediment?

Ms BANKS - I can't answer that; I think that is a question for the health department. I guess I would challenge the use of the words 'freely available' because private clinics require the capacity to access them.

Mr MULDER - Readily available rather than freely.

Ms BANKS - If there is a private clinic in your local area, if you can access a referral and can afford to go to that clinic, then I guess it is readily available, but given the economic situation of many people and the fact that the rate of teen pregnancy in this state is quite high, I suspect 'readily available' is not the way they'd describe their access to private clinics.

Mr MULDER - We're talking about this bill improving access for women who are suffering disadvantage at the moment, yet we constantly hear that we're not expecting any more terminations in the state as a result of this legislation. The two seem to me incongruent.

Ms BANKS - I don't know if it means there will be a change. I suspect there would be because history has shown that better access to reproductive health information and decriminalisation of abortion tends to result in better reproductive health more generally and that includes a reduction in abortion. I guess it's an odd outcome, but I suspect it is what is likely.

Mrs HISCUTT - Sorry, did you say a reduction?

Ms BANKS - A reduction, yes. I think it's because it then takes the stigma out of the full range of reproductive health choices.

Mr MULDER - On the point about the public health system not doing what the private health system is, if the current law is only designed to improve access it is a question of sitting down with the health department and saying, 'Why aren't you doing what the private health system is doing?'.

Ms BANKS - I think that's a valid question to ask the public health system. I can't answer it.

Mr MULDER - We have, and the result was, 'We don't expect any more terminations', which leads us into this quandary about if the bill is designed to give more people access but we're not expecting more people to access it, what is it about?

Ms FORREST - They didn't say not more terminations per se, but the ones who go to Victoria now wouldn't need to go to Victoria. That's what Craig was saying.

Mr MULDER - Yes, so these socially-disadvantaged people who can't afford to travel to the clinic in Launceston or Hobart are travelling to Melbourne? I'm just not quite sure whether that just means it is more expensive for them to access it in Melbourne than it is here.

CHAIR - The point is that for this part Robin cannot answer that.

Mr MULDER - We have had this thing about it being discriminatory or disadvantageous to all these women, yet whenever you probe in there - I am struggling to see where the disadvantage in the current arrangements lie?

Ms BANKS - I think there is the disadvantage in terms of cost and all the rest of it, but there is a broader equality issue that has been addressed extensively in international law, which is that placing a criminal sanction on women's reproductive health decisions treats women differently to men and, as such, it is an inequality issue much more broadly than simply whether it costs more or less, or the additional disadvantage that applies where women may not have access to private clinics.

Mr MULDER - But the current legislation does not provide any criminality to a woman's management of her own reproductive health.

Ms BANKS - It does.

Mr MULDER - In what way?

Ms BANKS - By making accessing an abortion potentially a criminal act.

Mr MULDER - But the current legislation allows for lawful abortions.

Ms BANKS - Under limited circumstances.

Mr MULDER - But taking that out of the Criminal Code and putting it into another piece of legislation does not reduce its criminality, it just changes the name of the act it is under. It is still a crime to have an illegal abortion.

Ms BANKS - But it won't be subject to -

Dr GOODWIN - The woman won't be subject to any proceedings, though.

Mr MULDER - That is fine, I am talking about the medical practitioners in public hospitals who are reluctant to perform these operations. We assign the fact that if it is not in the Criminal Code it does not have criminality, and that is not a fact. The fact is it is an offence against the state of the law, no matter which act it appears in.

Dr GOODWIN - I don't think it will be. I think it will only be an offence without the woman's consent.

Ms BANKS - That's right, or somebody other than a doctor performing it.

Mr MULDER - But that is the case today with the other qualification that it has to be with the other two reasons. My point is that taking unlawful abortion out of the Criminal Code and putting it into another piece of legislation does not reduce the criminality of unlawful abortion.

Ms BANKS - But it does for women. This bill removes the criminality -

Mr MULDER - Not for unlawful abortion.

Mr VALENTINE - A women accessing an abortion can't be prosecuted.

CHAIR - We won't have a debate on our side of the table as to the -

Mr MULDER - Thank you, Chair. The point I am trying to get at is that people say, 'We'll take it out of the Criminal Code and therefore it's no longer criminal'. That is not true.

Ms BANKS - My reading of the bill is that for the woman there will be no criminal event. For doctors, except where they perform an abortion without consent, they will not be subject to possible criminal sanction.

Mr MULDER - I am just getting to that point about the doctors. A medical practitioner who today performs an unlawful abortion is subject to criminal sanctions as provided by the Criminal Code. If this legislation was to pass, the doctor would still be subject to legal sanction if he or she conducts an abortion without consent or, in the latter stages, without the other conditions in relation to the mental and physical health of the woman. If he conducts an abortion which is unlawful under the Criminal Code at the moment it would still be unlawful under the Reproductive Health Act, in which case you're not decriminalising it, you are simply changing the name of the statute under which it is penalised.

Ms BANKS - My understanding is that the only circumstances under this legislation whereby a medical practitioner could be prosecuted would be termination without consent or, as you say, if the circumstances are outside the 16 weeks.

Mr MULDER - In unjustifiable circumstances it would still be an unlawful thing. We are not decriminalising abortion -

Ms BANKS - I think we are to a significant extent.

Mr MULDER - We are not decriminalising abortion for the medical practitioner who still operates outside the law. That is still a crime, still an offence.

Ms BANKS - That's true, but what the bill changes is the circumstances in which it is unlawful and significantly reduces those circumstances.

Mr MULDER - But you're not decriminalising it.

Ms BANKS - Not entirely, no, but for women we are; it absolutely decriminalises it for women. I haven't addressed the question of medical practitioners because they're not protected by discrimination law or international human rights law in that sense.

Mr MULDER - I was still in the space about why our public hospitals aren't doing what the private clinics are.

Ms BANKS - I can't answer that.

Ms FORREST - Robin, you were talking about access zones and we have had it suggested that this is not working and whether the Police Offences Act is adequate; you are suggesting it's not and you have gone to some way to explain why you believe that, including recording the people by using a mobile phone or whatever to record someone approaching or entering a clinic. It has been suggested that that is not workable because it means you couldn't even have a security camera, for example, that the clinic itself might establish for the security of their staff and people accessing the clinic. Is that an issue?

Ms BANKS - It could be an issue. It certainly may need to be dealt with, it does talk about 'without that person's consent' and whether or not there would be some process of getting consent. Perhaps it should include a provision that says for the purposes of safety or security it would be permissible. At the moment, I suspect it may have that potential effect so that may be a problem.

Ms FORREST - We have talked a bit about how you can treat different parties differently and positive discrimination or discrimination that is acceptable in the circumstances. There has been some concern about the fact that under proposed subsection (7) of the bill, medical practitioners who have a conscientious objection and don't refer the woman to another service or medical practitioner, that there is no

sanction because that sanction will apply under the health regulation, whereas for the counsellors there is a sanction under this act. We've had previous witnesses who are legal experts to say that was because there was no regulatory framework for counsellors currently but they agree that it is discrimination - do you agree this is an issue?

Ms BANKS - It certainly treats medical practitioners differently from counsellors; is it discrimination in the technical meaning of my legislation? No, it's not because neither have specific protection, there is no ground engaged, there is no attribute engaged but you are treating one group of professionals differently from another group - unless, as it sounds like you may have had advice, there are equivalent sanctions somewhere else in relation to medical practitioners that do the same thing. I suspect it wouldn't be expressed as clearly as it is in this.

This raises a broader question and that is, where there is an offence set out in this legislation, who prosecutes it and in this one, certainly in terms of the prohibited behaviour it's clear that it's a police matter. It's not necessarily as clear in relation to the obligations on medical practitioners and I face this is my legislation; there offences under my act but I won't prosecute them and it's certainly something that does require some consideration.

Ms FORREST - You may not be able to answer this so feel free to say if you can't, as far as proposed subsection (3) goes with counsellors, whose responsibility would it be to impose that penalty?

Ms BANKS - I can't answer that. That's one of those things were legislation is often silent and that makes it difficult to in fact enforce it.

Mrs HISCUTT - To clarify it in my head, so it is potential that we are taking doctors out of the Criminal Code and potentially putting counsellors into it? Is this the potential of this?

Ms BANKS - Not into the Criminal Code but it's an offence under what this act will be rather than it wouldn't be in the Criminal Code. There are offences in a range of other pieces of legislation, including the legislation that I deal with.

Mrs HISCUTT - But you are not sure who would prosecute that?

Ms BANKS - Yes, that's always a question for things outside the Criminal Code: who prosecutes them?

Mrs HISCUTT - So it could be erroneous.

Dr GOODWIN - One of the issues that you address in your submission is around the rights of the unborn child because often that is raised in the context of termination so

I think it might be useful just to get a summary of what human rights instruments say about the rights of the unborn child, or an overview.

Ms BANKS - It has been considered extensively because it's not just an issue of contention here in Australia and Tasmania. Consistently in all of the international and multinational human rights areas the right to life is considered to commence at birth. The one exception is in the American system. There is a human rights framework for all of the Americas and they include from conception, but even there they don't say it overrides the right of the mother to reproductive health and her own right to life; it is a balance in that circumstance but consistently the right to life is held to commence at birth.

CHAIR - Leonie raised this matter yesterday with somebody else and you commented earlier, Robin, to the effect that restricting a woman's choice - I can't remember the entirely right words - but then you suggested that her freedom of choice is less than that available to men. What about the role of a male in this process of determining whether an abortion is appropriate? Do you see a role for the father of that growing child?

Ms BANKS - The way in which that question has been dealt with in international law, the woman's self-determination has been held to be the central question. Obviously, if she is able to have that conversation and consider it with the person who has fathered the unborn child, then that is a good thing but the consistent approach is that the father's view doesn't override the woman's autonomy.

Mrs HISCUTT - I believe there was a case in England where there was a man who had a court injunction to make his wife proceed with the pregnancy and then he took the child wherever he wanted. Doesn't that set some sort of precedent that fathers who wish to participate should have a bit of a say?

Ms BANKS - I'm not aware of the case you are referring to. I certainly had a bit of a look at that question because it always comes up. I guess the important question is: if we as a country have signed the treaties that say that autonomy of women in relation to reproductive health is a central part of their healthcare right and if we believe that, then nobody else should be able to say 'No, you have to carry this child to term', because you are then saying, 'Sorry, you don't actually have the autonomous right to be in control of your own reproductive health, somebody can require you to do something against your will'.

Mrs HISCUTT - There is no other way you can have babies except through your body.

Ms BANKS - Indeed there is no other way to have babies at this stage.

Dr GOODWIN - It's a dangerous precedent to have set if that is the case that proceeded down that path. Sorry, I'm making a comment here. To force a woman to carry a

baby to term surely you would think would have potentially serious mental health consequences on her.

Ms BANKS - Yes, and there are certainly cases that talk about those and economic consequences and potentially health consequences. You don't know what's going to happen during childbirth; it is still quite a dangerous thing to give birth to a child.

Mrs HISCUTT - I'm not saying it should be in this bill but it is a consideration for future use because I have seen fathers in tears over this.

Ms FORREST - Robin, taking you to clause 3 of the bill, which is the interpretation section. It has been raised it's more at looking at the later-term abortions, particularly beyond the 16-week period. It says in the bill that 'terminate means to discontinue a pregnancy so that it does not progress to birth by -' and there are three things there. There is some concern about saying 'to birth' as it sometimes indicates you potentially have a viable baby and the termination occurring at a stage where potentially it could be resuscitated if there is not a condition that is incompatible with life. It has been suggested by a couple of people in the legal profession that removing at least the words 'to birth', or perhaps 'so that it does not progress to birth', would not diminish to interpretation of 'terminate' and makes it clear that we are just talking about ending a pregnancy. The inclusion of 'to birth' indicates a more live, viable baby because of that terminology, and we do not define birth. You might not have addressed your mind to that.

Ms BANKS - I have not. It seems like it would be an amendment that would not cause a problem, but you always need to double-check everything else in the bill; that would be the only concern. It is something that might be useful for committee to get some advice on.

Ms FORREST - I read your submission on page 3 regarding parts of the Convention of the Rights of Children, including article 1 where a child is referred to as a human being below the age of 18, and article 6 recognises every child has a right to life. While it applies exclusively the children unless a major revision of the definition of child is adopted were expressed, provisions are included to extend rights to the foetus, some jurisdictions such as Ireland and Argentina have done. Reference to a child is recognised as being a human being from birth to 18 years.

Ms BANKS - Yes.

Ms FORREST - I understand that in Ireland there was a recent case - and they are reviewing the legislation over there, I believe - where a woman died as a result of being unable to access a termination. It was well publicised and well described in articles because the law was that a termination was unlawful. She died as a result of not being able to have one, when she clearly needed to have one.

Ms BANKS - That has been a well-publicised case. We do not hear about that situation arising very often in Australia, but we have that concern about ensuring that a woman is not forced into a situation where here own health is so compromised, including to the point of death, by not having access to both the information they need and to the appropriate medical treatment. I think it is important that we get that right, that we understand a very significant part is about protecting the health and reproductive health and mental health of the women involved.

Mr VALENTINE - With regard to conscientious objection to terminations, it may be that a doctor does not have a blanket conscientious objection to certain aspects of termination. Do you think this bill is descriptive enough in that regard? It might be that a doctor has a conscientious objection to maybe late-terms abortions but not earlier abortions, pre-22 weeks or something like that. Is this too prescriptive in that regard?

Ms BANKS - At the moment the legislation is relatively open to interpretation. I hope that would be interpreted to mean the relevant conscientious objection of the person at the time, not saying that was not a conscientious objection as we understood it. I would hope that we would interpret in an open way. The minute you start trying to cross every 't' and dot every 'i', you potentially import -

Mr VALENTINE - Introduce other aspects.

Ms BANKS - Yes, other aspects that are problematic. It is important to try to keep it open to interpretation that may develop over time. The other thing is a question that I suspect only really arises because of the word 'refer'. Some of the concerns raised with me are that this has a particular meaning for a doctor and it is quite a formal thing, so if I have a conscientious objection to doing this, a formal referral may feel too close to facilitating a termination. I guess the question becomes does that need to make it clear it is not formal referral in the medical sense, but referring in the sense of providing information about other services that may be available.

Mr VALENTINE - Do you see the department possibly playing a role providing information that the doctor can simply pass on?

Ms BANKS - That certainly would be a way of facilitating that referral that minimises the impact on the conscientious objector.

Ms FORREST - A witness yesterday said that the terminology in the Victorian legislation is 'effectively refer'. Many doctors have spoken to me about their concern about the word 'refer' being generally a formal process referring a woman for a particular course of action, but 'effectively refer' provides an effective referral, though you might need to define what that is.

Ms BANKS - It is important that people not understand it to mean a formal medical referral in that sense. How you achieve that may be through it being on the record in

the parliamentary process so that if there is a need for a court to have reference to interpretive materials it can do that. It may be that you need to define 'refer' in the legislation, a bit of a tweak to say this does not mean formal referral for a specific procedure.

Ms FORREST - For further information.

Ms BANKS - Yes.

CHAIR - Robin, thank you very much.

THE WITNESS WITHDREW.

CLINICAL ASSOCIATE PROFESSOR BOON LIM, DIRECTOR OF OBSTETRICS AND GYNAECOLOGY, THO SOUTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Dr Lim, thank you very much for appearing before the committee and also for your written submission. You are probably aware of parliamentary privilege extended to you as a result of appearing before this committee. You are protected by parliamentary privilege in the evidence you give here. None of that can be challenged or lead to prosecution of you by anybody who might feel aggrieved by anything you say. However, if you are going to speak to the media or anybody outside about your contribution to this committee we would suggest you exercise caution because outside here you are not protected by parliamentary privilege.

Prof. LIM - Thank you for giving me this opportunity to address this committee. As you can see from the submission that I and my colleague Professor John Daubenton submitted on behalf of the Women's Adolescent and Children's Services, Tasmanian Health Organisation South, we have responded to the Reproductive Health (Access to Terminations) Bill which has been passed in the House of Assembly. We welcome the proposal to change access to termination to a reproductive health act rather than under the Criminal Code, because it gives doctors certainty in a situation where termination of pregnancy is to be considered, rather than being under the Criminal Code where the doctors will consider that he or she may be under disadvantage and worry about being prosecuted.

We have addressed some of the areas that have been highlighted in the proposed bill and any such termination will never be performed without the consent of the woman in conjunction with the doctor assessing her situation, unless there is a life-threatening situation facing the mother, in which case consent may not necessarily be obtained and the doctor has to make that judgment, usually in conjunction with a colleague in the same profession.

We welcome the fact that there is an exclusion zone for premises that carry out terminations. In particular, we highlighted the fact that the gestation cut-off was suggested at 16 weeks. We feel the majority of terminations - and I stress, the majority of terminations - are carried out in gestations below 14 weeks and the number of terminations carried out after 14 weeks, and certainly 16 weeks and beyond, are very small. I don't have the figures but I know from Victoria it has been shown the numbers are significantly smaller than those below 14 weeks. At the Royal Hobart Hospital we carry out a limited number of terminations and these are mainly for mothers who carry foetuses with significant abnormalities where they would either not survive the rest of the pregnancy or, if born, would have a significant handicap. These are the main group of women who have terminations. If the pregnancy was already beyond 23 weeks or if there was any doubt as to the indication of a termination we would carry out a termination review panel before we offered a termination to the woman.

Ms FORREST - Are the ones you conduct at the Royal generally after 16 weeks once there has been diagnosis of a severe foetal abnormality?

Prof. LIM - Once there is a diagnosis. They can vary from 14-15 weeks to 20 weeks or so.

Ms FORREST - With the main diagnostic scan at 18 weeks you are more likely to pick up things that have developed. How else can you pick up a hypoplastic left ventricle, for example?

Prof. LIM - That is usually from the 18-20 week scan. We usually would wait for a complementary scan as well. We do not base it on one scan to make a firm diagnosis necessarily. Sometimes we seek a second opinion from colleagues in another tertiary centre, such as Melbourne, or we have a review. We have what we call a 'perinatal management group', where we have clinicians reviewing each of these cases before we are confident there is a diagnosis.

Ms FORREST - You acknowledge you would generally wait to confirm, particularly with something major like that, until the diagnostic scan at around 18 weeks. I accept the numbers are small but, as your submission suggests, why would you want to look at reducing the time for a woman's consent with one doctor from 16 weeks to 14 weeks rather than putting it out to after 18 weeks? The majority of other evidence has been 23-24 weeks. That is the period where the indications are most clear. The very early ones you talked about are done well before 14 weeks anyway, there are some women who don't know they are pregnant for a variety of reasons, and there are those who have foetal abnormalities detected and confirmed at 18 weeks. Why would you want to bring that back rather than take it out to 22 weeks, say, to give women time to get a confirmation of unfortunate circumstances with their baby and have time to make that decision with their consultant at the time?

Prof. LIM - Some of these abnormalities are not necessarily diagnosed on scans, some would have had an invasive test at 13 weeks - and we would get the result at 14 weeks. Some are diagnosed earlier than 18 weeks.

Ms FORREST - I accept that, but even if they have the CVS at 13 years and get the result at 14 weeks you're saying you want to take it back to 14 weeks, which gives them no time to think before they have to go through another process of having another doctor sign off through that process. It makes it more challenging, I guess. The woman has to justify herself to another doctor when clearly it is unequivocal with a CVS, for example -

Prof. LIM - Yes.

Ms FORREST - I still struggle with this idea that you want to bring it back to 14 weeks.

Prof. LIM - Because the majority of these terminations are carried out at 12 to 14 weeks under the clause where it affects the maternal mental health - that is the group we are talking about - the group of women with lethal abnormalities or chromosomal abnormalities will invariably be, as you said, diagnosed from 13 or 14 weeks. In our set-up it is not difficult to access doctors to assess the situation.

Ms FORREST - You are in Hobart.

Prof. LIM - Yes.

Ms FORREST - What about the women on the north-west coast?

Prof. LIM - Invariably their diagnosis would be made; we provide prenatal diagnostic services. We get the majority of the referrals.

Ms FORREST - Do they still have the CVS up on the coast?

Prof. LIM - No more.

Ms FORREST - They don't do them any more?

Prof. LIM - No, they don't do them any more. We do all the CVSs down here.

Ms FORREST - They still do the 18-week diagnostic scans up there, though?

Prof. LIM - Yes, but they still send them down for confirmation. We run the high-risk clinic where they send all the people with abnormalities down for confirmation.

Ms FORREST - By that stage they're well past 14 weeks.

Prof. LIM - Yes.

Mr VALENTINE - Has it been suggested that if it goes too far out it is actually lengthening the period of their trauma, is that what you're saying, after 14 weeks?

Prof. LIM - Yes, obviously if the diagnosis has been made, clearly there's a degree of distress that will be associated with the condition, and the mother obviously and indeed the family are distressed by the diagnosis.

Ms FORREST - That is my point, doctor. When you go to the next criterion to get the approval of two doctors as opposed to one, who clearly has the capacity to say this is a lethal condition or the mother's condition is such that she requires a termination for her own health and wellbeing, I find it hard to understand why you would want to put that imposition so early in the pregnancy for that woman.

Prof. LIM - Again, not all the so-called lethal abnormalities are necessarily lethal. For instance, not all Down Syndrome babies will be born lethal. That is where the checks and balances come in, if you like, where two doctors have clearly counselled the woman and gone through the whole process, discussing options with the woman in terms of the diagnosis and what the long-term prospects are like. That is where I think it is useful for doctors to give an opinion.

Ms FORREST - I agree it is useful and generally it would happen in practice all the time because you often get a paediatrician involved at that point to explain to the woman.

Prof. LIM - That is right.

Ms FORREST - So why do you need to require, according to your submission, women once they get to 14 weeks to have to go through that process with two doctors compulsory when it may be they only need one. With Down Syndrome I agree, you get the paediatrician in talk to about it, but for something else it might be a maternal condition that warrants a termination as opposed to a foetal condition where the paediatrician is no use at all in that regard.

Prof. LIM - Another obstetrician can be called upon to provide that support. It also applies to women where there is no medical emergency, if you like, so it could be a group of women who get distressed simply because they can't cope with the pregnancy. That is where I think the professionals feel that they need to be sure they are helping the woman in the right direction with another opinion from another colleague.

Mr MULDER - You are suggesting it comes back to 14 weeks and I notice in the Victorian Law Reform Commission report that in the public sector it seemed that the screening abnormality testing was delayed until 18 to 22 weeks gestation for the public patients using the public system and I am wondering whether that applies here as well?

Prof. LIM - No, we offer what we call the first trimester screening from between 11 and 14 weeks.

Mr MULDER - Your request to bring it back to 14 weeks basically doesn't allow you any time, does it, to consider the options? For example, if someone comes in at 14 weeks for the first trimester screening and then discovers an abnormality they have to within the next five minutes make a decision as to whether or not to abort.

Prof. LIM - Yes.

Mr MULDER - Wouldn't you think that 16 weeks would be a better proposal, given the fact that you do the screening at 14 weeks?

Prof. LIM - I think in practice whether it is 14 or 16 weeks we always give the women and the family time to consider the diagnosis, consider the implications and the opportunity to speak to another person as well. In practice it hasn't really been a problem in terms of time scales.

Mr MULDER - Do the risks to the pregnant woman increase the later the termination or doesn't it make much difference?

Prof. LIM - There is a difference before 12 to 14 weeks. There is a different way to termination can be carried out. Beyond that, the majority of terminations are carried out as a medical means. Therefore any time from 14 weeks onwards the time difference in terms of the actual physical -

Mr MULDER - So we are talking about a chemical termination versus a surgical termination after 14 weeks, is that what you're saying?

Prof. LIM - Yes.

Mr MULDER - Does the surgical termination have more risk then the chemical one?

Prof. LIM - The surgical termination has more risk, yes, in the second trimester.

The final bit actually is more relevant to us. Because most of the terminations that have been carried out at the Royal are for foetal abnormalities, we feel that should be a clause that allows for that to be recorded because we think it is important that we know the exact reason for the termination. Under the clause where it has an impact on the mental and physical health and wellbeing of the mother, but where serious abnormalities are concerned if there is no such clause we may not be able to know what the true picture is.

Ms FORREST - Can you clarify what you mean by that?

CHAIR - We will go to that with some questions, I think. In terms of your presentation, have you just about concluded because you were getting to the end of your submission anyway?

Prof. LIM - Yes.

CHAIR - Let's stay with that because it is right there in front of us. Your submission sets out that whilst currently there is the requirement to take account of greater risk of injury to the physical or mental health of the pregnant woman in reality at the Royal you perform terminations for severe foetal abnormalities.

Prof. LIM - In the main, yes.

CHAIR - In the main. I take it, then, that you link that medical condition of the foetus to the likely impact on the mother's mental health to then fit within the law?

Prof. LIM - Yes.

CHAIR - Is that a reasonable linkage or are there concerns amongst doctors that at some stage if that is challenged that linkage might not be strong enough to have supported the termination?

Prof. LIM - Well, yes, clearly because as I said in the submission when a woman carries a baby with severe abnormalities, the impact on her mental wellbeing is significant, as is the impact on her family. Therefore we currently link the reason to support termination is to consider her mental wellbeing.

CHAIR - Yes. Is there any anxiety as to the legitimacy of that link amongst the medical profession?

Prof. LIM - In some cases there can be and that is why sometimes we convene a termination review panel to ensure we have considered all the options for the woman. In the current situation where it comes under the Criminal Code, people do get very uncomfortable.

CHAIR - Clearly, the strength of your submission in that regard is that, to put it beyond doubt, you have suggested the inclusion of those words towards the end of those words towards the end of your submission so that is a clear, defensible reason for proceeding with an abortion or severe foetal abnormality.

Prof. LIM - Yes.

Mrs HISCUTT - Would that inclusion we have just spoken about prevent abortions of non-handicapped foetuses, in your opinion? How would you go down the path of a woman who had mental problems who was affected by a baby she did not want, even though the baby was, in your opinion, a healthy, non-abnormal baby? Is this what you were hoping this clause you want to put in would achieve, keep the abortions to severely handicapped or abnormal babies and not others?

Prof. LIM - That would be point 5 that was alluding to in the situation where the baby is perfectly normal but the mother is distressed by her pregnancy and if it is beyond 14 or 16 weeks, wherever the cut-off is determined, one doctor might feel uncomfortable about necessarily supporting her request or would seek an opinion from another doctor to make sure that request is reasonable.

Mrs HISCUTT - If this bill is passed as it is, do you feel you would then not need to have a review panel, it would just need to fit the criteria of two consenting doctors?

Prof. LIM - Purely from a professional point of view, we would still, in some cases, want a review panel.

Mrs HISCUTT - How many would be on your panel normally?

Prof. LIM - It is convened by the chief executive board and director of medical services with an obstetrician, paediatrician and an off-site person not directly involved with the case.

Mrs HISCUTT - So at least four people?

Prof. LIM - Yes.

Mrs HISCUTT - Is that review panel peculiar to the Royal Hobart Hospital or is it normal practice throughout hospitals in Australia? What do other hospitals do?

Prof. LIM - I think other hospitals do that. I am aware in the north-west that they have convened a review panel. I know that they convened one two years ago to consider a request for a late termination.

Ms FORREST - In the north-west they don't always do that, though, they will have late term abortions without convening a panel.

Prof. LIM - Yes. In that situation the mother was referred to us. We then sought an opinion from Melbourne. She went across to Melbourne and then went back to the north-west and then I think they convened the panel there.

Ms FORREST - But there have been terminations beyond 20 weeks that have not had a panel convened but the woman has often been to Melbourne for genetic screening and counselling as well.

Prof. LIM - Yes. In the majority of such situations the termination would have happened across in Melbourne, but in that particular situation the woman requested to go back to the north-west. In the end I think it didn't happen but, as far as I know, they did convene the panel.

Ms FORREST - Terminations of pregnancy at that later stage have been done in Burnie?

Prof. LIM - I'm not aware.

Ms FORREST - They have, I used to work there. They have and not always with a review panel. It is a decision made between the obstetrician and the woman, and her family often. These ones are usually much-wanted babies, they are usually not unwanted pregnancies. Just going on what you just said and going back to the issue of early screening, CVS and that sort of thing, what percentage of women do have CVS around the state?

Prof. LIM - We do, apart from those carried out in the private sector, in the last year we did about 20 or between 20 and 30, so a very small percentage.

Ms FORREST - So there are a lot of women who don't have the benefit of CVS to determine those foetal abnormalities early? They rely on the diagnostic scan?

Prof. LIM - No, because the first trimester screening is offered universally and -

Ms FORREST - It is offered, but not everyone does it.

Prof. LIM - Not everyone does it, yes.

Ms FORREST - Do you know what the percentage is of the women who do take it up?

Prof. LIM - The uptake is probably about I would say about 70 per cent to 80 per cent of our women.

Ms FORREST - In Hobart?

Prof. LIM - In Hobart, yes.

Ms FORREST - What about outside, in the regional centres?

Prof. LIM - I'm not aware of the figures in Launceston or the north-west.

Ms FORREST - Is it also a reality that not every woman who has a foetal abnormality, even a fatal one, chooses termination?

Prof. LIM - That's correct, but that would be rare. Very few.

Ms FORREST - One of the proposed expectations that has been expressed to us with this legislation is that taking the conduction of a termination of pregnancy out of the Criminal Code and putting it into the reproductive health bill as you support will provide doctors with the security of knowing that it is a health act they are operating under and subject to the medical codes and AHPRA's regulation - it is not a criminal offence, as such, under the Criminal Code. The hope is that the early termination of pregnancy, which is the majority of them as you state, will be able to be returned to the public health system through the Royal and the LGH and the North West Regional Hospital, where those terminations are done before whatever period of time it is that only require the consent of the woman - informed consent, effectively. Would you envisage that happening at the Royal?

Prof. LIM - That could happen. Clearly that's something the commissioners need to identify and if that's something they are going to commission at the Royal I don't see any objections from the clinicians.

Ms FORREST - Have either you or whoever it would be who would have that discussion with the commissioner had that discussion - has that happened, because this is the time of looking at service provision?

Prof. LIM - No, that has not been raised with us.

Ms FORREST - Whose responsibility would it be to raise that with the commissioner in developing the next service level agreement?

Prof. LIM - I would imagine that would come from the DHHS.

Ms FORREST - DHHS rather than the commissions themselves?

Prof. LIM - Yes, that's the strategy for the health service at the moment.

Ms FORREST - We had the department in earlier and they sort of alluded to that, but they are coming back so I will ask them about that in future. Just going on from what Leonie was talking about with the terminations for foetal abnormalities, you suggest putting in a clause somewhere that says there is substantial risk that if the pregnancy were not terminated and the child was born to the pregnant women, the child would suffer from such physical and/or mental abnormalities as to be seriously handicapped. I assume you are just referring to late terminations here?

Prof. LIM - That would encompass things like if following the CVS we diagnose, say, trisomy 18, a significant abnormality.

Ms FORREST - Are you suggesting that the termination should only be carried out when there is a severe foetal abnormality?

Prof. LIM - No. What I'm suggesting is that if this would satisfy the reason for carrying out the termination, that would be the main reason rather than the physical - because clearly in a situation like that there is no risk to the physical health of the mother. There is risk to the mental health of the mother and therefore, if you were concerned just for her physical health, carrying out a termination for that reason is not the real reason.

Ms FORREST - Yes, I'm just unclear. The way it reads is - I'm not sure where you would want to fit this in exactly into the bill, because what it's saying is you're seeking the inclusion of a clause that terminations carried out at the Royal Hobart Hospital - but you can't make legislation at one hospital and not another -

Prof. LIM - That's true, yes.

Ms FORREST - It would have to be across the board.

Prof. LIM - Yes.

Ms FORREST - Okay, so you are requesting that a clause be added to the bill that terminations carried out in Tasmania are solely for pregnancies affected by serious foetal abnormalities and the clinicians feel that with the clause 'there is a substantial risk that if the pregnancy were not terminated and the child were to be born to the pregnant woman, the child would suffer from such physical and mental abnormality as to be seriously handicapped' should be included.

Prof. LIM - Yes.

Ms FORREST - Where would you include that, and why? You're saying to me there are the reasons why a termination is necessary - maternal ill health -

Prof. LIM - Yes.

Ms FORREST - Maternal choice -

Prof. LIM - Yes.

Ms FORREST - Earlier than this -

Prof. LIM - Yes.

Ms FORREST - How do you put it in there in such a way that you don't narrow down to that being the only reason you can do terminations? That's not what I'm hearing you say. You're not saying this is the only reason. This may be the main reason -

Prof. LIM - It's the main reason.

Ms FORREST - but it's not the only reason. But the way this is worded here in your submission would suggest this is the only reason the Royal, in your case - but I suggest you can't make it just the Royal, it has to be the whole state -

Prof. LIM - Yes.

Dr GOODWIN - I think you could reword 5(1) and come up with different wording and still come up with -

Ms FORREST - Yes, but I'm asking - the intention from this submission is that this is the reason so -

Prof. LIM - That would be the main reason. Let me see -

Ms FORREST - It is the last paragraph, paragraph 6.

Prof. LIM - Yes.

CHAIR - While Professor Lim is thinking about that, if the committee is of a view that the proposition being put by Professor Lim that this is another reason for termination, we will seek advice as to where it might fit into the bill, because at the moment there is only the consideration of the woman's physical or mental health. We've already established by other discussion with Professor Lim a moment ago that up to now doctors have linked severe foetal abnormality to the effect or the impact on the mother's mental health. They've made that linkage.

Prof. LIM -Yes.

CHAIR - I think what Professor Lim is suggesting is that his colleagues and he would like to see that as a specific and justifiable reason articulated in legislation.

Ms FORREST - That's what I'm trying to establish.

CHAIR - I understand that.

Ms FORREST - Yes.

CHAIR - I understand that but you put to Professor Lim where he would see that fitting in. If the committee decides that it's a reasonable proposition to insert something, we can get parliamentary counsel advice as to where it might fit in.

Ms FORREST - Yes.

Mr VALENTINE - But is that over and above what's already in the proposed bill? Is that what you're saying?

Ms FORREST - That's my question to the professor -

CHAIR - Yes.

Mrs HISCUTT - It's not exclusive.

Ms FORREST - The way it's written here it could suggest that that is the only reason that you would believe that a termination should be -

CHAIR - No, no. He's made that very clear.

Ms FORREST - Yes.

CHAIR - He's made that very clear that it's not.

Ms FORREST - But when you -

Prof. LIM - It's an additional reason.

Ms FORREST - Yes, the most common - frequent, yes.

Prof. LIM - Yes.

Mr MULDER - To sum it up, the problem is that if a child has a severe abnormality and the mother wishes it to be removed but has to concede that carrying it to term will have no effect on her mental or physical health, even though it may not be a life form she wishes to care for for the rest of its days and whoever else will care for it and I think that's the proposition.

Ms FORREST - I understand and I agree -

CHAIR - Yes.

Ms FORREST - but the way this - I'm just trying to clarify, if this is taken in isolation that it could be read that way and I'm just clarifying that's not what you mean, for it to be taken on its own.

Prof. LIM - No, no, not the sole reason. It is in addition.

Mrs HISCUTT - No. Well, I asked that question and he referred back to after 20 weeks in section 5.

CHAIR - Yes, that's clear.

Mr MULDER - I think the Law Reform Commission in Victoria had some interesting words around that.

Dr GOODWIN - I have a couple of questions. Dr Lim, I just wanted to get an idea of the incidence of foetuses with significant abnormality, if you're able to shed some light on that.

Prof. LIM - Just giving you a number, in the last two years I have been at the Royal we have only carried out eight terminations because of severe abnormalities. It is actually very small.

Dr GOODWIN - It is rare, I think you said, for cases where there is significant foetal abnormality for a termination not to be performed. So usually the mother or the parents request a termination in that situation?

Prof. LIM - Yes, the numbers are very small.

Dr GOODWIN - In relation to the termination review panel, can you tell me the composition of the panel members? Is one obstetrics, one a gynaecologist, a paediatrician? What is the composition of the panel in terms of expertise?

Prof. LIM - It is usually chaired by the medical director. The obstetrician and the paediatrician who are directly involved in the mother's care will be there to present her case and there will be invited obstetricians and paediatricians, and a midwife in some situations, to provide an independent view.

Dr GOODWIN - You have indicated that at the moment the Royal convenes a termination review panel after 23 weeks gestation. Is that standard practise to have -

Prof. LIM - Should there be a situation like that arising, yes.

Dr GOODWIN - Or when the reason for the request needs consideration by the panel. That is presumably when it is considered in a particular case where a review panel is warranted because of some concern?

Prof. LIM - Yes, because we are not necessarily sure that might be the right track to take.

Dr GOODWIN - At the moment is the Royal the only hospital performing terminations after 20 weeks?

Prof. LIM - Apart from the private sector, I am not aware. In Burnie they do as well.

Dr GOODWIN - In that instance, if the committee decided that it would be a good idea to have a termination review panel, your feeling is that would need to be included in the legislation to ensure that all hospitals performing these terminations after 20 weeks would have a termination review panel?

Prof. LIM - I am not sure whether that necessarily needs to be legislated because it is good clinical practice.

Mrs HISCUTT - Did you say there had been about eight terminations you have performed?

Prof. LIM - Yes.

Mrs HISCUTT - And about 1 000 babies per year in the abortion clinics? How many a year do we do here in Tasmania?

Mr MULDER - I think it is well over but it is anecdotal because no-one collects the data, so we are only relying upon a letter to the editor from Dr Paul -

Mr VALENTINE - We do not know how many people go to the mainland, for instance.

Mrs HISCUTT - So these other abortions being performed in Tasmania are not coming through the hospital system. Is it your opinion that this has happened because these abortions are currently in the Criminal Code, even though you fit into the right criteria, so it wouldn't be a crime. Why are they not coming to the hospital?

Ms FORREST - The early ones you mean, Leonie?

Mrs HISCUTT - Yes, only up to 12 weeks.

Prof. LIM - That is because the service has not been provided at the Royal for at least four or five years now.

Mrs HISCUTT - Why is that? It is legal if you fit within the criteria, so why do you not do it?

Prof. LIM - I am fairly new to Hobart but I asked one of my colleagues what the history was like. He is retired now, but he and another colleague used to run that service at the Royal until one of them had the police turn up at his door.

Mrs HISCUTT - So it is fear of being in the Criminal Code?

Prof. LIM - Yes.

Mrs HISCUTT - In your opinion if this is passed and it is taken out of the Criminal Code, do you think it would start up again at the hospital?

Prof. LIM - If it is something that the commissioner wishes to provide and we can find the right setting for the service, then we could consider that. We probably do not want to see it as part of the general clinics because these women have to be dealt with sensitively and in the correct setting. We need to make sure we provide them with a good service.

CHAIR - Existing section 164 provides protection where terminations are conducted lawfully, so there is no prosecution. We have had it suggested to the committee by a number of people that there is some nervousness amongst the medical profession because of the possibility of prosecution under the Criminal Code. Are you in a position to inform the committee as to what generates that nervousness amongst the medical profession with whom you associate? To round that question out, section 164 is almost being replicated in the bill in terms of the conditions sitting around, under what provisions a termination can be performed and when they cannot. It is almost a direct lift. Why the nervousness amongst the medical profession currently when it is very clear under section 164 that a person is not guilty of a crime if they comply with those provisions?

Prof. LIM - It may be. I am interpreting what colleagues tell me because of the experience of a consultant who was to be taken down to the police station, having been reported as having killed babies at the Royal. That probably led the whole chain of events into why doctors -

CHAIR - How long ago was that?

Prof. LIM - About four or five years ago. Because of that, there has always been a doctor's mindset that terminations are still under the Criminal Code. There is lack of clarity in the interpretation of the clause that you mentioned; that is why that nervousness continues. Once there is clarity doctors will feel less threatened by the risk of conviction or prosecution.

Dr GOODWIN - RU486 is going to be or is on the PBS. I am not sure what the timing is, but that will obviously dramatically reduce the cost of RU486. Can you tell me up to how many weeks that can be used to terminate a pregnancy?

Prof. LIM - RU486 can be used at any time in pregnancy, but under PBS, I understand, it is currently licensed in Australia to be used up to seven weeks. I come from the UK where it can be used at any gestation. We do use it where there is in utero death at term as well. We use that because we have found it extremely valuable in shortening the whole process. I was involved in the initial research, part of the multicentre trials. I was one of the principal investigators as well. It has been used in the UK for many years since the 1980s; it can be used at any time.

Mrs HISCUTT - What happens? Is the baby killed, euthanased, before it is delivered? What is the process?

Prof. LIM - RU486, or Mifepristone, is an antiprogesterone. Progesterone is a hormone that keeps the uterus calm. Once you block the progesterone receptors with RU486, it makes it more responsive to other hormones and start of labour. It is not RU486 that kills the baby, it is actually the contraction and labour process, and in a late termination the oxygen supply being cut off by the contractions can actually cause this.

Mrs HISCUTT - How does that happen? At what stage does the baby die and is it possible to have a live birth?

Prof. LIM - Rarely. It depends on the gestation period.

Mrs HISCUTT - Particularly late term; I mean, seven weeks I can handle, but late term?

Prof. LIM - Usually before 23 weeks the baby is not viable. The actual labour or contraction process would have cut off the oxygen supply sufficiently to cause the baby to die in utero before it is born.

Mrs HISCUTT - With a late term is it possible that a baby could be born live?

Prof. LIM - In good practice beyond 23 weeks we usually carry out foeticide before starting termination. In other words, we inject potassium chloride to the heart to stop it being born.

Mrs HISCUTT - Then give the drug.

Prof.. LIM - Then induce.

Mrs HISCUTT - And there is a dead baby born.

Mr MULDER - Just coming back to what has become a repeating theme, why is the public hospital system not performing early-term terminations when the private sector can do it? It seems that a visit from a policeman who makes an allegation which didn't result in a prosecution or charge seem to be fairly flimsy ground. A policeman making inquiries is a long way from prosecution or conviction, which you even talked about. The fact that is has only happened once and that it hasn't happened in the private sector at all where these procedures are going on, would seem to me that it is time the public health system had a rethink about this process, which as we heard earlier on, is disadvantaging women. I really can't understand why you would be spooked for so long by one simple action.

Prof. LIM - I think it has to be stressed that the private sector does provide a good service as well. It is not second-rate.

Mr MULDER - It doesn't seem to suffer this fear of prosecution - unfounded, I might say, given the history.

Prof. LIM - When that incident happened the unit was much smaller. I think there were only about three consultant obstetricians in the unit and out of those three only two were carrying out terminations and because they were spooked they suddenly decided not to provide the service any more. Even now when there are six staff specialists in the department I know are two of my staff specialists have conscientious objections to performing them, and I can't make them. I have to respect their wishes.

Mr MULDER - But the other four?

Prof. LIM - The other four will do it. If, as I say, the commissioners come to us and say this is a service we would like you to consider developing we would not object, but we have to ensure that it comes with the appropriate resources and the right setting for the woman as well, not in a clinic next to pregnant women or babies crying.

Mr MULDER - Yes, I don't have those issues, it's just that here we have a public health service clamouring for reform and, as the Chair quite accurately pointed out, this law

virtually does not change much in terms of the risks and the criteria you would face for conducting those terminations.

Prof. LIM - I think doctors would be reassured by the clarity.

Mr MULDER - What comfort does it give you, though, as clinicians, to have a piece of legislation that basically mirrors a piece of legislation you had no comfort with?

Prof. LIM - Well, we are not legal people; we look at the law simplistically. If it is clear that it is not under the Criminal Code I think doctors would be more -

Mr MULDER - But it's still an offence under the other section which has the same provisions, just in a different act of parliament. The legal processes are not that much different.

Ms FORREST - For all other obstetric procedures, like a caesarean section that goes wrong, the doctor could be taken to task under the medical regulatory authority -

Prof. LIM - Oh yes, definitely.

Ms FORREST - As a termination would.

Prof. LIM - Yes.

Ms FORREST - So doctors are more familiar with that process.

Prof. LIM - Yes, doctors would view a termination as a medical procedure.

Ms FORREST - Rather than having police knocking at your door you have APHRA on your back.

Prof. LIM - That would fall under duty of care issues.

CHAIR - I want to make the point that Professor Lim has given his answer as best he can about the nervousness of the doctors he associates with and I think we accept that. We can make our judgments about whether that nervousness is well founded or not. It is a debate we can have in the chamber and flesh that out.

Mr VALENTINE - Professor Lim, you state in point 3 of your submission that in this bill a woman is defined as a female of any age and there are no separate provisions for pregnant minors. While most pregnant minors are capable of giving consent, experience has shown that 12-14 year olds often need an independent advocate to be part of the consent process, especially where there are child protection issues. I don't see any suggestions as to how that should or shouldn't be addressed in the bill. Are you satisfied that the bill doesn't present any issues with regard to minors? I am wondering why you have mentioned that.

Prof. LIM - I think we wanted to be assured that if we are faced with a pregnant 12 or 13 year old that they are competent enough to give consent, but if there is some uncertainty we would have some position where we can ensure that consent and they don't feel pressured to make the request for a termination, and that pressure is not coming from the woman's health rather than from outside pressures.

Mr VALENTINE - You are not suggesting that there needs to be any additional clauses to cover that off?

Prof. LIM - I'm not sure how that can be addressed. We're simply highlighting it.

Mr VALENTINE - You are just highlighting that is something that needs to be considered?

Prof. LIM - Yes.

Ms FORREST - Wouldn't that be the case for any people coming for contraceptive advice or finding a breast lump? Any young person like that would possibly need the support of another in that circumstance, not just a termination; it could be any medical procedure?

Prof. LIM - True, but clearly a termination is more complex.

CHAIR - We are done, Professor Lim. Thank you very much for your evidence before the committee and for your submission.

Prof. LIM - Thank you.

THE WITNESS WITHDREW.

PUBLIC

Ms GEORGIE IBBOTT, GENERAL MANAGER, **Dr CLARE ROBERTS**, SENIOR MEDICAL OFFICER AND **Ms KATE WILDE**, REGISTERED NURSE, MIDWIFE AND SENIOR NURSE, FAMILY PLANNING TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I welcome you to the proceedings of the committee. It is important that I indicate to you that whilst here in the committee of the parliament you are protected by parliamentary privilege such that any comment you make is not actionable by anybody who may feel aggrieved as a result of the comments you make. The same protection which members of parliament have afforded to them is afforded to you. Outside the considerations of this committee you don't have that protection. If you choose to, or are invited to, speak to the media, then we suggest you exercise some caution as to how you might communicate the contribution you made before this committee. There is nothing wrong with you telling the media or anybody else anything that is of your view and your opinion, but as it relates to the proceedings of this committee and the evidence which you gave here, then there are some connections which can expose people to legal pursuit if somebody feels aggrieved.

As to the submission of Family Planning Tasmania, you are appearing as a group as to that submission, recognising that Clare and Kate have also provided personal submissions. We are happy to hear any evidence you wish to provide in addition to the submission or to clarify or to add to.

Ms IBBOTT - Thank you. I will give you a little context to Family Planning to start with. Family Planning Tasmania has been the leader in sexual and reproductive health matters in Tasmania for over 40 years and today I am joined by Dr Clare Roberts, who is our senior medical officer at Family Planning, working at our Glenorchy clinic and also Kate Wilde, who is our senior nurse and also a midwife also working at our Glenorchy clinic.

We operate sexual and reproductive health clinics throughout Tasmania. We have clinics in Burnie, Launceston and Glenorchy as well as clinics operating in Huonville, the Derwent Valley and Smithton, to name a few. We employ 14 doctors and seven nurses and all are specially trained and skilled in sexual and reproductive health issues specifically.

We are also the leading provider of reproductive and sexual education in Tasmania's primary and second schools and every year we interact with thousands of clients at our medical clinics and thousands more through our education programs and services. We are part of a broader network, nationally, of similar organisations that advocate for improved access to sexual and reproductive health clinics. We understand and deal with sexual and reproductive health issues every day and we are the experts in the Tasmanian community on these matters.

Our organisation lobbied for changes to the termination laws and that was based on the clients we see and the experience they share with us. We believe that women deserve to have access to contemporary, appropriate and equitable sexual and reproductive health services that are appropriate for their individual circumstances.

At Family Planning we do not conduct terminations. We provide women with options for them to make informed choices about which decision they choose to take. Today we would like to share with you our experiences and the experiences of the women we see who are faced with an unplanned pregnancy, so we believe we can provide some real-life stories and case studies to show the human side of this legislation and what it would mean for Tasmanian women who are faced with an unplanned pregnancy.

In terms of the first section of the legislation, terminations by a medical practitioner at not more than 16 weeks, as you would know, very much a large majority of the terminations are conducted prior to 16 weeks. In our experience, the majority are between about 7 and 11 weeks' gestation. We believe that this legislation clarifies the situation for women and provides them with equitable access to terminations prior to the 16-week gestation period. Clare, did you want to recount your example?

Dr ROBERTS - I think it's very relevant that Professor Lim was here just before us because this is a case which is actually very recent and relates to the Royal Hobart Hospital, not him particularly, but it brings me to your asking questions about why people are anxious about it and why aren't they doing it now after the student created so much trouble a few years ago.

I saw a woman in her late thirties, and I have expanded on it, but this case was presented in my individual submission. She came to see me for contraceptive reasons and told me how, due to unrelated gynaecological reasons, she had an appointment at the Royal and during investigations they did an ultrasound and found out that she was between six and seven weeks pregnant. She had had her tubes tied at the Royal seven years ago. She was absolutely devastated. She had lots of problems in her life. She did have six children and she wasn't living with any of them. She had had a break up, had a breakdown, she had alcohol problems and she had been at St Helens Hospital for a while and she had just got together with a good man as opposed to the angry man she had been with before. She felt she certainly wasn't in a state where she was capable of looking after a child.

After much-hushed discussion somebody from the gynaecological department came along and didn't take any mental health history from her and just told her that there were no medical grounds for her to have a termination, and gave her the phone numbers for two private organisations that are available. This woman is a pensioner and it was clear that she had to have a termination. She spent $300 of her $400 fortnightly unemployment benefit to have the procedure done. She couldn't see her children for a week or two after that because she didn't have enough money to feed them. It is totally iniquitous that this should have happened.

The doctor who saw her either didn't understand the system or had been told they just don't do terminations apart from foetal abnormalities. There is a lot of misunderstanding. I just feel that this is a prime example of somebody who really should have been offered a termination in the public system for a failed method of contraception.

Mrs HISCUTT - Do you feel that that particular case is not the norm, or are the bulk of them misunderstood, or is this an exception to the rule? Where would you put this lady?

Dr ROBERTS - I know at the Royal it wouldn't matter at the moment because apart from foetal abnormalities they're not going to do terminations.

Mrs HISCUTT - Is this lady's particular circumstances the norm of people seeking an abortion or is she outside the norm?

Dr ROBERTS - Contraceptive failure is a major cause of people seeking terminations of pregnancy; there's no doubt about that.

Mrs HISCUTT - So her major problem would have been mental health issues and this was just compounding her problems?

Dr ROBERTS - Well, yes. She had taken very active steps to not have any more children. She had had her tubes clamped, so it's not like she hadn't bothered to do anything.

Dr GOODWIN - On that point about contraceptive failure being a significant contributor to termination of pregnancy, what is the proportion? Do you have any idea of how significant it is in terms -

Dr ROBERTS - It depends what method of contraception you're looking at. If you look at the oral contraceptive pill, even if you take it absolutely correctly, one in 300 people will fall pregnant every year.

Dr GOODWIN - It's quite high, isn't it?

Dr ROBERTS - It is high. The real-life statistic is something more like 7 per cent to 8 per cent - those people forgetting to take them from time to time.

Ms FORREST - Or they get gastro or something.

Ms WILDE - I have a story as well. I have taken stories from women whom I have seen with unplanned pregnancies as well and this particular example is about contraceptive failure. It was this woman's first pregnancy and I saw her at just about 7 weeks. She had been taking the pill and using condoms because she was taking

antibiotics - she had tonsillitis so took antibiotics and she knew she had to use condoms as well because the pill might not work properly - and she still fell pregnant because she was vomiting and had diarrhoea. Her quote was, 'I really want reliable contraception for the future', so I think it is important to understand women are trying hard to control their fertility but it's not 100 per cent, it never is and never will be. She was horribly shocked by this pregnancy. It was not in her plan at all and she would like to avoid it happening again.

Mrs HISCUTT - So the norm is that most people present because of failed contraception?

Dr ROBERTS - I don't think we have those statistics but certainly there was a big study done by Marie Stopes in 2007 and they found out an awful lot of people had been using contraception.

Ms WILDE - I think it was something like 80 per cent of unplanned pregnancies on contraception.

Dr ROBERTS - I'm sure you know by now that half of conceptions are not actually planned and half of those unplanned conceptions are terminated; they're approximate statistics. They found at the time of the unplanned pregnancy 60 per cent of the women were using at least one form of contraception and the largest group of those were pill users. There were a number of people using more than one method of contraception and those were the group of women who were very adamant about the fact that they had really gone to a lot of trouble to not get pregnant.

Ms IBBOTT - The next section is on terminations by a medical practitioner after 16 weeks. In our experience a very large majority of people seeking a termination are well below the 16-week gestation period so we're talking about very small numbers here. We see people who have an additional inability to cope with parenting or carrying a child for a number of reasons. Some of them may be related to domestic violence, sexual assault, mental health issues or homelessness. There is a number of reasons this part of the legislation is crucial to provide those women in those particular circumstances with some options to consider what is in their best interests. We also believe that the two medical practitioners, one of them being a specialist, are very well placed to work with that woman to form an opinion on whether it is appropriate to continue with the termination. We are comfortable that is an appropriate inclusion in the legislation.

Dr ROBERTS - It can be hard for us to imagine what it's like to be one of those people if we are somebody who may be quite good at organising our lives. A lot of people are not very good at it at all. The example that I gave in my individual submission was of a woman referred from the Royal, because they'd basically washed their hands of her, who was about 16 weeks pregnant and had a serious drug problem and because of that she really was not aware of her body and didn't realise she was pregnant until it was quite advanced. She was certain she couldn't look after a child

and I felt she was likely to be very right there, and also the drugs she had been taking would almost certainly affect the foetus. We were able to find funding to get her to the mainland for a termination and at the same time they were able to insert an intrauterine device to at least delay this happening again. She was somebody who was difficult to keep track of. We repeatedly made appointments for her to come back to see us and we could never get her to come. She was somebody for whom it would have been completely inappropriate if she had continued the pregnancy. She felt that and we agreed with her. If we hadn't been able to somehow or other find that money for her to get across to Melbourne it would have been, I'm sure, one more child who would have to have been fostered. It certainly wouldn't have been wanted.

Dr GOODWIN - In the previous example you mentioned you cited a cost of $300 to access a private clinic here. What was the cost, roughly, of the Melbourne procedure that you mentioned, because there would be an airfare as well, presumably?

Ms WILDE - I don't know the cost but you have the cost of the procedure and the cost of transport and accommodation because have to spend the night and you're away from social supports.

Dr GOODWIN - She went to the mainland because she was more advanced in her pregnancy, is that the reason?

Dr ROBERTS - Yes. The reason for that is because people have to stay in hospital overnight and there are no facilities here for that.

Ms IBBOTT - In relation to section 6, conscientious objection and duty to treat, we are very respectful that there are a variety of views on termination. We are also very confident that doctors and nurses will always act in the best interests of the patient to save a life and prevent serious injury. We believe they are well placed to make those choices in those emergency situations, so we are confident that they are the best placed to make those decisions whilst also being very respectful that they may have differing views on termination. We also believe that this part of the legislation is very welcome to clarify this requirement in the legislation.

Ms FORREST - This is a point that we have prosecuted with a number of the witnesses. What this section does, in simplistic terms, is change the process. It doesn't change the access to termination as such. It's still legal before and after 16 weeks. Conscientious objection, sorry, I was looking at the other one. I was reading this comment that you made at the bottom of this one about the client, despite the death of her baby, this particular woman you talked about, she still had to endure the two psychologists' appointments prior to having the surgical procedure. Why was that in this case? When I read that I relayed that back to the 16-week issue because she had a scan at 18 weeks, but to me this relates a bit more to the 16-week versus or whatever other issue.

Ms IBBOTT - Yes.

Ms FORREST - While it's not in your section 6 it refers to the previous section about the 16-week cut off, which many have said shouldn't be there, it should be later or not there at all or whatever. Clearly, here there is a need for the woman to have a termination.

Ms IBBOTT - Correct.

Ms FORREST - There is no question here. She hasn't gone into labour by herself, so it needs to happen. By imposing any point where you have to have two doctors agree that it will affect the mental and physical wellbeing and the consideration of other factors, when there is a clear indication that it is necessary, why are we putting that in at all and, if we are putting it in, why are we putting it at 16 weeks? Do you have an opinion about that?

Ms IBBOTT - We believe a woman should be given all the information to make the decision herself. The women we see are very well placed to make that decision themselves and they don't make the decision lightly. They take their responsibility very seriously and the women we see are capable of understanding and making the decision themselves, irrespective of other views. It's important that they are given all of the options and that particular views aren't imposed on them. Particularly vulnerable groups, very young women need to understand their options, but certainly in relation to that example I believe it is inappropriate that that case required -

Ms FORREST - Having a blanket -

Dr ROBERTS - Family Planning was never in favour of the 16-week gestation limit.

Ms FORREST - That's the question I'm asking.

Dr ROBERTS - It was always in favour of either no limit at all or 24 weeks.

Ms FORREST - From your experience, too, as a medical practitioner, once you get to 18 weeks for a scan, you generally have involved a consultant obstetrician at that stage anyway. If you have a foetal death in utero then they are going to be seeing a consultant anyway, so does it need to be in legislation at all, in your opinion? This is a matter for us to decide later on, whether it needs to be there or not. I'm just interested in what your views are.

Ms IBBOTT - Our preference is for there to be no gestational limit.

Ms FORREST - Limit to the process - there is no gestational limit to termination.

Ms IBBOTT - Correct.

Ms FORREST - It's just to the process.

Ms IBBOTT - So this 16-week arbitrary figure.

Dr ROBERTS - The process becomes more complex the more advanced the pregnancy is because it is a more complex medical process and the consideration of the potential person is more paramount as the gestation continues. There is no set time and we might make a law now that's not going to keep up and the dates you choose are not based on science.

Mr VALENTINE - Are you saying, given the fact that obviously doctors will be involved in the later term, that it shouldn't be stated in here that two doctors' opinions are required?

Dr ROBERTS - I don't know that it is necessary. You would have two doctors required at the moment at any gestation, and then I think that there you can have what we call best practice. As Professor Lim said, they have a panel and different organisations might have different panels or groups but there will be guidelines for all professionals.

Ms FORREST - But this sort of case you wouldn't want to send to a panel; that'd just draw out the agony for that woman.

Dr ROBERTS - That's right. I think the whole problem is that as long as it's within the Criminal Code it's somehow treated differently from other medical problems, which is inappropriate.

Mr VALENTINE - It should be no different to any other procedure.

Dr ROBERTS - No, and we are all bound by our professional standards. We don't take them lightly.

Mrs HISCUTT - You may be able to clarify something for me, ladies. It says here that many women have accepted the advice of family planning experts et cetera with regard to contraception. Help me understand this, please. It says, 'For instance, the pregnancy rate is less than one per 100 women years.'. Does that make sense to you? Have you heard that term? It also goes on to say the perfect use rate is what is most often quoted. 'Users often appear not to acknowledge or may be unaware that the combined contraceptive pill in actual use has a pregnancy rate of three per 100 women years.'

Dr ROBERTS - Who wrote that?

Mrs HISCUTT - It's from the Ad Hoc Interfaith submission. Have you heard of those terms before - 'per 100 women years'?

Dr ROBERTS - It just means that if 100 women use that method of contraception for one year then three of them will get pregnant. The statistics are actually one per 300 for perfect use of the pill and about 7-8 per cent per 100 for everyday realistic use. I guess it's easier to explain it like that to some women rather than using percentages.

Ms IBBOTT - The next section is in relation to obligations on medical practitioners and counsellors. We strongly support the requirement for medical practitioners and counsellors with a conscientious objection to refer women to another practitioner who can provide the full range of options. In our experience we have seen a number of clients who have not been provided with adequate information in relation to this, and their medical practitioner or counsellor has expressed a personal view which, in these terms, is a conscientious objection but has not been stated as such. This part of the bill is really crucial to make sure that women have the opportunity to receive all the information so they can be empowered to make their own decision. Again, we've seen women who have not been given all the information and don't feel empowered to make that decision. They have had the views of a medical practitioner or counsellor imposed on them.

We also think this part of the legislation is really crucial to make sure women who decide to proceed with a termination can access those services in a timely manner. Finding a medical practitioner who may or may not support termination can be problematic so women need to have this part of the legislation to ensure they can access the services in a timely manner. This also balances the rights of women and doctors to make decisions that are consistent with their own personal beliefs and values.

Ms FORREST - We have discussed this clause quite a lot, as you can imagine. Subsection (2) is where a medical practitioner has a conscientious objection, and the clause in the bill requires them to refer to another doctor. But I have talked to a number of doctors who are GPs who have a conscientious objection but are happy to talk to them in broad terms about termination but not willing to give advice in that. Predominantly, they say they prefer to refer to services such as yourselves. When a woman is referred to Family Planning, they are referred to the service, not to Clare, for example, is that right? Or do they get referred to the doctor in the practice and does every service, like the one in Smithton, does that have a doctor there all the time?

Ms WILDE - People who usually come, book into to see one of us nurses and we do pregnancy options counselling with women. They don't need to see a doctor necessarily because the nurses provide the client-centred, non-directive counselling, education, advocacy and support.

Ms FORREST - The way this clause is written is, it says the doctor has to refer them to another doctor. We have suggested to some that maybe it should be amended to say, 'the practitioner must refer the woman to another medical practitioner or service who the first-mentioned practitioner reasonably believes does not have a conscientious

objection'. It seems that's what's happening in practice - that women are being referred to services such as yours and perhaps seeing the nurse who can provide that non-directive advice.

Ms WILDE - In practice, it would be to a nurse with our organisation.

Ms IBBOTT - Certainly they would call Family Planning, whether it be in Glenorchy or Launceston or Burnie and make an appointment. They would state the reasons over the phone to make that appointment and we would find a time for them to see either a nurse or a GP.

Ms WILDE - If they then needed to see a doctor for a treatment or a referral for an ultrasound or something like that, then we can talk to the doctor or book them in with the doctor. But generally they see the nurse first.

Dr ROBERTS - We work very much as a team. I believe you also have to discuss the word 'refer'. This is a slight problem and I did say that in my individual submission, that we do recognise that word as meaning a specific thing which requires writing, which in fact they don't need. They just need to be directed in a timely fashion to another service.

Ms FORREST - One of the suggestions made by another witness was that in Victoria the words 'effectively refer' or 'provide an effective referral' were used, which is not a formal practice, but saying that these are the services out there that you can get this extra information from.

Dr ROBERTS - I think that if this bill does pass then somebody needs to educate the medical profession here in Tasmania as to what it means.

Ms FORREST - So, if 'refer' or 'effectively refer', was used and it was defined in the bill as 'providing information as to where this information can be sought', that would overcome that fear of the doctors because I think it is a genuine fear of the medical profession.

Ms WILDE - That there has to be a formalised written referral and they are part of the care then?

Ms FORREST - Yes, that's what they believe and effectively it's asking for a particular course of treatment or care.

Dr ROBERTS - Yes, whereas we have just been given information. The doctor could just have cards that they can hand to the person, saying 'This is where you can go'. After the last bill passed, we produced quite a lot of information. Every single GP was sent one of these kits.

Ms FORREST - But did they read them?

Dr ROBERTS - I don't know but they have them there to refer to if it came up. You don't necessarily read everything at the time it comes in. You can but try.

Ms FORREST - With regard to the counsellors, that was another concern from the counsellors of some of the other counselling services, that they had to refer to another counsellor where some indicated they will refer to a medical practitioner or suggest someone go to a medical practitioner. If you put in a similar sort of thing to another counsellor or other service, which could be a medical practitioner service or a service such as your own, do you think that would alleviate some of these concerns?

Dr ROBERTS - Yes, I think so. I also think we all, when we are doing this, we need to be putting the woman first and I'm sorry, but I think some of the people who are doing counselling are not. They are putting their belief system first.

Ms WILDE - I went through and picked out some stories and I will tell the majority of the stories - I won't tell you all of them, but they probably deal with this issue of healthcare worker attitudes and the health professional putting their attitudes and beliefs about termination onto the client, which I think this legislation could address, which would be a good thing. This particular section would allow those practitioners who have conscientious objection to terminations to still act within their belief system and allow women to get access to information about services available, so it balances that.

I have two stories. One is about a woman I looked after at the Royal who was having a termination for a foetal abnormality. After a scan the prognosis was that once the child was born it would have a long-term intellectual disability and she and her partner chose to terminate the pregnancy. I was at handover as a midwife there listening to the other midwife saying, 'That's a terrible thing she's doing', and thinking, 'This woman shouldn't be looked after by midwives who have these views'. The midwives should also have the right to say, 'I don't believe in this type of care, I can't give this care now. I'll look after these patients instead'. It is about balancing those two things and I think this proposed change would address that, which is a good thing.

Mrs HISCUTT - With regard to the counsellors themselves, there is a penalty if they don't do that. Do you think a penalty is appropriate for not - shall we use the word - 'directing', and if you think there should be a penalty how do you see that happening, or who do you see imposing that.

Ms WILDE - Within the medical profession we have a professional code of conduct, ethics we have to follow, and I am assuming counsellors would as well. I am not sure.

Mrs HISCUTT - Not all of them, no.

Ms WILDE - As medical practitioners we have to work within those guidelines but maybe counsellors don't so maybe a penalty would be appropriate if there is no other regulatory system. As medical professionals we have that regulation and we can be deregistered.

Mrs HISCUTT - Kate, the midwife you were talking about who thought the woman shouldn't be going ahead with the termination, a doctor has the right to exercise their conscientious objection so they could say, 'I don't want to treat that patient'. Doesn't the midwife have the same right?

Ms WILDE - Yes.

Mrs HISCUTT - So they have chosen not to exercise it.

Ms WILDE - I guess. Maybe they don't know about that option.

Dr ROBERTS - But their judgment would be carried into the care of that person -

Mrs HISCUTT - Yes, so they should have declared that.

Dr ROBERTS - They should have.

Ms WILDE - I think that's what this part of the legislation clarifies, that expectation.

Dr GOODWIN - Yes, but it doesn't apply to nursing staff, it only applies to medical practitioners and counsellors.

Ms WILDE - Medical practitioners? Aren't nurses medical?

Dr ROBERTS - This is about counselling. We have moved on from the conscientious objection to treat and nurses are included in that section.

CHAIR - That's correct.

Ms FORREST - If I had a conscientious objection working as a midwife, the code allows me to step aside, as long as I don't deny access to an emergency. If I'm the only midwife on and there is an emergency then I have to.

Dr GOODWIN - Yes, you have to, and this is what it says here.

CHAIR - Thank you, I think we have clarified the position.

Ms WILDE - I have one more story about that. I saw a woman last week who came to me for counselling because she had an unplanned pregnancy. She was quite clear on what she wanted to do but most of the counselling session revolved around the

treatment she received from the GP she had seen before she came to me. When she said she wanted information about a termination the GP wrote an ultrasound referral to determine how far along she was in the pregnancy and threw the referral across the desk at her. I get lots of stories of quite abusive behaviour by doctors and maybe it is because they have a conscientious objection and don't know they can voice that and that they are protected.

The client I saw spent most of the time saying that she was furious. She left in tears from that GP's visit but she was really angry about younger, less confident women seeing that doctor who would not know about pregnancy options. She was a bit stronger, more resilient and a bit older so could still get the information and come to Family Planning, get the options and make her own choices, but she was so furious that other people wouldn't have that opportunity and I think that is where these proposed changes could be helpful.

CHAIR - Thank you. Are there any other areas?

Ms IBBOTT - Yes, (7) and (8) - the woman is not guilty of a crime or offence. At Family Planning we believe that termination of pregnancy needs to be regulated as a health issue and not as a criminal issue in the twenty-first century. We also respect that doctors are working in an environment of uncertainty and risk and this legislation helps clarify that so that we can provide termination services in Tasmania to women who choose that option. We very firmly believe that it is not a criminal matter, it is a health matter that should be dealt with between a woman and her medical practitioner. They are best placed to make the decisions around addressing that unplanned pregnancy and the woman herself is the best person to make those decisions. We are really confident that that is the appropriate way to manage this situation. Kate, do you have an example?

Ms WILDE - I already mentioned that it is the health welfare worker's attitude sometimes that becomes the biggest barrier for the women I see. A woman who came to see me was referred to Family Planning for more information and to get a referral for a termination. She doesn't actually need a referral from Family Planning; she can come to us for information, advice and support, but I think her GP didn't realise that it used to be that people needed to see one of our doctors for a referral prior to going to a clinic but they don't anymore. I think it is the fear of committing a crime that means doctors are nervous about referring people on for termination.

Dr ROBERTS - If people who are as well educated as us can be in a way intimidated, it screams out that it shouldn't be there in the Criminal Code. There is a doctor who is infamous for not only not wanting anything to do with people seeking a termination but also not giving any contraception. He eventually got around this problem by having another doctor work with him who does prescribe contraception. I was speaking to her one day and she was very confused about the law around termination of pregnancy and didn't want anything to do with it because of what she had been told, rather than what she had read. There are many doctors like that -

Ms WILDE - Dr Lim, here just before us.

Mr MULDER - On that point, you talk about the need to educate doctors and the need to get out there, yet here is a case where doctors are clearly misunderstanding. They aren't being educated, whether it is through desire or otherwise, so what hope do you have that fiddling around with the law somehow or other makes all this go away; that fiddling with the law will stop rude people from being rude?

Dr ROBERTS - It's not just rudeness, it's about litigation, and there have been cases - there is a case in Western Australia - where doctors have been taken to court. I think we are justified. It is very good that there is acknowledgement that social situation and poverty can affect people's mental health, which wasn't in the last act at all.. These things all interrelate. Women shouldn't have to feel that they are in any way connected to a criminal offence and doctors shouldn't have to feel that either.

Mr MULDER - Don't get me wrong, I haven't heard anyone around this table ever say that we don't think section 8 is a good thing. I certainly have no objection to section 8 - criminalising the victim, if you like.

Ms WILDE - One of the first things I say to women is that termination is safe and legal. People don't know that.

Ms FORREST - There are a lot of misconceptions out there still.

Ms WILDE - Yes, and this will clarify it.

Mrs HISCUTT - On the point of not taking into consideration a women's mental state, it says in the act already that a practitioner may take into account any matter. It doesn't say that they shouldn't take into consideration a mental condition.

Dr ROBERTS - The way it's phrased currently -

Mrs HISCUTT - The way it's phrased currently is:

> In assessing the risk referred to in section T - termination - the medical practitioner may take account of any matter which they consider to be relevant.

That is what is current.

Dr ROBERTS - It says whether it is in your opinion that the physical or mental health of that woman would be more adversely affected if she continued the pregnancy than if it were terminated. That is how it is actually phrased.

Mrs HISCUTT - But that's what it says.

Dr GOODWIN - I think, in practice, what they are having to do is rely on the interpretation of that through to court ruling and, as I understand it, in another one as well. It's probably open to confusion across those two decisions, I suppose.

Ms IBBOTT - Section 9 in relation to access zones - any woman dealing with an unplanned pregnancy and facing a decision on how to address her unplanned pregnancy, and one who decides to proceed with a termination, is obviously already going through a very difficult and traumatic time and is particularly vulnerable. This section of the legislation is very important to make sure that that woman is free from harassment and stigma as she attempts to exercise her decision around her own sexual and reproductive health.

Importantly, it doesn't remove the right to protest but it does ensure that we have some protections for women at a particularly vulnerable and distressing time, and we see that as really crucial to protect those women as much as possible.

Mrs HISCUTT - When was the last protest? Do you know?

Ms IBBOTT - I believe there were some last year at one of the clinics in Hobart. Clare has an example.

Dr ROBERTS - My example is of someone who was in Melbourne. She was using a method of contraception which masked the fact that she was actually pregnant until it was quite advanced and she had to go to Melbourne for a termination. She attended the clinic with her mother. She was in a pretty distressed state anyway and she was harassed and heckled as they both entered the building. This had a significant effect on her mental wellbeing afterwards.

Mrs HISCUTT - That's not legal anyway, that's harassment, isn't it, which is against the law already?

Dr ROBERTS - Well, they were protesting. They can shout and they can have placards and that's what was happening. They were close to the building and that is what we are trying to prevent and what section 9 is about. It's not saying that you can't protest but it is removing them from the place where these women are entering and leaving. It's cruel.

Ms WILDE - They are causing harm by doing the protest there.

Mrs HISCUTT - Personal harm?

Ms WILDE - Yes, causing more trauma.

Mrs HISCUTT - We would then be dealing with illegal protests if they stepped inside that, which is common in Tasmania, as we know.

Ms FORREST - Do you mean on other matters?

Mrs HISCUTT - Yes, there are illegal protests. This law may be good or not but I can't see any would-be protester who is hell-bent on protesting not encroaching on that.

Dr ROBERTS - They might well think again if they are fined $45 000.

CHAIR - Any questions on the matter of this exclusion area? That probably gets us to the end because you identified those as the points in your submission that were of particular import.

Dr GOODWIN - On something you raised earlier, Ruth, you may be able to give me the correct terminology for that test you were talking about with Dr Lim.

Ms FORREST - The CVS - chorionic villi sampling.

Dr GOODWIN - You said that not everybody has that. It is freely available but not everyone chooses to have it. Why wouldn't they have it because obviously it can provide an indicator of -

Ms FORREST - It's invasive and there is a risk of miscarriage.

Ms WILDE - Is that an early-on test?

Dr ROBERTS - About 11 or 12 weeks. You have to enter the uterus and take a tiny bit off the placenta to obtain living cells to grow and take the chromosomes from. I believe the risk of miscarriage is greater than with amniocentesis - it depends on how skilled the operator is. But it is at a much earlier stage so it means that somebody may be found to have chromosome abnormality. You would probably only be considering it for people at a more advanced age.

Mr VALENTINE - Is this to detect Down syndrome?

Dr ROBERTS - Yes, or other chromosome abnormalities.

Dr GOODWIN - So this one comes before the amniocentesis?

Dr ROBERTS - You wouldn't do both; it would be one or the other, but it is earlier.

Ms FORREST - You can't do an amniocentesis that early.

Dr GOODWIN - What age of the foetus?

Dr ROBERTS - I think it is 14 weeks there but it is generally about 16 weeks they'd do an amniocentesis.

Ms FORREST - And even that's problematic; it's usually about 18 weeks or more.

Dr GOODWIN - Is there another test at 20 weeks?

Dr ROBERTS - That's looking for things like heart abnormalities or a missing brain, something like that.

Dr GOODWIN - What I'm trying to get at is, there is a number of intervention points at which, depending on the outcome of the test or scan or whatever, a woman may want to have a termination because of something that has been detected.

Ms FORREST - The CVS and amniocentesis are usually done selectively in women who are at greater risk because of the invasive nature of them. They may have family history or they might have had a previous problem with a baby with some disorder. They are also expensive.

Dr GOODWIN - But everyone has the 20-week scan, presumably?

Ms FORREST - Pretty much everyone has an 18-week scan, but they are also very expensive.

Dr GOODWIN - Is the 18-week scan the last scan that a woman would have?

Dr ROBERTS - *Shaking head.*

Dr GOODWIN - No. Is it possible that in a subsequent scan a foetal abnormality not previously detected could be detected?

Dr ROBERTS - I don't know if I am capable of saying that, it's not really my jurisdiction. It is probably the last regular scan someone will have unless there is a problem - if the baby didn't seem to be growing properly or seemed to be breach, something like that.

Ms FORREST - In terms of counselling provided by Family Planning, when a women comes for advice regarding an unplanned pregnancy, particularly - generally an unwanted pregnancy; if they are seeking counselling it's unplanned but they still want it; it's usually not such a difficult experience but if it's unplanned and unwanted - how do you approach that and what information do you give the woman?

Ms WILDE - We talk to people about three different pregnancy options. We talk to everybody about that in the manner of what they come to us about. We always explore all three options. One is to continue the pregnancy and have a child; the second one is to continue the pregnancy and put the child up for adoption; and the third is a terminated pregnancy. A lot of people come and know what they want to

do, so you don't talk about termination much if they are continuing the pregnancy and having the child.

We do non-directive counselling and I always let people know up-front that I am there to support them and give information. I can't tell people what to do; I listen to their situation. We have a little pro forma we use to address different things. There are clinical things we talk to people about, like their age, when they last had unprotected sex, the contraception they were using, if they were, their last menstrual cycle, symptoms of a pregnancy. We do a pregnancy test if they need it and we can figure out the gestation they are at. On the more social side of things we talk about supports they can identify, if there is a relationship in the picture -

Ms FORREST - Support regardless of whether they choose termination or continuation of the pregnancy?

Ms WILDE - Yes. If it was a young person, especially, I would talk about support if they were choosing termination or continuing. I would talk about supports for both.

Age comes into it too. If they are young and are not safe we have to report to child protection. Accommodation - where they are living - their finances, their future plans, their aspirations and where does this pregnancy fit into that. We also do a STI screen as an automatic thing. Once we have talked about the three options we hone in on what they are thinking about and explore that, but we definitely cover all three.

Mr VALENTINE - How does that change with a minor? Do you expect somebody to be there in support of that minor?

Ms WILDE - It would be great if they did have support. We talk about having an adult around - an auntie, a mother, a father, a nanna - who can give support to a young person. If I think they are at risk of harm or are not safe, or maybe there is a risk to the unborn child if they are continuing the pregnancy, I would mandatorily report to child protection.

Mr VALENTINE - What about a minor who doesn't want their family to know? Have you ever been confronted with that situation?

Ms WILDE - Yes. We have something called the Gillick competency. It is how we assess a minor's understanding of a clinical procedure or test. We talk to them about the procedure of the test, about the good and bad things, the complications and the benefits, and we assess their understanding of it. If we think they are mature enough to understand what we are saying, we say they are Gillick competent. If I am unsure I will get another colleague to assess them as well, which we did to someone last week. It comes up fairly frequently that we see a minor on their own -

Mrs HISCUTT - And if they're not competent, then what?

Ms WILDE - We would have to get a guardian or parent.

Mr VALENTINE - You have to make sure that someone else was there with them as opposed to continuing on with the consultation.

Mr MULDER - We have heard much about the rights of women and the need to allow them to have safe and effective abortions. I go back to what was supposed to be one of the most controversial cases, the Roe v. Wade decision in the United States. The third principle that came from that one, and I am quoting from the Victorian Law Reform Commission, was:

> The state has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the foetus that may become a child.

I haven't heard much in relation to that particular principle as it relates to the life of the foetus that may become a child. I wonder whether you think that is a valid principle and if so how does that factor into the way you go about your business?

Ms IBBOTT - There are clear clinical protocols that govern and address a woman's rights and responsibilities and we take that responsibility very seriously in relation to working with that woman. We also believe that she has the right to make decisions about her sexual and reproductive health and to be empowered to make those decisions. We fundamentally believe that our responsibility is to manage her clinical care to the best of our ability.

Mr MULDER - So the second part of that principle I read out is not something you hold to be valid?

Ms IBBOTT - Our primary responsibility is for the woman we are caring for.

Dr ROBERTS - It was very interesting reading. I only skimmed it; the document you refer to is very dense. They went into great philosophical detail about when a foetus becomes a person. They came out saying it is not until you are actually born that you become a person as such, and that the woman's needs are probably always going to be paramount. It is very interesting but I think that it is going to be very difficult. I know there are some cases where people have believed that the foetus always comes before the woman.

Mr MULDER - It is not a question of being paramount; I think it is a question of the woman's interests being absolute.

Ms WILDE - There would be no wellbeing of the foetus if the woman wasn't taken care of.

CHAIR - Thank you for your evidence today.

THE WITNESSES WITHDREW.