PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON TUESDAY, 3 SEPTEMBER 2013.

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 INQUIRY

Ms GLYNIS FLOWER, HOBART WOMEN'S HEALTH CENTRE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Welcome, Glynis. Are you familiar with the protections of parliamentary privilege afforded to you while in this committee?

Ms FLOWER - Yes. For clarification, I have asked that part of my presentation be in camera because it is about personal details. However, given Tasmania is very small and some of those details are very specific, I have de-identified the name and amalgamated some of those stories so there is little possibility of identification. So, although as far as I am concerned it is the whole truth, I have mentioned in my presentation that that is what I am doing. So I would request that at least half of what I say in camera and that you understand that in giving my truth it is a combination. I am combining real stories sometimes into one.

CHAIR - I doubt the committee would have any problem whatsoever in that protection for confidentiality to go in camera at the time you suggest to us. That will still be recorded and transcribed but is entirely confidential to committee members only. We have had the opportunity to familiarise ourselves with both your covering letter and the newsletter.

Ms FLOWER - I come as the executive officer of the Hobart Women's Health Centre and I have over 23 years of experience in community sector management, but I have no legal or medical training. As such I do not appear to you to answer those sorts of questions but I would like to concentrate on a number of matters which, judging by the transcripts of previous sessions, seem to be unresolved in the minds of the Legislative Council members. There have been many discussions about the need for changing the legislation and its effect on access so I am hoping that I can clarify that in some ways.

I hope to illustrate my points from real stories of women who have come to the Hobart Women's Health Centre for support and/or counselling, those who have rung us from regional Tasmania and those who have come forward and told their history since we started the advocacy of the bill. These women have convinced us over many years that the current legislation causes confusion, entrenches stigma, limits open debate and as such limits access to information about services, especially in regional and rural areas.

Given the nature of these studies, even though they are de-identified to some extent I have asked for an in camera session for at least part of the presentation.

It is difficult for many of us to realise the lack of health literacy in Tasmania. The Australian Bureau of Statistics regional data tells us that 62.8 per cent of women and 64 per cent of men do not have enough health literacy skills to cope with everyday life,

and even highly educated individuals often have little understanding of health and medical matters. This is the worst figure in the country.

Dr GOODWIN - It is very high, isn't it?

Ms FLOWER - It is very high. Many people trust their doctor to make decisions or to direct them in their decisions with clear advice. On medical matters it is appropriate to offer guidance but with regard to termination there is still evidence that general practitioners believe they understand the current legislation while they have inaccurate interpretation. This is evidenced by market research - GPs' Attitudes to Abortion, November 2004, commissioned by Marie Stopes, which has been cited in previous submissions - which showed that 78 per cent of GPs surveyed believed they understood the state's abortion laws compared to 63 per cent nationally. Very few Tasmanian GPs were aware that an abortion may be legally performed if a woman will otherwise suffer serious social - 25 per cent - or economic - 8 per cent - consequences. This is backed by anecdotal reports from women contacting the Hobart Women's Health Centre saying their doctor says they are perfectly healthy and there is no reason for them not to proceed with the pregnancy or that they do not believe in abortions and will not refer, or, indeed, that it is illegal in Tasmania. This is not every doctor but we hear this from time to time on our calls we get from women.

Imperfect understanding of the law presents barriers to women's access and puts the doctor at risk. That is a very important point. The positioning of abortion, a medical procedure, in the Criminal Code in separate hard-to-find clauses causes confusion and, not surprisingly, services become risk averse. This is further evidenced by the decision not to offer terminations in the public system following the well known trigger to the last legislative change attempt.

There is no doubt it is also a contributor to the stigma around the procedure. We know women are still reluctant to talk about their experiences and their personal history of termination. Since our centre has been very public about its recent advocacy, women have talked to us more about their support for the change, confessing in whispers of their own abortion often a long time ago. We have also been thanked, again in whispers, for our attempts to clarify the law, sometimes by much older women who you might expect to have a more conservative view. If the subject has to be discussed in whispers, the normal channels for information-sharing do not work. While we agree with the MLCs' comments that community education is necessary on these matters, clear-cut stand-alone legislation would be much easier to explain and an easier guide for professional and community members.

One of the MLCs raised the issue about information being readily available in phone books but the information doesn't necessarily differentiate counselling services which are for all options. For instance, on page 3 of the current Southern Tasmania phone book, under counselling and personal emergency, five of the services are not unbiased and will not refer for abortions. A similar list is recorded in pregnancy counselling in the Yellow Pages section and only one or two are unbiased counselling and it is not obvious that the average phone book user would understand that. Even abortion services which are transparent in their description in the Yellow Pages are listed under pregnancy headings, not abortion or termination. Given literacy in general and health literacy, it is not surprising people don't find information easily.

The requirement for two doctors also causes difficulties, especially for women in rural areas. There are still parts of the Tasmania where finding one appointment in a timely manner is difficult. It is also hard to find a female doctor, which, understandably, is the preference for many women. Even when there is a male family doctor who is known and trusted, women choose not to see them for more intimate and sensitive matters.

Most of the women we see have family responsibilities already. We do not usually see very young women and we assume that this is because they go to the two youth health centres in Hobart which cater for young people under 25. We do occasionally see younger women but very rarely do we see younger women under 18.

I would like to offer some scenarios based on real conversations with women who are not identified by their name and also the stories, although essentially true, are a mix of more than one woman's story. They show the complex nature of women's lives, the barriers they face to good care and the social and economic pressures they face. They show the difficulties of poverty and the cost of the procedure, distance, transport and the need to be apart from families and support. The most striking part of these stories is that they are, like all human stories, complex. In many cases, one or two of the factors could have been overcome but it is often the final added factor which leads to the belief that they have no other choice.

The steps required under the present legislation and the stigma attached to a law governed through the Criminal Code present significant barriers to access to services. The evidence from Victoria shows the number of abortions do not increase markedly as a result of removing the laws from the criminal framework. However, I believe this change in Tasmania will, in fact, ensure that women have access to information and support earlier in their pregnancy and thus ensure healthier outcomes no matter what the woman's decision.

In the case of the public debate, there have been stories in the media of people who have faced great challenges but still gone ahead with their pregnancy. All parents face great challenges. The most common difference in these stories is that they have some form of community support, either from a parent or partner or a community. For some of those women we see the challenges are overwhelming and they face them with little or no support. Everyone should have options.

It is often cited that there is a great deal of services for women in pregnancy and in other aspects of their lives, but none of those services are comprehensive across this state and none of them are adequate for all needs.

My caution in presenting these stories reflects the continuing problems of stigma and concern for confidentiality on this small island. Once again, I need to emphasise: no woman ever makes this decision lightly. The next stage of my presentation is about those stories and I am happy to answer questions at this stage on that general point.

Mrs HISCUTT - Thank you for coming in. You talk about the stigma and we all know that it is a social stigma and it is socially unacceptable. Do you think that changing it from the Criminal Code to the medical code will change that social stigma out there?

Ms FLOWER - I think it will. I don't think it will happen overnight, but as the members have suggested, some form of education around the changes to the law should come into play immediately. I think over time it will make a lot of difference. It is clearly stopping doctors, in some cases, referring or even giving information. It is clearly stopping information going out there.

Mrs HISCUTT - Even though within their current existing framework there are legal criteria?

Ms FLOWER - Yes. If I told you that driving your car at 45 kph was in the Criminal Code, you would be very cautious about that, even though you might think it might change. That's probably not a very good example. Mr Mulder, I could see on your face that you thought it wasn't. If anything is in the Criminal Code, your average person is going to question the details of that. It is more complicated, too, because in the Criminal Code it's not even in one place. There are clauses here, clauses here and clauses there, and so it is hard for people to understand the law. If doctors are not understanding it, how are women supposed to understand it and how are services supposed to understand that? When women come to see us, as I said in my piece, it is whispered; it is something secret because they don't know where they stand and they know that they are judged by other people quite seriously.

Mrs HISCUTT - Are you implying that the judgment is based on whether they could face a criminal charge or whether it is a social stigma?

Ms FLOWER - I think it's a social interpretation. In other jurisdictions there certainly have been some criminal [prosecutions] or penalties attempted - the Queensland case a few years ago being the most obvious one - but I think much more than that, the barrier is around the stigma as well. It is in the wrong place. It is a medical health issue.

Mrs HISCUTT - You think changing that to the medical code will -

Ms FLOWER - I think it will help enormously because it will also open up the debate. It will also make it more a matter for people to consider. It is going to say very clearly: this is a health issue. This is something between a woman and her doctor. It is not something for the law, for the police and for heavy-duty penalties. It is not something that you shroud because it is considered still to be something of shame and crime. That is my opinion and it is an opinion I share with a lot of people. Most of the research that has been done nationally and in Tasmania has shown that about 80 per cent of people, across the board, think that it should not be in the Criminal Code. I will be careful with my examples from now on.

CHAIR - Don't be spooked, especially by Tony.

Mr VALENTINE - With respect to conscientious objection, do you think providing a properly compiled pamphlet of services that are available in Tasmania, counselling or otherwise, being handed to the doctor's client at the time he realises that he has a conscientious objection, would be sufficient?

Ms FLOWER - I think it is an interesting discussion. The more information that is out there and the more clarified information that is out there, is a good thing. However, I think

that even though it is part of the doctors' code, we have seen examples and heard of examples where doctors have not adhered to that code. I don't think it is hugely widespread but it is significant enough for us to hear these stories on a regular basis. I think entrenching in the legislation something that clarifies that and endorses that, is really important. It is very important from the point of view of protecting conscientious objection, while at the same time clarifying that this is, very specifically, a vulnerable area, so it is really worthwhile having it still in the revised legislation.

Dr GOODWIN - Glynis, you talked about the lack of health literacy in Tasmania. I wanted to tease that out a bit more as to how it actually impacts in terms of the legislation we are discussing. What is the impact of that lack of health literacy when it comes to women seeking assistance with terminations, or even if they are just contemplating what to do?

Ms FLOWER - Again, literacy alone is an issue but health literacy is very specific and interesting in that it cuts across education levels. When people are seeking services it is quite easy for us to say, 'Wouldn't you just ring a doctor?', or 'Wouldn't you just go to that service?', or 'Wouldn't you ring up Family Planning?', but a lot of people do not have the ability to work out whether this service is the right one for the specific thing they need - that is a very big aspect of health literacy.

It is also the same when people go to their doctor and get medication. They will be told it is a good medication and are often not asked any questions and not even know the questions to ask about, 'Will you take that medication with this other medication?', or 'Will you eat or drink that with that medication?'. It is an example that has come out, including in contraception, for instance, that often women who think they have taken the pill every day but because they have had a vomiting virus or antibiotics in some cases, that might affect the efficacy of the pill.

I suppose what I am saying is that we cannot always assume that people will know how to go and get help for a particular thing, and that is why I think it is really important that women seeking this help get time and information that is comprehensive.

Dr GOODWIN - On the contraceptive failure issue, we have heard that is reasonably common.

Ms FLOWER - Yes.

Dr GOODWIN - Is that your experience as well with women coming to the centre?

Ms FLOWER - Yes. I should make it clear that we do not have droves of women coming to the Hobart Women's Health Centre on this issue. We have a very wide agenda with our organisation and the number of women we see would be sort of 'this big' but, indeed, partly I suppose because of the age that we see women, they are almost always on pretty rigid contraceptive path that has failed in some way for some reason. It is not absolutely always the case and the research on it is that over half of unplanned pregnancies occur when contraceptives are used. Something like 43 per cent, I think, are on the pill, but also other forms of contraception - nothing is fail-proof.

Ms FORREST - Going down that health literacy area and the part of the bill that says at 16 weeks we changed the process where currently it was 24 weeks but it requires the

consent of two doctors. Bearing in mind the poor health literacy of people in Tasmania - eventually a woman will find her way to a doctor if she is seeking termination, you would hope that is the path she gets to. Does that confuse it or is it something that is completely separate?

Ms FLOWER - Some of you were approached long ago by me and other people, and our preference was at that time to have no gestation period because if it is a health issue it is between a woman and her doctor. The truth is that by stage anyway there is usually another doctor involved. With the bill we are discussing now my personal view is that it would be better if there was no gestation period. Obviously under a legal framework the woman has to find a doctor somewhere and, as I say, after that kind of period of time there is likely to be a second practitioner involved anyway. So that is our view and we still hold to that view, even though the bill has brought in an arbitrary period.

Ms FORREST - I notice in your flyer it says -

> Hobart Women's Health Centre does not provide abortion services but we are approached by women in person or by telephone from other parts of the state for information and help, provide a counselling service which makes no judgment but provides options and information.

We are looking at conscientious objection and the need for a doctor or counsellor with a conscientious objection to refer either to a health practitioner or perhaps a prescribed service. Is that the sort of service you provide, the counselling aspect - looking at who might be a prescribed service? It is quite clear that Family Planning would fit that bill, and they also don't do terminations there. Can you tell us a bit more about the service and how it works?

Ms FLOWER - We have face-to-face counselling and a statewide women's health information line, so we have phone calls from all over the state about all sorts of things. Quite often it is just, 'Where's the nearest family planning clinic?' or 'Do you know of a doctor in Burnie who is still taking patients?', or it may be, 'Can you send me to a website that's worthwhile about a particular condition?' We do not give medical advice at all on that information line. We would refer to medical practitioners or other practitioners if people need that. It is an information link.

We also have women who come through the door. Some don't even know whether they are pregnant so we will administer a pregnancy test. When they are not sure what they want to do, we have specific health workers who will do what we call ambivalence counselling, which is about helping them see some of the things they need to think about. It is a counselling that does not suggest anything, it doesn't persuade, but it gives all the options open to them.

Ms FORREST - So if they then decided or felt they wanted to proceed down the path of a termination, what is the process from there?

Ms FLOWER - Normally we would refer them back to their own doctor because we believe, wherever possible, if the history is there that will be useful.

Ms FORREST - What if you knew the doctor had a conscientious objection?

Ms FLOWER - In that case, I'd probably ask them to see Family Planning, where they do have doctors. We used to have a doctor on the premises until just after I came on board about four years ago. A doctor of 14 years resigned and moved on and since then we haven't had a doctor in the service, but we have a nurse practitioner. We tend to refer on to Family Planning if we can't help.

CHAIR - We will move to in camera now.

Evidence taken in camera.

Mr MULDER - I note your observation that it is the doctors' ignorance of the law that makes them reluctant to assist women.

Ms FLOWER - I don't think it is entirely that because, as I said earlier on -

Mr MULDER - Well, there is a high degree of ignorance of the law and doctors just don't feel comfortable because it is in the law somewhere, and as a result of that women are not getting the advice, support or assistance they need at the time they need it. I also note from your examples that, worse than ignorance, are some of the examples of advice that women are getting from doctors. I am just wondering if maybe we should criminalise poor medical advice rather than the procedure itself. By moving this from the criminal law into the medical regulations through codes of practice or standards or those sorts of things, how does that overcome the other problem where this appalling advice is currently covered by the medical codes of practice yet no action is taken? How does that make it any more effective?

Ms FLOWER - I think there is a combination of things there. One is that we are suggesting it go into a new bill, so there is still going to be a legal framework. We are also suggesting that the conscientious objection remain in there as a reminder so it is very clear and is clarifying it. We are suggesting it goes in one place so doctors or the general public can see where it is, so I believe all of those things will help with the clarity. Additional to that, once it is clear it will be much easier for those of us who want people to understand to be actually clear about it and I think as stigma becomes reduced, it will also be easier for women to take the appropriate steps to make the point when a doctor does not do the right thing. As it is at the moment where it sits, are you going to jump up and down and be on the front page of the paper to say, 'Dr so-and-so wouldn't refer me for an abortion'? It will never be something people want to be public about, any more than you might want to tell people about your appendix. I don't think this is going to solve everything all on its own but I think it is an absolutely major step that needs to be made, for all of those reasons.

Mr MULDER - Would you agree with the proposition that one of the fundamental problems here is the attitude of the medical profession on this?

Ms FLOWER - I don't want to give the impression, particularly since this will be published, that we have no faith in the medial profession; that is not the case. The medical profession are as fine as any other members of this community, but there are exceptions who will not refer, even though they know it's in their code of conduct that they should. By taking this out of any confusing legislation and putting it into a nice, neat bundle and

also reinforcing those codes of conduct with the conscientious objection regulation, even though it's still within their code rather than a penalty under law, I believe that in itself will make it easier for them to see and other people to understand when they are breaching that. On top of that, hopefully when this legislation goes through, we will be continuing our struggle for good sex education and relationship education and good access to contraception, and we will continue our part in educating the general public about what is law.

Mr MULDER - I guess it's that educating of the doctors; that even should this law get through as it is or something very similar, you still are going to confront it with, I hate to say, uneducated medical professionals who will continue to behave in exactly this way. You start to wonder that if all the education programs with this elite professional group have produced the results of those statistics, what hope do you have after this law is passed?

Ms FLOWER - Most of the education programs for doctors, though, are about doctoring; they are not about legal boundaries. It would be very advantageous to make this change to the law. I think putting it into a clear framework that is easy to find, with all the clauses in one place, and reinforcement of the aspects of their own code of conduct, is going to make a difference.

Mr MULDER - We've had a discussion with the Royal about the fact they don't do early terminations. They do late terminations for foetal abnormalities but they don't do early terminations. Basically they are saying it is just because they haven't been required to do them, and the reason you don't have them available at the North West General Hospital or anywhere else in the public system is because of their reluctance to even bother to inform themselves about the legal situation.

Ms FORREST - Not only them, the commissioners as well.

Mr MULDER - Ruth picks up the point that it is not only the practising doctors, it is also the commissioners who don't require those services. That can be done simply by making that requirement that that is a service they provide. If the doctor has a conscientious objection he is not going to do it, but that is all it takes for him to do it. My point is, surely it is possible to educate these doctors?

Ms FLOWER - I think it is, but one of the parts of the education is to change the law. It is going to be a much easier thing to do if the law is clear.

Mr MULDER - All the other things that are already in medical codes of practice, they are clearly breaching them now and they are not in the criminal law and the education hasn't helped there. I am wondering how you think moving this particular procedure is going to change that?

Ms FLOWER - Often people are brought to task in areas such as medical or legal practice by highly educated people with money who can fight when they have been treated badly.

Mr MULDER - I am wondering about that particular case where the specialist gave that piece of advice, 'You'll change your mind when you hold the baby in your arms', and the

fact that was a procedure I would imagine someone could have gone to the medical complaints council about.

Ms FLOWER - Yes, it would be.

Mr MULDER - Would you? Did you, on behalf of that woman?

Ms FLOWER - No. We would assist them to make that complaint if they wanted to. We are very much about what women want and making choices for themselves, we don't impose anything. We make that information available and we also do general community education around health complaints. We have done a series of workshops across the state in the last 18 months with the Health Complaints Commission. We do not persuade people on any path, under any circumstances.

Mr MULDER - Should this law get through and we have a repeat of that, which is quite possible because this law won't change that, what I am saying is: isn't it about time someone stood up as an advocate and at least started to make these complaints to hold the medical profession to account? The criminal law doesn't hold them to account and the codes of practice certainly aren't holding them to account unless people make complaints. It seems to me that we need to attack those procedural issues rather than worrying about whether the title is Criminal Code or codes of practice.

Ms FLOWER - I don't think I can comment any further than that.

Mrs HISCUTT - Bearing in mind those stories that you related to us and bearing in mind that some of those were their life circumstances, as opposed to any law, and bearing in mind some of them related to community attitudes, can you really see that by relating those stories that you did and passing this bill is going to help people in those situations? Bearing in mind that a lot of it was their life's circumstances, which probably couldn't be changed by a passing of this bill anyway.

Ms FLOWER - These examples that you have heard are, of course, life circumstances. I am glad that we haven't heard the term 'lifestyle choice' here because I have heard that before and I am not happy with it. But people's lives are complex and if the public health system is not offering the procedure, if there is a shortage of doctors in different places, there are a whole lot of things that might change in those life circumstances. I don't think the stigma is going to go away overnight; there will always be people who think they can judge others unfairly.

Mrs HISCUTT - But passing this bill won't stop any of the abuse, as you have relayed - I'm not going to repeat it - the woman who is abused by her partner and stuff like that. Passing this law is not going to help that because that is covered in other laws.

Ms FLOWER - I guess what I have been trying to get across is that these decisions are not made lightly and they are often made in very complex situations, and any one of us who had that overload of those different things might at some stage in our life feel we needed to consider that option. I think the stigma will be affected by the change in the law because it will recognise community attitudes have changed on this, just as all those years ago when same-sex relationships, homosexuality, was illegal here. The law was in

place, nobody had been prosecuted and the people who wanted to get the change happening even tried to get arrested but they didn't get arrested, but the stigma was there.

Since that law has changed, there is no difference in the number of people arrested for that act, but in fact community attitudes have changed dramatically over that period because it is not against the law anymore. I think this has parallels in many ways in terms of the time it may take to change that stigma. It will never go away completely in some people's minds who judge that in a particular way, but I think in the end it will make a lot of difference. In some aspects it will make a difference straight away.

It is my belief that if this law changes, women who need to make this decision will make it earlier and they will make it, whichever way they go. They will be able to get the services they want quicker and they will be able to make those decisions in a timely manner which are good for their health.

Mr VALENTINE - The issue of two doctors needing to sign - you may have covered it but I might have missed it, I was reading a couple of things. In the more remote situations, are you suggesting that it should only be one doctor to sign as opposed to two?

Ms FLOWER - The changes in this bill are very good from that point of view. I do think it is a matter for a woman and her doctor and in the early stages that decision can be talked over with her own GP. The idea that then you have to run around and find a second doctor - which is not difficult if you go to a practice like the one I go to where there are maybe four or five doctors on the premises - if you are in a remote part of Tasmania, finding one doctor who will see you within a reasonable time is hard. To get a second is difficult.

Mr VALENTINE - With respect to the gestational limit, and I am not expecting answers from a medical perspective, what is your position on that, can you reiterate that for the public record?

Ms FLOWER - Yes. Our position has always been that it is a matter between a woman and her doctor. It is a health and medical matter depending on what stage it is. I don't think there is any need, and our organisation doesn't think there is any need, for a gestational period at all. Not because we are for late-term terminations at all but because other things come into play because later on in the pregnancy there will be two doctors anyway. If is being considered at a later term, there will be two doctors involved anyway. The 16-week limit is a totally arbitrary period; it has nothing to do with medical tests at a particular stage. It is not that it does one thing or another. We think this is a health matter between a woman and her doctor, and that is where is should be.

CHAIR - Thanks very much, Glynis.

Ms FLOWER - Thanks very much for your patience and good luck with your deliberations

THE WITNESS WITHDREW.

Dean RICHARD CHARLES HUMPHREY, ANGLICAN CHURCH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Dean, thank you very much for joining us. You are well familiar with committees of the parliament which afford you parliamentary privilege so we will not go down that track. We understand from your letter that you will be addressing both your own personal submission and that of the Bishop. We have those and we would be grateful to hear from you.

Dean HUMPHREY - First, thank you for the opportunity to speak on behalf of the Anglican Church and Bishop John. I wish to speak briefly on three areas: philosophical questions, personal stories, and pastoral concerns. As any good preacher, there are three points and they all start with 'p'. That may help you to remember as it helped me remember them.

The fact is that we have a bill. That is a philosophically important thing. It demonstrates that a termination is not simply yet another procedure or another health issue between a woman and her doctor. If that was the case, there would be no need for legislation. There is another factor involved in this discussion and it is the unborn child that the woman is carrying. If the very fact of the bill demonstrates that the unborn child has value, a fact which is demonstrated and enshrined in the UN Declaration of the Rights of a Child, why does the bill not seek to give principal protection to the child? It is there in the current legislation with a medical risk provision. It is on the case of a medical risk to a mother that a termination be sought and it is also there in section 165 of the Criminal Code.

Those who promote this bill and this committee need to consider why and what basis there would be a change in the status of this unborn child. The bill, as it stands, seems to indicate that a child has no value. I can see nothing in the bill which gives any value to the unborn child, which is surely extremist and is undercut by the very fact that we have a bill. If it is granted then why is that not said in the bill and a principle set out that would seek to protect the life of the unborn? Without such a discussion there is no protection for the child, who may simply be unwanted or of the wrong gender or, as in a case in England recently, had a cleft palate.

There is a discussion around this bill of the need to provide protection for the vulnerable and, as a society, we certainly need to do better at educating and protecting vulnerable women and to increase their health literacy, but we also need to protect the life that they carry. The bill does more than push an extreme position on this matter, to my mind, but seeks to silence those who oppose it and trample any who disagree with it, forcing to refer - which, to my understanding, is a medical term that has meaning; it is not simply saying, 'Go and see someone else' - and thus participate, pushing anyone who counsels women, presumably including clergy' - I can't see how I would be not included in the provisions of the bill if someone came to see me for advice - on a path we believe not only to be wrong but detrimental to the woman, we can be criminalised, which is interesting in a decriminalising bill.

Good decisions can only be made when there is good unbiased information that is made freely available. To see the current legislation in terms of a parable - something which our Lord and master did on a regular basis - the current legislation is like car legislation

in that it ensures only the car dealer can give information about the car, trusting that the dealer will of course be advised. That is a philosophical question.

Such extreme legislation will have impact on those who give medical care. Many of you will know my father, who is a well-known obstetrician and gynaecologist in Hobart. One of the great joys for me in returning to Hobart a few years ago has been the number of women who have approached me in all sorts of circumstances to tell me how wonderful my father was with the care he gave them through both the joys and difficulties of caring for their health. I am very proud to be the son of Dr Denis Humphrey.

My father was trained in England but, after amendments that were made to the National Health Act in 1967 which made abortions legal in that country, as someone who would not do them he could not get a job and, in good conscience, could not take any jobs he was offered. So, having seen an advert for Dr Hull's medical practice at 173 Macquarie Street on the back of a magazine in England, the whole family was shipped off and here we are. England's loss was Hobart's gain.

Would you want to put in place laws that would make good doctors like my father feel that, in good conscience, they could no longer be part of the health system of this state? This is not simply a philosophical historic question. I know a midwifery student who I think will be wonderful in that role who is pulling out of training because she feels she will have no conscientious objection protection from being forced to participate in terminations.

Perhaps more important, I believe, are the pastoral concerns that are raised by this bill. In every parish in which I have worked, women have come to seek counsel from me after terminations. They may have had them many, many years before or they may have been recent, but they have been unable to find peace over a decision they made or, to be more precise, they felt they had no choice, they felt compelled to have an abortion and could find no peace over what happened. Such times are harrowing and difficult and I fear that this bill will simply mean there will be many more recessions to come. Abortion is not simply a medical procedure from which one recovers. The mother is forever changed and, let us be clear, the baby dies.

We have recently had an apology, rightly given, to those children who were forcibly removed from their parents, yet now we create a situation far worse and in which case an actual apology can never be given to the true victims. The women who came to see me wanted to ask their child for forgiveness. The Christian message can bring forgiveness and resurrection, even hope in such situations, but the consequences and grief remain. The bill simply ignores that reality.

But it is not only women. I have also had men speak to me whose partners have had terminations. Sometimes the decision was mutual but at other times the father had no say and in each case they were affected by the memory and hurt of what happened. I have spent many years caring for a man whose mental health is ultimately pushing him into alcoholism, who was severely impacted by his girlfriend aborting his child without discussing it with him first. The fathers of aborted babies can be victims too, and they are often the forgotten ones. Fathers are conspicuously - one is even tempted to say 'miraculously' - absent.

I would argue that this bill be rejected and only allowed to progress if significant amendments were made. In not treating the child in the womb as human, we start to deny our own humanity and that of our culture. I ask that the bill be either rejected or heavily amended.

Mr VALENTINE - Having been delivered by Dr Hull and having three of my children delivered by your father, I can attest to his ability in the gynaecological area. One thing you talk about in your submission is the standing of the father's wishes. I understand your concerns with abortion but have you given any thought as to whether the bill might be amended to address the concern of yours and others that the father has no say at the moment?

Dean HUMPHREY - In practical terms as to where it would go in the legislation, no. In many circumstances this would be extremely difficult because there will be times when the father may be unknown or the wishes of the father may be inappropriate for a number of reasons. I would love to pretend we were discussing this in a *Playschool* world where it was all happy families making decisions, but I know that's not the case. It would be very difficult to work out how you could put legislation in place that would recognise all those circumstances without the bill having so many subclauses that it would reduce any sense of clarity one was looking for. I would hope that as part of the consultative process, and I can only speak from my own experience when people have spoken to me on this matter, that will be something I would say to them, having spoken together - what does the father want in this?

In the case I was referring to, the thing that hurt this person the most was that he found out after everything had happened. That was the tipping point for him. I am well aware of the ethical, social and relational complications in many people's lives, so I have not sought to work out how we could enshrine that in the legislation. I would hope those with cleverer legal minds than I may be able to work it out.

Mr VALENTINE - With regard to conscientious objection, do you see a pamphlet that spells out the services available to woman, maybe pointing out which ones do or don't provide pro-choice, with the doctor providing it as being sufficient? It would give the doctor a way out. He or she is not referring a woman for abortion as such but is simply saying, 'I can't do this. I can't talk to you about this aspect but here is information on the services available'. Would that be sufficient?

Dean HUMPHREY - I'm not a lawyer so I can't give you a full answer on the issue of referring, but that sounds reasonable to me. One of my concerns in the way conscientious objection is talked about in this debate is that it is not a two-ways of talking about conscientious objection. There is a way of saying, well, this is what everybody thinks but there are a few crazy people who don't think that and we allow them to conscientiously object, or that there is a range of opinions here and we understand these are all good ideas in the public space and we allow a variety of opinions to exist and they all seem to be reasonable opinions.

This bill, to me, treats those who conscientiously object to terminations as those in that first category - it is an aberration to view it that way. That seems clearly inappropriate to me given the way in which people think about this matter. Those who would object - my

father would not be saying, if I may speak on his behalf, that he does not do this because it is simply his personal opinion. He would believe it is bad for the women, and obviously for the child, to have that procedure and therefore he cannot be involved in the medical treatment that would lead to that outcome. Does that make sense? He can provide information so the woman can make that decision and seek other medical advice but, in his opinion, it would not be a good outcome for his patient or clearly for the child, therefore he cannot refer. It is not just saying, 'I can't do that particular thing because I don't have the skill'. He is saying, 'I believe this would be bad for you' and how can he then refer? If somebody gives other information to those who will, I think it would be a better outcome.

Ms FORREST - I have a few questions on this particular point. You mentioned your father's concern leaving England and he also talked about a student midwife who decided not to continue. The bill, as it is written, actually provides protection, as I see it, because it enables those people to have a conscientious objection. The medical codes and the nursing and midwifery acts guide your practice and your codes of conduct under the health regulator. All make it very clear that you are quite entitled to have a conscientious objection, which means that you don't wish to participate in providing advice about that option, whether it be circumcision of newborn baby boys or termination or a range of contraception - vasectomy, sterilisations. There is a range of things that individual doctors may have conscientious objection to.

What this does is say that if you have a conscientious objection then you need to refer that woman - and I will take us briefly to an AMA Victoria document that says in advice to the medical profession:

> ... conclude that the word 'refer' under the legislation requires that, at a minimum, the practitioner send or direct a patient seeking abortion to another practitioner who does not have a conscientious objection to abortion or otherwise facilitate access to such a practitioner. In the panel's view, this duty will be discharged if the doctor provides the patient with the name of a non-objecting medical practitioner of health service, such as an established family planning centre or an appropriately accredited abortion clinic.

You can give the name of a family planning clinic that doesn't conduct terminations at all in their facility - that is all you would have to do to meet your duty to refer. When you look at that and you also look at a woman giving informed consent, for any doctor to enable a woman to make an informed consent about continuing her pregnancy, she will need to consider all her options in that.

Dean HUMPHREY - Yes, absolutely.

Ms FORREST - Isn't this a protection?

Dean HUMPHREY - For me, Ruth, I am not a medical lawyer so I am not someone who can speak with full confidence on this but that duty to refer still places an obligation on that person to say, 'I think this is a very bad idea but let me facilitate you do'.

Ms FORREST - No.

Dean HUMPHREY - It still says 'a duty to refer' and you have to provide information about those who will do it.

Ms FORREST - No, you have to provide information, or you have to refer to someone who doesn't have a conscientious objection who can provide information and advice about all options to enable a fully informed consent. It is not saying that you have to refer them to someone who will conduct a termination. That is not what it says.

Dean HUMPHREY - I would hope that my father would have given full and free information but he would then have given his advice as to what were good health outcomes for that person. Strangely, being of my gender, I never saw my father in a professional capacity so I can't speak for what went on in the sanctity of the consulting room. I can only speak in terms of when I am counselling that I have a clear view on this matter. That does not mean that I don't give information about other options that are there. To disagree with something does not mean you can't speak about it or give advice about it.

Ms FORREST - If you look at the medical code, it makes it very clear: if you have a conscientious objection to a certain aspect of care, not just termination, such that you are unable to provide a full range - you are effectively saying, 'I can't refer you to that service for that particular procedure because I object; you need to go and talk to someone who can talk about all your options openly and transparently so that you can then make a decision'.

Dean HUMPHREY - I can only say again, my father would say that is a bad health outcome for the person, and I would say it is a bad health outcome for the person.

Ms FORREST - What, that they don't get to make an informed decision?

Dean HUMPHREY - No, your question runs with the assumption that a termination is a good health outcome.

Ms FORREST - No. The question I asked was if they were referred to someone who can give the full range of information and advice about all options, including continuing pregnancy, because if they go to Family Planning they will discuss all that.

Dean HUMPHREY - Then your question assumes that my father is unable to do that and somebody in my father's situation is unable to do that. He is able to give full advice about the options, but could not recommend one of them. That is a different situation.

Ms FORREST - A conscientious objection, according to the medical code, would not enable someone to provide that full range of options. If they could provide a full range of options then they don't have a conscientious objection.

Dean HUMPHREY - You didn't say that, you said 'information about the options'. My father could certainly give full information about the options. He would not be able to perform one of the services.

Ms FORREST - Yes, that is at the point when the woman said, 'I really want to know more about a termination, that's the path I want to take'. He would then refer her - or what would he do at that point?

Dean HUMPHREY - Again, not having been with him, I like the option that Rob has put forward that there is information freely available to that person as to how they may research that, but it does seem to me that it puts things upon medical practitioners who have a reasonable conscientious objection, not simply because it is an odd view they have but that it is actually an unhelpful and unhealthy medical procedure.

Ms FORREST - No, it's not; it's saying that if you can't provide that, whether it is the advice or the service, then you need to refer the woman so she can.

Dean HUMPHREY - If, in your opinion, that is what the legislation puts forward, that is okay, but to my mind it places an onerous and unfair mandate upon a medical practitioner who may not feel comfortable to do that.

Ms FORREST - That is already within the medical code. How is that an unfair mandate when they already have to operate that way? It is very clear. The health regulator could prosecute them - not prosecute them, but could discipline them under the Health Practitioner -

Dean HUMPHREY - In which case why does it need to be in the legislation?

Ms FORREST - That is a point; you could leave it out, but they will still have to do it. It just makes it clear, one would suggest, that remains an important part of care for the women.

Dean HUMPHREY - If that's your opinion, that is fine. I can only assume my father, being a person of high moral standing, would have done what was required under the code. In my understanding of the word 'refer' - I had not seen that constitutional issue before - if it does have a meaning of supporting the action, then my father would not be able to do that. Please understand that I am speaking without having my father in the room, so I would -

Ms FORREST - Your father would have also worked under the RANZCOG code of ethics and the code of ethics makes it clear to RANZCOG, which is the professional body he would have operated under -

Dean HUMPHREY - I don't feel particularly comfortable speaking further about the hypotheticals about what my father may or may not have done.

Ms FORREST - I'm not talking about your father, I'm talking about all obstetricians.

Dean HUMPHREY - Sure, but I don't like the inference. It doesn't seem ethically fair to me to infer that simply because you have a conscientious objection to a particular procedure, you are therefore not able to provide advice.

Mr MULDER - Just on this point, I think sometimes we are talking about two different things. I have looked at clause 7(2), which states 'if a woman seeks a termination or

pregnancy options advice from a medical practitioner and the practitioner has a conscientious objection to terminations, the practitioner must refer' et cetera. This is in the context of seeking advice relating to pregnancy options. I do not read in there, as a lot do, that the doctor is not allowed to even say, 'I don't believe in that and here are the previous options, but I'm duty bound to refer you to someone else who doesn't have a medical objection to discuss the issue'. It is almost like a second opinion.

People keep reading into this that the doctor is not even allowed to talk about it, and I don't see that in the law at all. It seems you are saying your father would have felt the right to give advice to these people that it is not a good health outcome, and I don't see anything in here that would prevent him from giving that advice, provided he then went on to say, 'That comes from the fact that I have a conscientious objection, but I will now give you a list of doctors who can give such a advice who don't have that objection'. Does that give you some comfort?

Dean HUMPHREY - It does in one sense. Clearly I am not an expert in medical ethics or medical law, but the conscientious objection in this case is not simply saying, 'My conscience does not allow me to do this'. I know that when the life of a mother was at risk, my father did what was necessary to save her life. The issue is that you are asking people to give advice about something which they have not just a conscience issue about but they believe is a medical health issue for the person. It would be like saying, 'We need to find some doctors who will say smoking is good for you'. That does not come up. I am sure my father would say that this is a bad health outcome if it's simply a choice being made, unless there is a medical risk to the mother. It is not just a philosophical issue, it is a medical issue. I get your point that they can still give advice and refer on.

Mr MULDER - He could say that, and the law won't stop him from saying that. Anyway, on the access zones, we have had some discussion about that and I am wondering what your view is on those.

Dean HUMPHREY - I am always very nervous about things that put into legislation or make law things which would seem to limit freedom of speech. It would seem to me it is an unnecessary piece of the legislation. My understanding from speaking with police officers is that under the existing legislation they have things that can be put in place. My memory is that when the minister put forward the bill she said in her speech that all these provisions are already there, so why put them into the bill on this matter?

Of course I need to say that some of the demonstrations that have happened outside health clinics that provide this service have been abhorrent. Nobody should be made to feel diminished or attacked for seeking what they believe for themselves is an appropriate health outcome. I would very strongly denounce any group that sought to bring shame upon those seeking health services. Having said that, there are so many dangers in a fairly arbitrary distance - it is not clear what is appropriate or inappropriate in that area - that I would argue that that whole section be excised from the bill. I can't see any benefit to it if the things are already protected by the legislation that is already in place.

Mr MULDER - What about actions that are intended to intimidate, even if they are not technically against the law in a sense - for example, holding a placard with some of this graphic stuff? I might say both sides of this debate inappropriately use graphics. To do

that outside of parliament might be fair enough, but outside a clinic where someone who is, by your own admission, engaging in something that is highly sensitive, is hitting people in a place and at a time when they are most vulnerable to emotive pressure.

Dean HUMPHREY - Sure. Again, I would not support such behaviour and if I was made aware of it I would seek to ask them to move. I am not aware of it being a particular problem in Tasmania. You may have evidence before you -

Mr MULDER - The law covers things like jostling, insulting, haranguing, annoying, and using threatening and intimidating language, but it doesn't cover things like the silent protest with excessively graphic and emotive material. If that was going on outside the clinic you could go to the police all you like but they would say, 'Sorry that's not against the law', whereas this actually brings that collective issue to a point. If it's not appropriate why -

Dean HUMPHREY - I'm not a lawyer so it is hard for me to answer. I can only say that my discussions with both the police and my recollection of what the minister said was that everything that was in this bill, apart from the distance, is already covered by simply collecting powers the police already have into one place.

Mr MULDER - It goes beyond that, as I just pointed out - and that's from my experience as a police officer.

Dean HUMPHREY - That's fine, Tony.

Mr MULDER - To me it seems that that provides a case for this, and I notice that you've taken on the minister's assurances in the second reading speech and other things, that provided it isn't broadcast to the general population or targeted at a particular individual you can say what you like.

Dean HUMPHREY - For sure. You may notice both in my submission and the diocese one it is not an area we particularly focused on in terms of concern. We don't think it's a good way forward for legislation because it would start to mean every special interest bill might suddenly have a freedom of speech impact put on it. I assume that's not the case, but once that's there that's a possibility. My concern, though, is with the legislation. Yes, she gives assurances in her speech but she also gave assurances in her speech, for instance, that this bill could not be used for gender selection and yet within weeks after that the bill is based on the Victorian bill and a situation came up with that in Victoria. If we're given assurances by the minister, why are they not put into the legislation? Why is it not clear in the legislation? People will use the legislation as it is written, not as it was intended.

Mr MULDER - The purpose of the second reading speech is to provide public record and some guidance to the courts that should someone come along and say -

Dean HUMPHREY - But why not make that clear? For instance, on the gender issue, why is that not in the legislation? I know you can say that the second reading speech is part of the public record - I know we're getting off the topic of your question - but it seems to me that we want protections of some kind for the child in that matter.

Mr MULDER - In order of your priorities, the question of access zone is not right up there with the question of terminations?

Dean HUMPHREY - Absolutely not.

Dr GOODWIN - Dean, I wanted to raise a couple of matters with you. You mentioned a UK case about a cleft palate. Can you elaborate on that a bit?

Dean HUMPHREY - It was in a report from the National Health Service 2012 in the footnotes and I think the safest thing would be for me to direct you to the footnote. It's been some time since I read my own report in full with the footnotes. I thought the time had passed for the presentation to this, so it was put to one side, but it said in England one of the reasons people were choosing to have abortions or terminations was because of very minor defects in their child, such as a cleft palate.

Dr GOODWIN - Just on the clause 7 objections on medical practitioners and counsellors around the pregnancy options advice issue and how that relates to the service that you provide in your role as Dean, have you had any legal advice that you are covered by this clause?

Dean HUMPHREY - I have forgotten to bring my copy of the bill with me but the language, it seems to me, is fairly vague in terms of what a counselling service is. In my current role I have all manner of people from all sorts of places who come and tell me their stories and I can certainly think of a number of women who have come to see me. These are people with huge needs who are often homeless or the way they find accommodation is by sleeping with somebody.

Ms Forrest - That's the cold, hard reality.

Dean HUMPHREY - Absolutely. I remember sitting down with a lady who I bought a McDonalds lunch for and over lunch she said, 'I've got to go and get a pregnancy test because I had to pay the rent last month'. That is the kind of situation I am dealing with, as are many others - I need to make that clear. If that person was to become pregnant, I assume she would come and ask me for advice. I would give my advice as best as I was able under my ethical understandings, but my understanding is that as soon as I am doing that I am counselling her and I would fall under the provisions of that bill.

Now I know the bill is not trying to pick up the clergy but I would certainly prefer it to be clear. I appreciate that in the second reading speech the minister spoke about one of the problems with counselling is that the whole thing is so vague and unregulated as it currently is that I can't see how I wouldn't be caught up in it.

Dr GOODWIN - I suppose the point to make is that your parishioners would be seeking advice from you because they feel comfortable with you, they know you. That is whole reason they come to you in the first place.

Dean HUMPHREY - We also have people who come to us simply because we're in the city and we're there.

Dr GOODWIN - A convenient location.

Dean HUMPHREY - I spoke in my submission about people who came to see me. I have had a person come to see me at the cathedral who had an abortion 15 years ago who just walked in off the street and said, 'I need to talk to someone'. I know that was a post-counselling session; I had not done anything to engender this conversation, but if someone is pregnant and wants someone to talk to, for whatever reason they chose to come into the cathedral and speak with us, we would want to help them and encourage them to make wise decisions and put good information before them. Again, in that situation, I struggle to see how we wouldn't be caught up - it is the vagueness of the wording there which worries me.

Ms FORREST - With regard to counselling, if a woman parishioner came to you who needed to have a termination or she really believed she should; it was her most difficult choice, perhaps because of a severe foetal abnormality, her health issues, or carrying a genetic trait she did not want to pass on - and this can come back to sex selection because the sex of the child carries that gene that creates the problem - how would you deal with that?

Dean HUMPHREY - Prayerfully would be my first answer, and by listening and seeking to understand where the woman was at. If she started by saying she needed a termination, that would create a different dynamic in terms of wanting to understand why she felt that was necessary. In the end, I am only a pastor and I can only give advice on the way in which I think God would want us to act and behave towards caring towards those who are more vulnerable. One of the concerns for me is that if the child is in need or is somebody who has some difficulties, as a society our solution is not to remove that person from society or allow them existence, but to care for them. I would be wanting to explain things like that to the person.

It is incredible to me that we had a newspaper article yesterday about the dangers women are causing to their children with smoking and drinking during pregnancy and yet we can then merrily be advising people, 'But okay, perhaps if you've done that maybe you could terminate the child'. The ethical confusion there seems to be huge.

Having said that, the days in which a churchman could say, 'You must do this', or, 'You must not do that', and everyone responded and bowed down and just did what we said, I'm not sure ever really existed and certainly doesn't exist now. Our course of action would be continue to care for that person, whatever choice they make.

Ms FORREST - Would you advise her to talk to someone else if she still thought it was the only real option she had, even after talking to you? I would expect that a woman coming to you would know that you had a fairly firm position on this. It would be a bit of a surprise if you said you were pro-choice and happy to discuss it all.

Dean HUMPHREY - I can be pro-life and happy to discuss it all. I reject that option.

Ms FORREST - I said pro-choice, I didn't say pro-abortion. We're talking about different things here.

Dean HUMPHREY - Yes, but I can be pro-life and talk about talk about all options. I am sorry, Ruth, I do not understand why I have to be seen to be somehow not able to provide appropriate information to someone.

Ms FORREST - No, I am not saying that. If after talking to you she says she still needs to go down the path of a termination, what do you do at that point?

Dean HUMPHREY – I am not a medical professional but I know where the clinics are so I would advise her to go and see a doctor who can give her the advice she needs and I would continue to care for her through that very difficult process.

Ms FORREST - Isn't that exactly what this provides for, this conscientious objection phase you are talking about? You are saying you will talk to her and give her your view.

Dean HUMPHREY - I can imagine a situation where someone would come to me and I would believe their decision was purely selfish on the basis of what they where doing and I could not support their action in any way. Under this bill, that would get me into trouble.

Ms FORREST - Why?

Dean HUMPHREY - Because I am counselling them and not providing any options. I am just saying it is a possibility.

Ms FORREST - But wouldn't you say to her, 'I don't want to discuss that because that's the wrong thing to do and if you want to talk about that, you're going to have to talk to somebody else.'?

Dean HUMPHREY - My understanding of the bill is that I have to go beyond that and give them the options. I can't simply say, 'This is a bad decision, you are doing the wrong thing', which as a priest sometimes I feel I have to do. I would then have to say, 'But here's how you go about it anyway'.

Ms FORREST - No, more like, 'But if you really want to discuss this more with someone else, you need to go somewhere else.'.

Dean HUMPHREY - But I would have a real ethical issue with that. I think she is about to make an incredibly selfish and damaging decision, so why would I facilitate such a decision?

Mr VALENTINE - What about a list of services on a pamphlet which does not dictate?

Dean HUMPHREY - If that's the way around that then that can be a way around it, but it just seems to me that there are all sorts of minefields for us. I mean, I get what this trying to pick up; I understand that. My mum ran the Pregnancy Support Service for many years which was there because my father, with his position, felt it wasn't enough just to simply not provide terminations but they needed to seek to give care for those who had made the decision to carry on with their pregnancy, so Pregnancy Support came into existence. The other thing is that we continue to care for lots of people who make bad decisions, including ourselves at times.

Ms FORREST - Would you accept, though, that if you took the approach where you actually said, 'You're a making a wrong decision - wrong, wrong, wrong - I don't want to talk about it', that you then make it very difficult for the woman to even think, 'How else can I do it?', except to think, 'I'll just do it myself.'? One of the problems we had with the law reform in the first place is that women were being told that they were bad, bad, bad -

Dean HUMPHREY - I didn't say that.

Ms FORREST - No, I'm not talking about you. I am saying this is what happens historically. They had nowhere to go so they did it themselves with disastrous consequences.

Dean HUMPHREY - Absolutely. I prefer the kind of thing of 'safe, available but rare'. I would struggle to see how a priest saying something to someone in that circumstance would force them to do a backyard abortion.

Ms FORREST - But you are making them feel like it is the absolutely wrong thing to do and not giving them any other option.

Dean HUMPHREY - I am saying I believe there would be times when I think that would be the right call on my part from my ethical position.

Mr MULDER - I think there is still some misunderstanding. This legislation is not saying that you should refer them for an abortion. All it is saying is that you should refer them to another counsellor or medical practitioner for options. We have heard from a lot of people here and not one of them has ever said that they have a conscientious objection to not aborting when asked, so whoever you send them to will be providing the options so I don't really see the other -

Dean HUMPHREY - Let me explain a situation. I get what you are saying, Tony.

Mr MULDER - The referral is about options. The referral is not about the actual termination itself.

Dean HUMPHREY - Let me give you an illustration - I am thinking a little bit on the fly here - but say a woman comes to see me at 34 weeks. The relationship with her partner has just broken down, she is distraught and because she now doesn't like the husband she is determined to get an abortion. To my mind, I would really struggle with anything that would support that.

Ms FORREST - Where is your evidence of that ever happening?

Dean HUMPHREY – I am simply giving that as an example, Ruth, but the legislation doesn't give me the option to be able to have the ethical decision to say, 'I think that is a bad and selfish decision but here's how you do it anyway.'. That's the bit I would struggle with.

Mr MULDER - From what I see, the legislation gives you the absolute right to make the point that it is a bad and a poor decision. You have given her alternative options to the one she might have in mind and if she then persists on going ahead with it you have to

say, 'I can't assist you any further with dissuading you but I can give you a list of people who you can discuss the options with'.

Dean HUMPHREY - Tony, I'm struggling - and Ruth, I'm sorry if my illustration was offensive -

Ms FORREST - Well, it's just that it doesn't happen.

Dean HUMPHREY - I'm not seeking to be offensive. I meet all sorts of people in all sorts of places who make all sorts of poor decisions but, Tony, in my position I would consider what that person is doing is getting pretty close to murder. Are you wanting me to be able to say, 'I can't support that heinous act but here is somebody who can.'? Do you want to place that ethical burden on me of supporting something that I really think is wrong?

Mr MULDER - I want to elevate this a little further. I want you to elevate your thinking about what this law requires of you, because earlier you said that you would refer people on, that you didn't have a problem with it. Now you are saying that if one of the options that that other person is prepared to countenance is abortion, you would not be able to refer that person?

Dean HUMPHREY - I said under certain circumstances, Tony. I was not saying that I would not do it in any circumstances. I am saying I can imagine circumstances in which that would be difficult for me ethically.

Mr MULDER - We always sit here having huge debates about exceptional or rare circumstances but policy doesn't always work that way. What we are talking about here is a routine procedure and the example you cited was quite extreme. If at the end of your initial discussion this woman says, 'Yes, I've heard the options but I'm still going ahead with an abortion', how could you possibly have a conscientious objection to saying, 'I've given it my best shot. Here is someone else who doesn't have my conscientious objection to it but will talk through these options with you.'? I am not sure how the fact that one of those options they are prepared to countenance isn't one you are prepared to countenance puts you in a moral dilemma.

CHAIR - To be fair to the Dean, he is entitled to his view. It is not for us to question how on Earth he could have a conscientious objection to refer on. We should respect the fact he has that view, given the current wording.

Dean HUMPHREY - Tony, you ask if that is what I would do in most circumstances. Absolutely. My role is to care for people as I can. I am not a medical person so the first thing I would be doing if somebody came to me with an unwanted pregnancy - and I know it's a different circumstance to the one I was talking about before - is ask them, 'Have you been to see the doctor? What is their advice?' We need to get that opinion. Our job is not to take over roles that are not ours. I am simply putting forward that I think there are times when I would find it extremely difficult to support in any fashion a choice that was being made. Again, I know I am choosing extremely difficult ones, but in general I have no problem with the matter you are proposing but the legislation doesn't give you that possibility. It seems to me that that area needs to be worked on.

One of the things about legislation is that it becomes a game for people to get round things, so if you put in 'excluding religious practitioners' then I presume a whole bunch of people would suddenly jump in and make themselves religious practitioners to get themselves outside the bill. That is not what I am looking for, but there are concerns for me of what that section is. The other thing is the assumption it means that my view is somehow less valid than somebody who can talk about [inaudible]. It seems to be built into the legislation.

Mr MULDER - Do you see the need for the legislation to deal with counselling at all? I can see why it would deal with medical practitioners because they perform these actions, but counsellors?

Dean HUMPHREY - We could have saved ourselves a long discussion a minute ago if you'd done that. I don't know enough about the background to the bill, but I assume there have been reasons as to why counselling needs to be in there. I would have thought that for places such as Pregnancy Support it was pretty clear what their line was and the advice they could give, but if that was clear upfront that may not make it necessary for the counselling section to be there.

Another thing that would be helpful would be if there was a set not just of providers. When I marry people I have to give them the document referred to in paragraph 42(5)(a) of the Marriage Act of Australia 1961. Apparently I am supposed to say that to you as I give it to you.

Mr MULDER - Since you are under oath you do.

Dean HUMPHREY - Absolutely I do. You have to actually give them two documents according to the act, but one of them has not been in print for 15 years, so there is one for the lawyers for another time. It would perfectly possible, I would imagine, to create a document of a similar kind. I can imagine there would be all sorts of fights over what would be in it, but one that would give some views, some providers, and here are the things they will do. That could the kind of stuff that would be there from the beginning. I would have less problem doing that at the beginning of a conversation. As I said I can only imagine times - I've never had them - where I would struggle with it.

Dr GOODWIN - I suspect that if you were faced with a parishioner who was about to make a decision that you thought was wrong, you would advocate your position fairly strongly to them - is that fair?

Dean HUMPHREY - I hope I would advocate it strongly but compassionately.

Dr GOODWIN - Nevertheless, you might be seeking to persuade them that the decision they were making was wrong in accordance with the way you felt.

Dean HUMPHREY - Yes. The other issue is that I would be wanting to tease out why they felt they were in that situation. One of the things that I find really distressing when I talk to people after the fact, again I am thinking of one in my previous parish, is that she really felt she had no choice at the time and nobody had spoken to her about choices. All the pressure was on her, 'Come on; you can't have this child'. I would be wanting to make sure that every opportunity had been given for her to reflect and consider that

option. In the end it's not my role to say, 'You must choose this way'. I would pray with them and seek God's wisdom on what they were doing. I cannot speak on this particular matter but I have had other very difficult ethical situations where the people know that I have disagreed with the decisions that they are making, but I don't think it has impacted my care for them. I cannot think of a situation where I have disagreed with somebody on an ethical matter in a pastoral situation where it has led to a breakdown in relationship or a failure of care for them.

If you mean by putting my view forward strongly, 'strongly' I hope would not mean in a diminishing, belittling or offensive fashion.

Dr GOODWIN - No. I am more getting at by putting your position forward strongly you might be hoping you would dissuade her from going down the path of a termination.

Dean HUMPHREY - Yes, that would be a hope, but in the end we all have to be responsible for decisions that we make. I would be seeking to put a variety of decisions. For instance, I've sat with people who have discovered that as soon as their baby is born it will die - that's just the medical reality - and they have made decisions as to what to do from that time forward. I have argued one way; they have argued another and we have cared for them until the child was born and died. I think we all put forward our points of view in the way that we hope that everybody will agree with us.

Dr GOODWIN - And that's the point.

Dean HUMPHREY - Everybody has a right to my opinion.

Dr GOODWIN - It's a bit of a fine line and this is the grey area that is emerging from this clause. Even when you read the second reading speech it's a bit of a grey area as to the provision of advice - you might be strongly advocating for one position or against another position - and at what point it's trying to push the person in a certain direction, or dissuade them from taking a particular course, that you then fall foul of this clause. That is the point I'm trying to tease out. It is not clear. I thought it was clear but having now read the second reading speech I am less clear on what this means practically.

Dean HUMPHREY - I hope the committee does not take up all its time pondering how clergy are going to be impacted by this bill. There are far more important parts to this bill than that, but it seems to me that is an area of concern. The other thing that raises for me - and I am thinking particularly in relation to the church - is that our role should not just be involved at this end part of the discussion. We need to be encouraging government to have appropriate sex education in schools, relationship counselling and working on the social issues that are likely to create environments where terminations are felt to be required. There needs to be a far larger conversation taking place rather than ethical quibbles of the church at this point. I hold my positions firmly and strongly but it does seem to me that we need to have that as part of a wider conversation. I know that is outside the issue of the counselling, but I don't see how we can have an attitude and opinion there and not be dealing with it in terms of the kind of context that create the conversations we have.

Ms FORREST - Earlier you said, Richard, that women come to you sometimes many years after a termination to talk about it. You made the point that the termination always

changes a woman. Is it fair to say that a miscarriage on the birth of a child also fundamentally changes a woman?

Dean HUMPHREY - Absolutely.

Ms FORREST - It is a life-changing event, whether it is a termination or proceeds to a birth?

Dean HUMPHREY - I have counselled people who have had miscarriages and they have been greatly traumatic for the people involved. To me, the difference is that a decision has been made in one case and no decision being made in another. One is part of a natural and unfortunate process, but one is the outcome of a decision. I may have people come and see me who are saddened by the child they didn't have due to a miscarriage. It is a very different circumstance to the person who comes to see me 15 years later because they chose to have this procedure.

Ms FORREST - Do you also accept that some women have terminations because there aren't any other options?

Dean HUMPHREY - I am sure that is the case. Where the life of the mother is in danger, that clearly would be a case for that. To go back to my original point, my concern is that the bill as it currently stands only considers the issue of the mother and her circumstances. It does not argue anywhere where in this case abortion cannot take place. It does not give any value to the child; it only assumes the value of the mother's life. In later life when they reflect on that, many struggle with the decision they made.

Ms FORREST - You made a point earlier on and in your submission that the rights of the child to life and care, enshrined in the UN Declaration of the Rights of a Child, are not recognised, but those rights only exist when the child is born.

Dean HUMPHREY - No, that's not true. The UN Declaration says 'before birth'.

Ms FORREST - We don't ascribe any rights to a child before it is born so far as it having a right above the mother.

Dean HUMPHREY - I am struggling as to how that would be the case.

Ms FORREST - That is the way it is at the moment.

Dean HUMPHREY - Currently under the legislation, the unborn child is recognised as a child, so under the Criminal Code section 165, causing the death of unborn child, it is recognised as a child. There is nothing in this legislation that recognises we are talking about a child. That creates a huge ethical problem. All the other things we have talked about are interesting and helpful, but to me the fundamental issue is at what point is any value placed on the child. I cannot see how it is simply a matter between a woman and her doctor. There is another life involved.

Ms FORREST - If that is a concern you think needs to be addressed - and I think the diocese's submission was that we should make significant amendments to deal with that - what would you suggest?

Dean HUMPHREY - No. I think it is the place of the parliament and the Council to have worked out what is the basis on which we are making this decision, what is the philosophical framework on which we are doing this and let's enshrine that in law. At the moment, the child simply has no value.

Ms FORREST - If that is the opinion you hold, that is fine. But this is about a piece of health law that is trying to be brought in to enable a framework whereby women can access a termination as a medical procedure. Some argue that we shouldn't even have it all because it should be just like every other medical procedure where there is informed consent, and any inappropriate or negligent behaviour under that is dealt with through the health regulator. Others have said it should be a criminal offence and remain where it is, in the Criminal Code. Some people say it should be illegal altogether. Then there is this view that the minister has put forward, suggesting that it should be health legislation in a separate act because it is different because we are dealing with a woman who is pregnant here. There is broad range of views.

Dean HUMPHREY - The very fact that we have a bill philosophically says we are dealing with something other than simply a medical procedure. When that argument is put forward to this committee, in which case, if they saying that, then they are really saying there should be no legislation and it should simply be dealt with as a medical procedure. We have a bill, so we are recognising there are philosophical differences. The recommendation that we put in the diocese report was that section 165 should remain in the Criminal Code and that the medical risk category continue as part of the good reasons for having an abortion, the reason being that it then recognises that the child has value. There is nothing in my reading of this bill that gives the unborn child any value at all. It is simply a decision by the woman.

Ms FORREST - Some people have said this is more of a middle ground.

Dean HUMPHREY - I don't hear anybody describing this bill as 'middle ground'.

Ms FORREST - No, I am seeking to explain why people are saying that. Is it that, if you don't have a specific piece of legislation for it and treat it purely as a matter of a health decision between a woman and her doctor, some people prefer that? Some people prefer it to stay in the Criminal Code and there are some people who prefer it to be completely legal. It is different and that is why this has been proposed, to recognise that difference. You don't agree with that?

Dean HUMPHREY - No because, again, there is nothing in this bill which recognises the right of a child to life, the value of the child and by removing the medical risk category, that child is not even recognised at all. That is the reality of the bill and I'm sorry, Ruth, I don't hear anybody describe this as a middle-ground bill.

Ms FORREST - It has been in this forum.

Dean HUMPHREY - Certainly by nobody with whom I discuss; this is seen as very extreme.

Ms FORREST - Very extreme? More extreme than what we have now?

Dean HUMPHREY - It is more extreme than what is in Victoria, in terms of the freedom of speech things that are around it inside it.

Ms FORREST - We are not talking about freedom of speech here, we are talking about a baby here.

Dean HUMPHREY - I am talking about the bill in total.

Ms FORREST - But your concern seems to be around the fact that it doesn't recognise the unborn baby and you say it's more extreme than Victoria.

Dean HUMPHREY - I mean the bill in total is more extreme. In which case I retract my comment about Victoria. But in terms of this bill, under the previous legislation it talked about medical risk to the mother and recognised that the child had value. I cannot see anything in this bill that recognises the value of the child.

Ms FORREST - Under the previous legislation it recognises the child has value?

Dean HUMPHREY - Because it talks about medical risk to the mother. That was the reason by which terminations were provided.

Ms FORREST - This talks about medical risk to the mother.

Dean HUMPHREY - But it goes wider than that.

CHAIR - I am going to intervene at this stage. We have gone over an hour and the Dean has given his opinion about his view of the bill. We can form our opinions. I don't think it's terribly productive that we go back and forth as to that challenge.

Ms FORREST - It wasn't a challenge, it was taking another line.

CHAIR - I have indicated where I sit with that. We have taken a long time. Are there any other questions you have, Ruth?

Ms FORREST - Only the one I wanted to pursue, if that is all right.

Mrs HISCUTT - You spoke about the nurse who left the profession because she felt this might impinge -

Dean HUMPHREY - To be precise, it is a student training in midwifery. I can think of other examples, but the one I referred to was one who had started her training and felt that she could not continue with her training

Mrs HISCUTT - Is this recent and is that due to this new bill?

Dean HUMPHREY - It is not training in this state, it is in Victoria, and my understanding is the bill is very similar to the legislation.

Mrs HISCUTT - If it is not in this state then it probably doesn't refer to this bill.

Dean HUMPHREY - No, but I am simply saying that that is the kind of outcome that comes from not enabling people to reflect their conscience in the way they train and there will be people who would be good and a great blessing to the health care of this state but who would feel, under this legislation, that they may not be able to participate.

Mrs HISCUTT - Yes, because under proposed section 6 of the bill a nurse has a duty to treat but they don't have to unless it is to save the life of the mother.

Dean HUMPHREY - Yes, it says 'in an emergency' and emergency is not in our submission. We talk about the fact that an emergency is not discussed very well. What does 'an emergency' mean? Who describes it as an emergency and at what point is this called an emergency? The other thing worth thinking about is that there will be women for whom it won't simply be a conscientious objection but they will have had medical procedures that would make going through this traumatic, if they were forced to go through it - people who perhaps have had a miscarriage or had an abortion themselves and that has not been helpful -

Mrs HISCUTT - Are you talking about the nurse?

Dean HUMPHREY - The nurses, yes. There should be a category which says, 'I simply cannot do this. It's actually bad for my health to be involved in this'.

Mrs HISCUTT - Section 1 says that they don't have to.

Dean HUMPHREY - Not in the emergency section.

Mrs HISCUTT - And section 4 says if it is necessary to save the life of that pregnant woman they will have the duty to treat at that stage.

Dean HUMPHREY - I think 'emergency' needs to be spelt out more and we cover that in our submission.

CHAIR - I think we are done. We have had more than an hour. We appreciate your time, Dean.

Dean HUMPHREY - That is fine. If I can leave you with one question, it would be interesting to know what success looks like in this bill.

CHAIR - Thank you.

THE WITNESS WITHDREW.

PUBLIC

Mrs PAT GARTLAN AND **Dr BRIGID McKENNA**, CATHOLIC WOMEN'S LEAGUE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Good morning, Pat and Brigid. We will keep going because we have a quorum and we can tag members in and out. Pat, you have appeared before parliamentary committees and you understand the notion of parliamentary privilege, I would think. Brigid, you are clear that you are protected by parliamentary privilege while here so we won't go into the detail of that.

We have your submission so we are happy to hear verbal support of that submission, which will then form part of the public record, as you understand, whichever way you want to handle that.

Dr McKENNA - Good morning and thank you for this opportunity to appear before you on behalf of the Catholic Women's League of Tasmania. I am a member of the League, but I also hold degrees in both medicine and bioethics and I am currently the national research officer for the Catholic Women's League Australia, as well as a lecturer in health care ethics.

Mrs GARTLAN – I am a member of the Catholic Women's League and I am currently the convenor on the Social Issues Committee and as well I am a founding member of Pregnancy Support Service, now known as Pregnancy Counselling Support in Hobart. We have been there for 22 years and I helped to set up the whole thing and made decisions about how the operation would work. I stress today that I am not speaking on behalf of the Pregnancy Counselling Service because I am no longer associated. I did also serve a term as national president of the Pregnancy Support Service Centres Australia. I am a qualified pharmacist.

Dr McKENNA - As you can see, the Catholic Women's League consists of a diverse range of women who have had a lot of experience. Our organisation has a particular focus on the dignity and the rights of women and children. It's one of our key focuses when it comes to public policy. I say at the outset we certainly don't rescind from the fact that our approach to this broader issue and to this bill is founded on our recognition of the humanity and therefore the dignity of the unborn child.

At the same time, however, we are also sincerely concerned for the one in three Australian women who in their lifetime may have an abortion. Not all women suffer after abortion, but sadly some do. By this account CWL Tasmania believes that really the only legitimate goal of abortion law reform is something that would attempt to strike a balance to minimise the loss of pre-natal human life and the possibility and potential for harm to women.

We don't believe that this bill has this goal in its sight. We are especially concerned and it's largely what I would like to address today, about provisions that would effectively introduce abortion at the request and consent of a woman. What advocates for abortion rights used to be happy to call abortion on demand - I know that that's not a favoured term at the moment - but effectively that is what this bill would create for pregnancies up to 16 weeks.

The fact is that unlike the current law, in this bill there is no requirement for terminations up to 16 weeks of pregnancy to be legally justified. All that is required is the woman's consent. I know that supporters of the bill argue that this is the position that is most compatible with full respect for a woman's autonomy, but the flip side of this position is that it accords no public interest in the preservation of the life of a human being at the embryonic and the foetal stages.

One way of looking at this bill, then, is to say that really it's trying to re-frame abortion as a normal medical procedure, as a reproductive health service. We would submit today that no matter how much re-framing is undertaken, this doesn't change the reality of what abortion is and whom it involves. Clearly, it is the deliberate ending of a life of a pre-natal human being and whom does it involve? Obviously, most intimately a woman and her unborn child, but also too, as I'm sure you're aware, the father, possibly other siblings, grandparents, health care professionals in our institutions, our professions and, as you've just been discussing, our counsellors.

From our point of view law and social policy need to respond to the reality of abortion. I agree that that is a very difficult task for legislators. We need to respond to the reality and not some sort of re-framing of the issue, particularly when it is such a sensitive issue and when we know there are strong ideological positions at play.

We have argued in our submission that the current requirement that abortions up to and beyond 16 weeks of pregnancy needs to be legally justified; that at least it provides some recognition of the value of early and nascent human life. Re-framing the issue in the way this bill does simply renders the human foetus invisible. Re-framing abortion in this way also, to some degree, misrepresents women's experience of abortion. Women know abortion is so much more than this.

As an interesting aside, even in Sweden where abortion on demand has been available since 1974 for up to 18 weeks, there has been a good study recently that says six out of 10 women undergoing abortion report existential thoughts about the life and death and the meaning and morality in relation to their abortion experience. Almost half the women felt the need to make some sort of special act in relation to the abortions and almost seven out of 10 women thought of the pregnancy in terms of a child. The conclusion of this study - and it is published in a reputable journal - was that there is a challenge for abortion personnel because the situation involves complex aspects over and above medical procedures and routines.

The reality of what abortion is and who it involves is the very reason abortion is such a difficult, complex and considered decision for women. Research again shows that ambivalence about the decision and in the midst of the decision-making process is extremely common. In our view, this accounts for, not against, the current requirements for independent review by two medical practitioners as well as the value of offering counselling on other matters related to terminating a pregnancy or carrying the pregnancy to term.

We think this bill removes these opportunities for information, professional support and accessible counselling to aid women's decision making.

Ms GARTLAN - It's on this point that I draw upon my experience of 22 years listening to the stories and accounts of women in this situation. I am passionately of the view that to remove the opportunity to gather all the information needed to make this decision, to have no presence of what we already have as a requirement from the doctor, is absolutely dreadful. It means you are putting people in a position of having to make a decision on the basis of no information.

It is interesting that some speakers before this inquiry, many of whom are abortion providers from interstate - and I have been reading the transcripts - seem to be using this inquiry in order to facilitate law changes in their own states. They are of the view that this provision of discussion with the doctor about the medical risks, the pros and cons et cetera, restricts access to abortion. It is an unreasonable restriction and it casts a slur on the status or the ability of women as competent and conscientious decision makers. That seems to be the inference; if you have to go in for all this, it means you can't make up your own mind and you're not very bright.

Having been in the League for quite a long time, I assure you that in no way does the Catholic Women's League have the slightest doubt that women can be competent and conscientious decision-makers. Such a suggestion is something that we simply do not accept. However, who can make good decisions about a matter as complex as this if they do not have the information in order to consider, and the time and the opportunity to consider it?

So we feel it is a matter of justice that provision for information gathering should be present in any legislation pertaining to abortion law.

Thus it establishes in law the true significance, as Brigid was saying, of the abortion decision which the Victorian Law Reform Commission describes as a decision of deep moral significance.

The present requirements for information about the physical and mental health risks of induced abortion and carrying the pregnancy to term and the offer of counselling should remain. It does not serve the welfare of women, whatever their point of view might be on the matter at hand, to remove that. The other point is that if you do remove it then it just becomes, quote, 'another medical procedure'.

The pressure on women to, quote, 'get rid of it' will be greater because people will think there is no real problem - 'What are you carrying on about, why is there a problem? - because, clearly, there is nobody to -

I would like to get on to the question of counselling because this seems to be a big issue. The previous federal treasurer, Wayne Swan, got the news that he had cancer - this was a couple of years ago - and he talked about how he felt. He said, 'The specialist called me one morning - it was a Friday morning, I was sitting in my office by myself - to give me the bad news.'. He just hung up then. 'I was devastated. I thought a lot about life. I didn't make any phone calls, I just sat there and thought about it. I didn't know what it meant.'. There are probably not too many others of us here who possibly understand it either.

He was facing a sudden, unexpected, life-changing situation and he had crossed with me on a variety of levels, not just with medical conditions, and I can see this - I have seen it - in women of all ages who have come for counselling and this is it - they are stunned, they are devastated - a major life-changing issue.

The boyfriend or the husband is unexpectedly unwanted for the time being at least. They are in new territory; this is something that they have not experienced before. The next thing you say is, 'What does help them?', and I want to talk about what is meant by counselling.

As a pharmacist, counselling is now: 'Here are your tablets to be taken after food - and you had better avoid driving a car while you are on this course of tablets.' You go to the bank - it is called counselling there too; do I do this or that with my investment or do this or that with my bank account? You get counselling from the bank.

Counselling means all sorts of different things depending on the context. The counselling which has been accepted as the most satisfactory in this situation is what is called 'Rogerian counselling'. A man named Carl Rogers developed this and it was the counselling that was selected by the Hobart service, and we were trained in this by practised, experienced counsellors in Tasmania and elsewhere and it was picked up also by the federation. The basic principle is that counselling is a process. It works within a relationship and the counsellor believes the client is able to deal with the problem respects our clients' rights to autonomy and self-determination.

How does it work? You have someone coming in, she is very upset, crying or throwing things, in a terrible state: 'This is dreadful, I can't do it, I feel numb, I am out of control, I don't know what to do, this is terrible'. In a counselling situation that could go on for five minutes or an hour and what she needs is somebody to sit and listen to her so that she then eventually gets to the point where she can start to think, because it is well known that nobody can think clearly when they are in a state of high emotion. It just can't be done - you are talking about being frightened out of your wits and this sort of thing - that is the situation we have there.

I have to reach the stage here where we are getting to the situation of who can counsel on all options? For people in the community who view abortion as a very disturbing element of life from the point of view of the individual and the community there are two options available really: one is to take up political action, to go into the public space to educate, to discuss the ins and outs of abortion and what it does, and to try to persuade people like yourselves to pick up what they are saying. The other, they are separate - the other is to establish a counselling service, as Dean Humphrey was saying, and your focus then is on giving the maximum opportunity for a person to make a good decision and all that she needs to go through the pregnancy or if she has an abortion, to come back and talk about it if that is what is needed. They are two separate things.

If you have somebody coming into the room in a counselling session and she sits down and you say, 'What's going on? Tell me what's going on.' 'I'm pregnant and I can't do this and I want to have an abortion,' and you say, 'Good heavens above, you can't do that; that's terrible and you can't do that'. What is she going to do? There are a few things she might do; she might throw something at you, she might get up and walk out or if she is a very well behaved lady she might sit there and hope for goodness she might be able to go

soon. It is ineffective. The aim of counselling is to provide an effective method for this woman to make up her mind.

The notion that you don't talk about all the options is maybe the case in some areas - certainly, this is not something I have experienced. How can you make a decision unless you have all your facts about all of the options? That is my feeling there about this difficulty of understanding of what you mean by counselling. The notion that it may not be necessary to have it in the bill at all is possibly worth thinking about during your deliberations. I haven't talked to Brigid about this so I don't know what she thinks about that.

The other thing is this question of the suggestion that it is for the government to tell people who they can talk to about these things. The notion that if you are in this situation you can talk to some people but you can't talk to others about it seems to me an extraordinary suggestion. We are talking here, I suppose we would say, about a pluralist society - everybody has their own milieu, their own connections, their own particular culture. There are places where they feel comfortable, where they feel okay, where they feel they can go and open their hearts and there are places where they can't.

For a person with an unexpected pregnancy, shopping around is simply not something you can do, so if you go to a counsellor and, according to the bill, the counsellor says, 'I'm sorry, I can't,' and they have gone to the trouble of coming there - which is a big effort - because this is a place they feel that they want to be while they are talking about all this, I think it is ridiculous - the notion that the government comes in and says, 'Sorry, you can't go to that one' or, 'You go to your GP and the GP can't talk about it because they are not too sure whether they're fully on-side with the whole idea. What I'm trying to say is that I think this is a terrible intrusion on the rights of people to deal with their problems in the way they wish to and the way that's most likely to suit them and to be effective for them.

Somebody mentioned the situation of a school counsellor. Say a 16-year-old girl in high school goes to the counsellor and says, 'I think I'm pregnant, what do I do?', and the counsellor says, 'Sorry, I'll have to send you off to the clinic'. This is not rational. This is Big Brother at work really; that's the feeling I have.

Ms FORREST - Brigid made a point around the issue of the unborn baby not having any status and the involvement of partners, families and that sort of thing. There is evidence, and this has been reported broadly in terms of literature and medical commentaries and stuff, about women in abusive relationships, where they are very much a victim of a whole range of abuses and one of the controlling behaviours is getting them pregnant deliberately and controlling her more through that. Those women often are also subject to repeated violence during the pregnancy. When we talk about those sorts of issues, how do you see all that?

It seems to me that the discussion tends to get a bit railroaded by this argument for 'abortion on demand', and I agree with your point that it's not a term that should be used. You can't 'demand' anything in medical terms, you have to give consent. However when there are those really complex situations it's not just about women who found themselves pregnant who perhaps weren't even using contraception at the time and took a risk. We hear a lot of evidence that most women who seek termination of pregnancy don't fit into

that category. The majority of them are actually using some form of contraception, what we'd deem to be very effective contraception, even sterilisation procedures and the like. How does that work in with the comments you made, those more complex and less straightforward ones?

Dr McKENNA - I would say that those complex situations are precisely where we should be doing everything we can to protect women and enhance their decision-making. I would argue that the current legislation at least affords the maximum opportunity, particularly in relation to the bill before us, for women to have those safe places to go - the requirement that she is consulting two medical practitioners and is offered counselling on other matters. I think because of those very difficult situations that women find themselves in, their reasons account for, not against, the removal of the current status quo.

Ms FORREST - Let us take the case of a rural community where there is limited access to doctors and if a woman is going to consider all her options it needs to be done in a timely manner. If termination is to be one of those options, which she may or may not proceed with, if you have a requirement that there be two doctors - bearing in mind that currently because of the stigma associated with a termination generally she may not want to go to one in her own small town - if you are trying to allow the women to make an informed choice that may include continuing the pregnancy, if you don't facilitate some sort of process that is relatively straightforward at the beginning in the early stages, aren't we doing them a disservice?

Dr McKENNA - No, I think it's very straightforward. The woman firstly would seek her own general practitioner.

Ms FORREST - Maybe. We've heard plenty of stories that they don't, particularly in small rural communities.

Dr McKENNA - There are a lot of doctors that woman can go to. I'm not saying -

Ms FORREST - There aren't in rural communities.

Dr McKENNA - I'm not saying that we should be making this harder for women. I believe that the present act gives women more opportunities for information-gathering and decision-making in a safe space.

Ms FORREST - The point I am putting to you, though, is that in Tasmania there are not a lot of opportunities in rural communities. You could have one doctor in town, or two, and if that doctor has a conscientious objection you are going to have to go somewhere else if they feel they can't discuss it.

Dr McKENNA - According to this bill you have to, don't you?

Ms FORREST - No, according to the medical code you have to.

Dr McKENNA - No. If I was a GP in that community and had a conscientious objection to abortion, this bill would make it impossible for me to give that woman counselling on all three options.

Ms FORREST - How does it make it impossible?

Dr McKENNA - Because I would be obliged to refer her to someone who I know does not have a conscientious objection to abortion.

Ms FORREST - That doesn't mean you can't talk about those options to start with.

Dr McKENNA - I don't think I'd feel safe because I don't think that's been clarified.

Ms FORREST - Aside from that point, if you have a situation where there is only one or two doctors in town, you say the current framework provides for women to get the information they need, but if you're going to give informed consent, if both those doctors have a conscientious objection you're not going to be able to give informed consent anyway.

Dr McKENNA - I don't see how this bill makes it any easier for that woman to access information and, if she wants, a termination.

Ms FORREST - It doesn't make it harder, though. You're saying it makes it harder.

Dr McKENNA - No, I'm not. I'm saying it doesn't make it any easier for that woman. I don't see how this bill improves access or provides that woman with adequate opportunities for good medical counsel and the option of other counselling. I don't see how this bill increases access for those women. The current act contains some provisions which I believe are, on the whole, good for women.

Ms FORREST - But isn't it true that conscientious objection and not wanting to be involved in a decision that involves a termination is adequately covered in the medical codes which doctors still have to operate under currently?

Dr McKENNA - Doctors have to give information on all three options. It does not require me to refer to another provider.

Ms FORREST - Yes, it does.

Dr McKENNA - No, it doesn't.

Ms FORREST - Can I take you to the medical code? This is 'Providing good care under the Medical Code'.

Dr McKENNA - Which code are we looking at?

Ms FORREST - The Good Medicine Practice - A Code of Conduct for Doctors in Australia under AHPRA. Paragraph 2.1 says:

> In clinical practice, the care of your patient is your primary concern. Providing good patient care includes …

> 2.1.4 referring a patient to another practitioner when this is in the patient's best interests;
>
> 2.1.5 recognising and respecting patients' rights to make their own decisions.

Dr McKENNA - Can I stop you there? The words 'in the patient's best interests' would be a critical clause.

Ms FORREST - In 2.4 about access to medical care:

> Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves …
>
> 2.4.6 being aware of your right not to provide or directly participate in treatment to which you conscientiously object, informing your patients and relevant colleagues of your objection, and not using your objection to impede access to treatments that are legal.

Dr McKENNA - I am not using my objection to impede access to treatments.

Ms FORREST - But if a woman is going to make an informed decision, surely they have to have all the information. This goes to Pat's point, and I absolutely agree. Pat made the point that anyone making a decision in regard to their health needs to gather all the information they need regarding their options and people being required to make a decision should not be required to do so based on no information.

Informed consent must always be given to any medical procedure, otherwise it is a criminal offence and will remain so under this bill as well. If a termination were conducted without consent it would be a criminal offence. I am struggling to see here how the call for having all this information available to women - if a person is not willing or able to discuss fully their options, then how can that be gaining all information and making an informed decision and thus providing informed consent?

Mrs GARTLAN - I agree with you. You should be able to look at all your options. It depends on what she sees as her options. She might see her primary option as abortion; she might see her primary option as keeping the baby and working out how to do it. Seldom is the option of adoption really raised. You concentrate on what the first thing is and how that would affect you, what would that mean to you, what is involved in that and what we know about it - 'I don't know much about it, but my girlfriend had one.' You do need to look at all the options and you do need to have information about them.

Ms FORREST - This is the point I am making - that the bill and the medical code ensure that people do get all that information because if someone has a conscientious objection, they are not required to discuss all those option if they do not feel able to. If they cannot do it, they need to be able to refer or they are required to refer.

Dr McKENNA - A professional understanding of the professional with a conscientious objection should recognise that patient still has the right to receive all information. In this case, they have the right to receive information about all pregnancy options.

Ms FORREST - The RANZCOG code of ethics is even more explicit.

Dr McKENNA - That is a very limited one. That would not, for instance, apply to me. It is really important that we separate the two contexts in which counselling is occurring here. Counselling by counsellor, as they are known in the bill, is very different to what could be undertaken in a doctor's surgery, for instance. So too is this notion of referral because, for a doctor, referral has a very specific understanding. It is above and beyond and it is a recommendation of a procedure, usually to a trusted colleague.

Mr VALENTINE - Is there a different word?

Dr McKENNA - Perhaps, because I think they are very different situations.

Ms FORREST - Where do you work?

Dr McKENNA - I am not practising at the moment.

Ms FORREST - Are you familiar with the Victorian legislation?

Dr McKENNA - Yes, I am.

Ms FORREST - The AMA in Victoria put some policy guidance in their journal, *Vicdoc*, in June or July this year. Some concerns are being raised by doctors with a conscientious objection about whether it is right and appropriate to have that there because people should be able to express that. It talked about the word 'refer' and the performance and professional standards panel of the AMA concluded that 'refer' under the legislation requires that at the minimum, a practitioner send or direct a patient seeking an abortion to another practitioner who does not have a conscientious objection to abortion, or otherwise facilitate access to such a practitioner.

In the panel's view, this duty will be discharged if the doctor provides the patient with a non-objecting medical practitioner or health service, such as an established family planning centre or an appropriate, accredited abortion clinic. They are saying that a referral will not be effected by providing some information about the family planning clinic. We have had a lot of discussion about what 'refer' means and generally it was seen as a referral for a particular course of treatment.

But other doctors have sat here and said that even as a GP referring to a specialist you cannot tell what that specialist will do because it is their assessment and their clinical judgement. They are saying, 'This person has this condition or is pregnant or whatever, and I ask you to provide ongoing care and advice.' That person who receives them has to start from scratch, more or less, don't they?

Dr McKENNA - Yes.

Ms FORREST - 'Refer' is not such a big issue in that regard?

Dr McKENNA - That is what has happened in Victoria subsequent to the enactment of their legislation. For a doctor with a sincerely held conscientious objection to abortion,

referral is a recommendation. It is a part of being complicit in the decision and in possibly the subsequent act.

Ms FORREST - If a doctor advised the woman to attend the family planning clinic where they don't conduct terminations, how can that be complicit? She is only going to get further advice regarding the pregnancy and she may continue with it or adopt the baby out.

Dr McKENNA - Women are free to seek any information they want to.

Ms FORREST - Yes, but a lot of women don't know where to go to get advice. Their doctor is often the first point of call.

Dr McKENNA - I think everyone has heard of Family Planning Tasmania. If we want to talk about what is really happening Tasmania, sadly, too many women, I would say, because I think it is a shame, are bypassing their general practitioners anyway because they can go to the private, free-standing abortion clinics where there will be two doctors who will sign off and they can have that abortion that day.

Back to this bill before us, in terms of access I don't see, as I said before, how this bill does increase access; I think it removes opportunities for women to have counselling offered to them and the opportunity to discuss with two medical practitioners. It removes those opportunities up to 16 weeks in pregnancy and, as I have said before, the other flipside of the position is - and we are already going to somewhere where I didn't really want us to go because I think we need to keep talking - this is a woman and her unborn child so at least the present act recognises that abortions need to be legally justified, that there ought to be some limits.

CHAIR - I have allowed that exchange to go on because we do have to be careful, in my judgment, of seeking to convince our guests, whoever they are, of what the circumstances are. You have put your position and we are quite at liberty to ask you questions about those, so Ruth has gone to matters related to the codes of practice that may help in your understanding; if you still hold those views you are entitled to the views which you have.

Mr VALENTINE - It is not about conscientious objection as such, but it is regarding your concern with respect to the level of information available to women making decisions. Would it be the case that when a woman consults a doctor regarding a situation, even prior to 16 weeks, that the doctor would be providing the full level of information at that stage at the initial consultation? First, as was pointed out by Ruth, a form of consent is needed before a doctor can go ahead and conduct such an operation, but would it not be the case that they would get that full information at that point?

Dr McKENNA - Yes, that would be good normal practice.

Mr VALENTINE - I am trying to sort out what the concern would be, then, in terms of the level of information. You made a statement that you were concerned that the woman had the full information available to her rather than just being pushed along the line of abortion, but wouldn't that happen as a matter of course?

Dr McKENNA - There is the provision of medical information, and again this is where we have doctors and we have counsellors -

Mr VALENTINE - I am talking about doctors now because you are talking pre-16 weeks.

Dr McKENNA - Okay, so pre-16 weeks going to a doctor. This bill says that all that is required is the request and the consent of a woman. To give informed consent, we would hope that that woman is receiving full information on pre-pregnancy options available to her, as well as counselling about the potential medical risk of continuing the pregnancy or having a termination. What I have been saying is that the value in the present law is that we specify that that also happen, that there is a discussion and consideration of the medical risk.

Mr VALENTINE - But wouldn't that happen, though? Wouldn't that happen in that consultation? I know the current law dictates and mandates that, but isn't that going to happen anyway?

Dr McKENNA - I hope it does, yes. We have a big change here. It's a change in philosophy almost because what is required is the request and the consent of the woman. In many ways, the doctor's professional judgment is being pushed aside.

CHAIR - Except that, as Ruth has indicated by reference to codes of practice, which are called up by federal law, the doctor has no option but to provide the relevant information as to the options which the woman might have available to her. It's not just a simple process, just for clarification.

Mrs HISCUTT - Brigid, in your submission you mentioned some of the after-effects the woman may suffer from having a termination and you mention special acts which they may do?

Dr McKENNA - I was referring to a Swedish study. The reason for referring to that study was to say that women know that abortion is so much more than an aspect of their reproductive health or a medical procedure. They know that it intimately involves their unborn child. Sometimes I think we lose sight of the complexity and, I would say, the existential or moral dimensions to the decision-making. It is an utterly unique decision-making process and that study just highlights that women have special needs over and above what you might be normally able to provide in the medical context. That is the value that, as the law currently stands, women are reminded of.

Mr MULDER - A couple of questions and you have already touched on them. I will go back to that whole issue of 'must refer' and your interpretation of that as meaning a recommendation in relation to a procedure. Would you take any comfort, and I'm not sure how you would do it, if we made it absolutely clear that the reference isn't relating to a medical procedure, but as the section itself said, a reference in relation to pregnancy options advice? You are referring to them for advice on pregnancy options, not recommending a particular procedure?

Dr McKENNA - Yes, but I believe that I could provide counselling or information on what are the pregnancy options.

Mr MULDER - If a patient came to you and said, 'I want a second opinion,' would you refuse them?

Dr McKENNA - No. I think there is a distinction between 'I can't impede their access to information and 'I should specifically refer them to a provider or someone who I know will facilitate the abortion if that is what they want'. That is a very different matter.

Mr MULDER - We have had the example of circumcision given to us, and as a medical practitioner they had a strong conscientious objection to circumcision. In your case, in that scenario, if someone says, 'I want the circumcision, I've heard your advice, can you refer me to a doctor who would?', would that doctor then be duty-bound not to make that referral?

Dr McKENNA - If it was a deeply held conscientious objection, then they shouldn't have to make that referral, no.

Mr MULDER - What about referral for advice as to whether - in other words, a second opinion about whether I agree.

Dr McKENNA - Yes, but doctors don't usually refer someone for a second opinion; they invite the person to seek a second opinion themselves.

Mr MULDER - But if sought, you wouldn't provide the names of someone with a second opinion that might differ from yours?

Dr McKENNA - Sorry, who would this person be? I would provide the name of someone that's -

Mr MULDER - Someone you know doesn't have an objection to circumcision.

Dr McKENNA - I would see no need to do that. I'm not impeding their access -

Mr MULDER - It goes to this issue about referral.

Dr McKENNA - Yes, okay, I see the parallels that you're making.

Mr MULDER - It's not a referral to a procedure or a recommendation of a procedure, it is simply referral for advice options.

Dr McKENNA - Why should the law compel me to do that? I just think it's an unnecessary imposition upon a professional's practice. I'm not about impeding access or withholding information, but I have a conscientious objection - not an aesthetic objection. It is not that I think abortion is unpleasant; I have a deeply held conscientious objection.

Mr MULDER - I am trying to get away from the meaning that you have ascribed to 'refer', which is the normal medical one of referral for a procedure. I am now talking about referral for advice, options or opinions. You hold the same strength of objection to that as you do to referral for a procedure?

Dr McKENNA - No, I don't, but in practice I think it is a distraction from what is at issue here. This is about women receiving information in a safe way, and not being coerced either way. In practice you don't say, 'Here's what I think. Here's my advice' and do it to the best of your ability. You don't refer someone on to someone else for that whole process again. Men and women are free to seek advice and counsel from whomever they want, and they do.

Mr MULDER - We will switch it back to the abortion example. They come in and get advice from you - and that is another thing to make clear - this doesn't prevent you from telling someone who comes to you seeking advice that you don't think abortion is a good option.

Dr McKENNA - I would make my views clear.

Mr MULDER - Absolutely clear - and this law does not stop you from doing that?

Dr McKENNA - No.

Mr MULDER - What it does say, though, is that if the person then wants to seek further advice or doesn't agree with you, you should provide them with information as to someone else to run through those options with them.

Dr McKENNA - What I am saying is, I think that is an unnecessary intrusion upon professional life. I don't see why that is necessary. There will be doctors for whom even that is too much - good doctors for whom that is too much; doctors who make contributions to society in many ways. I think there is a risk that there will be people who will say, 'I'm not going into that profession. It's too hard'. We already see that in the whole area of obstetrics and gynaecology. I don't think the law needs to go there. I see no reason for it at all.

Mr VALENTINE - What about a list of services, a pamphlet the government puts together that says, 'Here is the list of services available'?

Dr McKENNA - The government puts it together and puts it on their website, in doctors' waiting rooms, but why do I have to?

Mr VALENTINE - Why couldn't the doctor say, 'I am not directing you to any service, but here is a list of services'.

Dr McKENNA - Well, I'll have it in my waiting room. Why is the law compelling me to do this? There are so many other things we could be talking about in order to look after women, make sure they have choices and are supported in those choices. We are obsessing on this. I would happily put that in my waiting room, but why does the law say I have to hand it over?

Mr VALENTINE - By way of trying to provide a fine line, it stops the doctor from being charged with -

Dr McKENNA - Absolutely, and I take your point. There is a difference between information-giving and, in the medical context, a referral.

CHAIR - They are matters we will need to get our minds around as the legislators, and this is that information-gathering exercise.

Mr MULDER - I don't see how that idea of giving information is the kind of referral we are talking about. We are not talking about referral for a procedure. As to counsellors, clearly that is the only thing a counsellor could refer for. There is no requirement for a counsellor to refer someone to a medical practitioner for a procedure, but there is a requirement on counsellors to refer to another counsellor, which puts you in the same position. The 'refer' there clearly must relate to options and advice, not the procedure itself.

Dr McKENNA - I am perplexed why counsellors are dealt with in this bill.

Mr MULDER - I will agree with that, too, except for perhaps helping us to understand what is meant by a referral in the medical practitioner sense.

Dr McKENNA - It is the type of counselling that Pat has spoken about - pregnancy options counselling, as it has come to be known - that is the process that begins and has a definite end point - a woman makes her decision and that is where it ends. Say that woman decides at the end of that process that she will go ahead with an abortion, it is not even a referral; the only advice that ought to be given is that that woman goes back to see her general practitioner.

Mr MULDER - What counsellor, should they be approached by someone on this highly sensitive issue. would not say at some stage, 'Go and see your doctor.'?

Ms GARTLAN - Can we follow up this point of counselling because so far we have talked about pregnancy options and clearly none of this happens in [inaudible] and it is mentioned in the information paper about the bill that there are complex things. We are all in relationships, we all have connections, relations, history, past relatives, grandmothers and all this stuff, so a lot of the counselling you are talking about involves a women sorting out all these things in her head, where they are important to her.

Take the example of a 22-year-old university student. She is the eldest in the family, she has siblings and mum and dad are really proud of her, she is doing well - and she finds out she is pregnant. She might not want to tell them so she comes to the pregnancy counsellor and says, 'I don't know what to do.'. In view of playing the pregnancy options - 'You can do this, this and this' - the first thing is getting used to the fact that she is pregnant and is in this family situation and the consequences she is going to have there. How she is going to tell mum and what dad is going to think and what the siblings will think. One of them might twig to the fact that she's pregnant because they saw her with one of those little things.

In other words, the counselling aspect of it is very important for the woman to look at all these facets in her life and work out how you are going to tell mum, what you're going to do about it, what you think should come first. It is not just a matter of saying you are going to do this or this or this, it is what is going on in your life here and now and how you are feeling about that. It is hugely important in a situation like that to have someone outside your community, outside your family - a stranger - you can talk these things over

with, because you can say out loud things you would not normally say and that helps you when are talking out loud about something, you get the language and you start trying to understand what is going on.

Mr MULDER - I don't think anyone underestimates the difficulty of counselling and the issues and the fact that if it was simply operating in a vacuum you wouldn't go to a counsellor anyway because you would have made the decision. What we are trying to get at here is the prescription of this law which tells counsellors what they have to do under certain circumstances. If no counsellor worth their salt, when approached on a medical matter, wouldn't automatically say, 'You also need to talk this over with your medical practitioner', why do we need three in here at all? Why wouldn't we simply have that a counsellor, in the process of this delicate issue, must refer the person to a medical practitioner, and then if you got into the issue with the medical practitioner having an objection to carrying out the procedure we would leave it all with the medical practitioner to sort out what it was. Why should counsellors have to refer on to another counsellor when they are going to refer on to a general practitioner anyway?

Dr McKENNA - I'll have to think about that one but, as I said, I don't understand why the counsellor is there.

Mr MULDER - I am trying to say that.

Dr McKENNA - I take your point. We're talking about decision-making counselling, so the woman comes to spend time with the counsellor to aid her decision-making and when that process is finished, it's finished.

Mr MULDER - So you wouldn't say, 'Well, now you've decided not to have an abortion, you shouldn't even talk about it with your doctor?'.

Dr McKENNA - No, but my job there is finished as a counsellor so I don't see why we need legislation. Are we going to do that for all counselling?

Mr MULDER - If it's good practice - maybe you need to get a code of practice that says that.

Dr McKENNA - We are long way from it.

Ms FORREST - On the point of counsellors, you'd be aware that counsellors aren't regulated and that's one of the issues and why it was felt necessary to put it in the bill, as I understand it. I think we would all agree that you need quality counselling in such a time as this because it is a difficult decision and we have heard clear evidence that no woman makes this decision lightly. When there is no regulation and we have been informed that there are counsellors who impose their own views, that is not a good counselling service obviously.

Mrs GARTLAN - That is not counselling.

Ms FORREST - No, but because there is no regulation, that is the problem here. This is one of the reasons it has been suggested that it should be here, to provide a framework that ensures that women who need all that information that you said, Pat, to make those

decisions, get it in a way that enables them to make an informed decision. If that is the purpose, is that not an unreasonable expectation of why it is there?

Mrs GARTLAN - My feeling is that it could be done separately and could be dealt with. If you want to look at the whole counselling situation of who is registered and what the code of practice is and stuff like that, do that in a separate bill.

Ms FORREST - That might happen at a national level at some stage.

Dr McKENNA - One of the things I am curious about is the assumption that a counsellor with a conscientious objection to abortion is unable to counsel on all three pregnancy options.

Mrs GARTLAN - If I could follow that up, that is absolutely true. That is the whole point of your training - what is your aim here? Nobody is unbiased. Everybody has a bias one way or another. You like AFL, you like rugby, or you like steak or whatever. That is a bit frivolous but everybody has an attitude about things. It is a case of what you do with it. There will be people in abortion clinics who have an attitude that it is a very good idea, so the notion that you focus on people who are offering a service like pregnancy support and you say, 'You've got to watch them' - what about the other ones.? The point I was trying to make was that you are trained. What is your aim here? Your aim is to give the greatest opportunity for this person to do her thinking and arrive at a conclusion.

Ms FORREST - We agree on that.

Mrs GARTLAN - You leave your bias, if you want to call it that, outside.

Ms FORREST - But the problem is, Pat, we have heard time and time again that some people don't, and that is the point.

I would like to go to another area. Brigid, you made the point that women are free to make decisions about who they see and to access that information and you believe that there should be no compulsion for you to refer. We heard from a previous witness today that the health literacy rates in Tasmania are abysmal and women don't know that family planning clinics exist, which is a sad indictment on our state but that is the reality of where we are. Having that in mind, it makes it difficult to assume that a woman will know how to find a service in a timely manner to get all the information she needs.

Going back to the AMA's policy advice and position on conscientious objection, they say:

> Essentially our advice is to consider your conscientious objection as a conflict of interest. As with other conflicts of interest, the conflict should be avoided where possible and made known if necessary. To avoid the conflict, signs placed in your waiting room or on your website stating that you are not available for advice or assistance in terminations of pregnancy would serve to ensure that you are not confronted with a dilemma.
>
> If it becomes clear that a patient you are seeing is wanting help with a termination, you must stop the consultation at that point and advise that you

> have a conflict. At this point it would seem that you could refer the patient to a family planning clinic.
>
> Doctors who are troubled by this should remember that at the family planning clinic the patient will be discussing her pregnancy with another doctor and, regardless of her intentions from the outset, it is not a certainty that she will proceed with the termination.
>
> If you refer as soon as you become aware she may be considering a termination - that is, if you refrain from any further discussion - you are in fact referring her to family planning for advice on her pregnancy. AMA guidelines on conscientious objection require a doctor to ensure help is available elsewhere, which we interpret to mean that the patient may need assistance to access non-conflicted help, depending on the patient's personal circumstances and attributes.

It goes a little bit further but it is trying to assist doctors in your situation.

Dr McKENNA - I will respond to that. A conscience objection is a right and with rights come responsibilities. A practitioner has the responsibility to be courteous to the patient, to be transparent and to treat them well. I have no problem with that at all.

Ms FORREST - Do you see that as a way of dealing with that?

Dr McKENNA - I'm not going to here and now endorse everything you just read out.

Ms FORREST - No, I'm not saying that. Do you think it is a reasonable thing that you could treat it as a conflict of interest and put up a sign and say, 'I don't deal with that.'

Dr McKENNA - Yes, transparency is important - absolutely.

Ms FORREST - When you get advice at a bank, the financial advice is very well regulated. If you want to call it financial counselling you can, or financial advice, but that is very well regulated because that is another serious issue if people don't get good advice. This is an area that we are trying to regulate in a way that is not regulated yet under the national framework. It may come.

Dr McKENNA - Transparency is important.

Dr GOODWIN - I just want to ask again about this conscientious objection issue. It just seems that there is a lot of confusion about this clause related to the use of the word 'refer' because it has a well-understood meaning within the medical profession, but I think more broadly as well within the general community because most of us have had experience of what a referral means, practically speaking. Is there another word or phrase that you think would better reflect what we have been talking about, or is it the case that, as far as you are concerned, we should scrap this clause altogether because it is already adequately covered through the AMA guidelines or whatever it happens to be?

Dr McKENNA - I think I would lean towards scrapping it altogether because it is adequately covered.

CHAIR - We are going to conclude there because we have gone way over time. We thank you for your contributions and your time.

Dr McKENNA - Thank you very much and we wish you very well in your deliberations.

Mrs GARTLAN - Thank you very much. It is excellent that you are looking into it in such detail and I think that is great.

THE WITNESSES WITHDREW.

Mr MARK BROWN AND **Mr MATIU CHAMBERLIN**, AUSTRALIAN CHRISTIAN LOBBY, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome. I am not sure you have appeared before a committee.

Mr CHAMBERLIN - No, not before.

CHAIR - Do I need to explain that you have the protection of parliamentary privilege in here? Mark is well aware of that protection which then means that just as a member of parliament is protected by the privilege of parliament, anything you say in here is not open to legal challenge by anybody but outside here if you choose to speak to the media or, indeed, they seek your comment we would suggest that you exercise some caution in terms of reflecting on what happened in here. You are entitled to your view and you can communicate that view freely wherever you wish, but if it reflects on matters which were raised here you are not afford that privilege outside.

Mr CHAMBERLIN - Thank you.

CHAIR - We have your submission and, as with all other people who have come into give us information and evidence, we are more than happy to hear some verbal contribution from you and it is a matter of the public record then and we will most likely have some questions. Mark, if you want to proceed that would be fine.

Mr BROWN - Thank you very much for this opportunity and I would like to introduce Matiu Chamberlin who is a very close friend of mine and who has willingly given up the day to come down to beautiful Hobart, so Matiu will be sharing it shortly, but I am just going to do a few introductory comments. Matiu has a story that he would like to tell of his own experience that is quite relevant and to add some comments to that experience.

I will talk to our submission and the opening statement clearly paints where we stand. As a Christian lobby, ACL believes that life begins at conception. From a scriptural point of view we read in the Psalms that:

> My frame was not hidden from you when I was made in that secret place. Your eyes saw my unformed body and all the days ordained for me were written in your book before one of them came to me

- in other words, before I was born.

In that context of talking about acknowledging life and existence of personhood prior to birth, for those of you who remember the story, Mary came to Elizabeth, her cousin, and John the Baptist was in Mary's tummy at six months - 24 weeks - and when Mary introduced herself and said a greeting, the baby leapt in the womb and that was John the Baptist leaping for joy, as Elizabeth said later, again acknowledging the fact that there is a sense of identity and personhood prior to birth. That is the world view from which our submission comes from and I am glad that is out there front and centre.

What I want to articulate today is that that world view is not simply one held by religious people alone. In the whole concept of personhood and sanctity of life, we have seen clearly concerns in the community about this, particularly with regard to the original draft bill with a 24-week no-assessment period for doctors; that was one of the key things that people were very upset about and you probably remember all the different ways in which people showed their concern about that.

But I was interested to hear, as part of the debate in the lower House, that even members from those on the progressive side of politics, like Cassy O'Connor, made the comment that she was very uncomfortable with that 24-week period, so I am just trying to make the point that it is not simply those who have a religious perspective on this issue who had concern. My question is: what is it that made people concerned about that particular part of the legislation and why all of a sudden do we find it is now 16 weeks? My understanding is that at 24 weeks a baby can be born healthy and will survive. This whole aspect of viability is something that people find hard to understand - how in certain parts of the hospital or the medical fraternity babies have been saved and even at that stage where they are viable their lives have been taken.

Part of the information paper referred to this concept of community standards and this legislation wants to realign itself further toward what we consider to be acceptable in the community. I would like to challenge this whole aspect of personhood; as this relates to this legislation, if there is a time where a baby in the womb is considered a person and considered to have that sense of life or that they have an entity in themselves, I believe that is when the right should also be attributed and therefore the proposal to move all of abortion out of the criminal code and into a health framework, I don't believe is something that the general community and community sentiment is in agreement with.

I would like to handball to Matiu to talk about this whole aspect of his experience with his son in terms of personhood, particularly around the 20-24 weeks where the laws we have seem to be acknowledging life, particularly with stillbirths at 20 weeks getting a birth certificate, the road toll acknowledging a life that is taken in a car accident at, I think, 20 weeks and how that plays out in someone's personal experience.

Mr CHAMBERLIN - Thank you for the opportunity to talk to you today. I appreciate your role and the responsibility you carry because the decisions you make today will impact the next decades. I respect the authority and responsibility you ladies and gentlemen carry.

In 2008, my wife was pregnant with our fifth child. We had four beautiful children and were having a great time as a family. We decided to go on holiday on the east coast to Coles Bay. My wife started to spot bleed - we had that same experience with our first child, but we prayed and thankfully it turned around. We were in Hong Kong at that time and it was quite a difficult time, but we pulled through and had this beautiful daughter at the end of it. With this fifth child we had this instance where we thought, 'Maybe it's similar to what happened the first time. It's not uncommon to bleed'. We were trusting that everything would work out all right, but the next day my wife started to bleed a lot and experience pain.

I said to my mother and father, 'I need to take Lesley to the hospital because it has gone up a gear, it hasn't subsided.' I raced her to the hospital but, unfortunately, she

miscarried on the way. At the end of that day I was holding a little boy in my hands and that was probably the most difficult time or experience I have had as a father and a husband. It was very difficult. From that experience, I felt that difficult things happen to everybody but there is often an opportunity to provide something good out of a difficult time.

From that I decided that it would be good to reach out because it shattered me and it has shattered my wife. Some people go through that multiple times. I had a new and deeper understanding of not only someone who has gone through a miscarriage, but we also had close friends who had a stillborn child. The baby was born right on the due date and it died just a few days before its birth, and it was shattering for that family. It took years for our dear friend to recover from that. I endeavoured or I made an intention to reach out and see if I can help people in that state who have gone through a miscarriage, a stillbirth, or have even made a decision to have an abortion. The reason for that is that I was shattered by it and it was very difficult to come through that. It was my first funeral as a minister, but how much more difficult is it if someone has had the difficult option of considering whether or not they can terminate a life, their child? It goes to another level.

I didn't know what sort of response I would get. I did three adverts over the Commonwealth Games period offering hope, offering that first step towards healing. We put together these Hope Packs, through my wife's and my journey, mainly through my wife, of the journey of healing that she received. There were some good books, good materials, good DVDs that she thought would really help people who have gone through that circumstance. We did these adverts and we had a website and it's called Hope for Women if you want to look it up later. Anyone who wanted to get one of these Hope Packs who had gone through some sort of - one of those three categories -

Ms FORREST - Pregnancy loss.

Mr CHAMBERLIN - Pregnancy loss, yes, would receive some help. I also had another close friend who runs a ministry to help ladies who have had an abortion to recover from it. It's called Survivors of Abortion. She is not running it now, but she had been running it for about 10 to 12 years at the time when I did that. She said, 'Matiu, I don't know if you're going to get very many responses because I've been doing this for 10 years and I haven't had anyone give me their name and I haven't had anyone give me their address.' I was asking for their name and address so that we could send it to them and for no other reason. I could have brought the folder of the emails of all the responses that we got. It was in the hundreds. We did it twice in Tasmania and once in Victoria as well, but that wasn't the intent. To gather data wasn't the intent of it and basically it was a confidential thing and I hold quite strongly that I'm not at liberty to pass that information on.

I can share the dynamics that came through. Basically, from all the people who responded, from my assessment as best as I can, I did not take data and I did not numerically take it all down, but from a general perspective about 40 per cent of the responses were from ladies who had an abortion and the rest was miscarriages and there were a few stillbirths. Again and again and again, it comes up that these precious mothers said, 'Why didn't someone tell me? Why didn't someone warn me? I thought it was just a procedure'. My petition to you as a committee that holds the authority and responsibility to make the decision on this is that I know that the current bill is angling towards anyone who has a conscientious objection to make sure that they pass it on to

someone who will provide that service, is there a strong enough mandate so that a mother who is looking to find advice on the options, is she given enough information about what are the potential consequences for someone who goes through an abortion? Is it clear? I don't think it is.

The problem is that this current law actually angles it so strongly that someone who might offer some concerned, loving advice can get fined $32 000. Depending on the definition of what a counsellor is, it seems they can almost suffer some sort of legal ramifications. I think that's way too strong. The actual consequences are often that a lady who has had an abortion - I am not speaking about myself, I am a man, right? - I am also a father so I think I have a right to speak about my unborn children. That's another issue that needs to be raised because it's not just the mothers who are suffering, it is men who haven't had the opportunity to speak for the welfare of their children, whether they are inside the womb or outside the womb. I held my son at 18 weeks and he was precious to me. If he was in the womb, do I have no say about his care? I'm his biological father. Is there some avenue where I can speak and to provide some care or responsibility for my children?

The responses that we received were, 'I thought it was just a procedure and then I've struggled to love subsequent children', 'I weep every day', depression, marital stress, struggle. I could list it all out for you but we only have 45 minutes and I think with such ramifications from those difficult decisions, I would not put a slur on anyone who is considering the option because it is difficult - I don't agree with it but I realise that it is a difficult decision.

But when I get such a response of so many people, it's like a minefield and unfortunately this bill is like opening the door wide for mothers to walk through a minefield and get their emotional, relational and even their conscience to get their legs blown off - that is the reality of it. People who can't function in relationships, who can't function as a mother, who can't function because they are struggling with depression, that is a minefield.

If you open it wide and don't give some sort of warning then you are reneging your leadership and your responsibility to care for mothers. This law is too strong. It opens the door too far and the damage for someone who doesn't get the adequate warning about - I agree that people need to have the right information but are they getting the other side of the story? I don't know.

For me, that folder, the number of people who have read the emails in that initial folder are probably the same number of people counted on one hand - four or five people. But whenever I read that - I get through two or three emails and I start to weep. That's the hidden damage of what happens when people are faced with this sort of circumstance and the reason why we don't understand it or we don't acknowledge it - I didn't understand it as much as what I do now - is because people have gone through that, they stuff it down, and they hide it, they deny it.

My close friend who had had an abortion when she was younger denied it for 10 years and then finally one day, she opened up and wondered that perhaps 'I could think about this another way', and the dam burst and she cried and she cried and she cried. Denying something and stuffing it down is not a healthy thing.

I'm not here to push my views but I'm expressing from what I have experienced from the response of that campaign that it is a dangerous thing to angle it so strongly that someone like myself even - I do not consider myself to be a counsellor, I have a friend, Pastor [inaudible] who is a counsellor - but in the context of my leadership role I am able to offer counsel that is vague in this bill. This is a bit sloppy. It opens up so anybody who gives counsel to a woman who is potentially considering abortion can get done for like a dinner. That's not acceptable legislation. It needs to be clearer.

With the encouragement that I can give, it is potential too that I could get fined $32 000. The whole campaign costs a fair bit. We have so much community favour behind it because it wasn't a negative judgmental thing, it was offering hope and support for women who are going through this.

If this law had been done a few years earlier, we could have been stung with a $32 000 bill and I have done nothing because instead of the all the money I gather to do this thing that helped a lot of people, I had to pay some bill. That is not acceptable for a government that cares for the women of the state. It is a huge responsibility you have on your shoulders and my encouragement to you is to please consider it carefully. Before I did this campaign I had talked to maybe one or two people who had had an abortion, but they did not want to talk about it too much. It is a bit like a war veteran; they don't want to talk about.

Because I shared my story, it must have opened up some people to be able to share and in came a lot of responses. From that, as a community that cares for the women of this state, we need to be very careful about how we angle the laws. If we angle them so that they easily get one side of the picture but don't readily get the other side, we are reneging on our responsibility to care for them and leaving them to walk into a minefield, saying, 'It's a medical procedure. It's all right. It's nothing'. It is a mother's instinct - this is what came to me so strongly through this campaign - a mother's instinct is so strong to know 'That wasn't just a procedure; it wasn't just a circumcision, it was something I am instinctively designed to nurture and care for and bring life to.' It goes against the grain. In my role, where someone is double-minded inside they suffer a lot of trouble and trauma. I respect and honour your position but that is my concern.

Mr VALENTINE - You mentioned in your submission this period of 72 hours between referral for abortion and the procedure. Could you expand on what your reasoning is behind that?

Mr BROWN - The cooling-off period?

Mr VALENTINE - Yes.

Mr BROWN - That is giving a little bit of time to reflect on what has been heard as part of that initial assessment, in terms of counsel that was given. You have to look at what is happening at the present, on what we can understand. You can go into an abortion clinic without a referral and have an abortion on the same day, and therefore under the current act there must be some sort of counsel or pregnancy options advice. We are saying there has to be at least some sense of timing to be able to go away and think about what you've heard.

Mr VALENTINE - Wouldn't a person take that time to ensure that is what they want to do? It's not like a contract between an individual and a service provider. It's like a chance to make sure someone's not coercing them; it's an individual's decision.

Mr BROWN - It is, but you have weigh up the circumstances in which they are going there whether it is a 16-year-old girl who is trying to keep everything secret. There are instances where I believe that cooling-off period would be very beneficial. The majority of people don't realise that in the instances we heard from Dr Hyland - the *Mercury* article - the way things are set up in Tasmania is that the same doctors who are performing the abortions are the ones providing the counselling and assessment. People would be horrified if they knew that.

Mr CHAMBERLIN - It is a very difficult decision and life-changing. As a safeguard - whenever I make a big financial decision such as buying a car or a house, or even smaller than that, it is good to process it properly because the ramifications are huge. The ramifications are large enough that if a young woman, or any potential mother, is in that situation, it would give them opportunity to not make a knee-jerk decision. It gives a little bit of clutch to it, which I think might be helpful to make it a better decision.

Ms FORREST - I accept the negative impacts that termination of pregnancy can have on a woman's mental health in the sense of wellbeing, but would you also agree that there could be negative mental health effects of illness, sadness and other feelings after miscarriage and after birth of a full-term healthy infant at times?

Mr CHAMBERLIN - A lot of mothers struggle with depression after giving birth to a healthy child so that is obviously true, but if you talk to any particular mothers who have gone through that and asked them if they are thankful for what they have gone through because of the subsequent joy of seeing a young child grow up, I think the majority of the time, 99.99 per cent of the time, you will get a positive response. That is my understanding.

Ms FORREST - I accept that, and the people who contacted you obviously had negative experiences in one way or another and hence the call to seek support?

Mr CHAMBERLIN - Yes.

Ms FORREST - So you are not potentially hearing from all the others who may not have had a problem, but to put it into context here, because there are many women who have a positive experience in a birth and then have a negative experience of birth - and miscarriage is one - and with miscarriage what we do not do very well is generally, as a health professional looking after those women and their partners often after that, too - partners are often overlooked in that area, too, don't worry -

Mr CHAMBERLIN - For sure.

Ms FORREST - I think to say that this is entirely the result of a termination of pregnancy is probably not quite the reality?

Mr CHAMBERLIN - Sorry?

Ms FORREST - All these negative impacts are only associated with termination?

Mr BROWN - It is a loss whichever way you look at it. For those who may only at a later time understand the ramifications of what they have done - and I think it was what Matiu was saying - at times that is stuck down and not considered a lot.

Mr CHAMBERLIN - I think if anyone has lost a potential child or child and they say that it is okay, I would be really concerned for that person because it is a real dynamic and it is not something that is imaginary, even at an early stage. I think to consider it is a bridge and you get over it and then you can carry on, there is a danger in that even with that mental mindset of counselling and some people will say, 'Just get over it, sort it out.' They minimise the loss and they accentuate that it wasn't really that bad and just get on with their life and, unfortunately, there is something deep within - from my experience and from my observation - a mother that knows that that was something more than just a nothing.

Ms FORREST - It is the same with miscarriage, though, you would have to agree; people tell them to get over it. People tell mothers to get over it with post-natal depression.

Mr CHAMBERLIN - Absolutely. That is true, too, and depression is probably a big thing. It is misunderstood as well.

Ms FORREST - That is the point I am just making.

Mr CHAMBERLIN - I agree with that, that that is often -

Ms FORREST - One of the concerns that you had about women feeling distressed and it was only a procedure; they were not properly informed and that is a big issue.

Mr CHAMBERLIN - Yes, it is.

Ms FORREST - The medical code of conduct for doctors in Australia talks a lot about 'informed consent' and it says: 'Informed consent is a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved'. There are more guidelines on the MRC website which I was trying to get up but I can't find it at the moment. But that is the point - if women don't get the information they need from counsellors or their medical practitioner or wherever to make an informed decision then that is against the code for a start and not in the best interests of women. Would you agree?

Mr CHAMBERLIN - I think it is certainly true that they need to have the full spectrum of information about abortion but, unfortunately, the ramifications of abortion are most often hidden.

Ms FORREST - But if you're applying this principle they wouldn't be hidden.

Mr CHAMBERLIN - No. I'm not talking about a male doctor who has never had an abortion because he can't have one, I'm talking about a mother who has gone through that experience, has been told that it is just this and then the emotional reality and the

relational impact on her with subsequent relationships as well was not made clear to her because it is so hidden because it only someone who has gone through it who really knows it.

Ms FORREST - Hence the need for really quality counselling. One of the discussions we had was about the need for counselling to be somewhat prescribed in legislation because there is no regulation around counselling -

Mr CHAMBERLIN - No, it is a danger.

Ms FORREST - It is difficult and you're saying how important it is that women get the information they need to make an informed decision.

Mr CHAMBERLIN - Absolutely, I agree with you, they need it.

Mr BROWN - I don't currently know what information they are receiving. For instance, you had the fertility control clinic doctor here during the briefings and I think someone asked for the information sheet they give to women who come for the use of their services. I'm not sure if you received that or not but I would be interested to know at what level currently that counselling is defined.

Ms FORREST - Park of the problem, Mark, is that there is no regulation around it. I think we all agree that is a bigger issue in itself.

Mr BROWN - In regard to the community sentiment, you have probably all seen the Galaxy poll that was commissioned in February this year around the 24 weeks and all the consternation that saw that drop to 16 weeks. As part of that survey, the question was asked, 'Are you supportive of late-term abortion?', which was post-20-week abortion, and 73 per cent of Tasmanians - and I think it was 300 surveyed - said they opposed late-term abortion. Interestingly, 78 per cent of 16 to 24 year olds said they were not happy with late term abortions.

The point Matiu and I hope I am making is that we're not talking about just any other medical procedure here. We're not talking about having an appendix out or a circumcision. In the community's eyes, I believe we are talking about something at a point around 20-24 weeks where there is a differentiation made that this baby takes on a personhood which may not have been there at 16 weeks. I don't know why 16 weeks was chosen or 12 weeks or whatever, but in terms of community standards, it is apparent that there is real concern about what justifies abortion. There is a whole lot of reasons abortion could be justified as part of that survey and it was interesting that only severe disability was considered an option where abortion was justified.

What I believe with regard to this current legislation is that somewhere in that continuum of pregnancy there has to be a point where personhood is acknowledged and whether that is 24 weeks when there is viability or 20 weeks when there is foetal pain acknowledged, I don't know. If you were trying to say what community sentiment is, it is clear, I believe, that late-term abortion is not something that the community is in agreement with. Therefore, with the current legislation wanting to be removed from the Criminal Code, if it is true that there is some sense of personhood at that later stage, with that acknowledgement there must be an acknowledgement of rights, and I believe the

Criminal Code is the right place to keep this legislation, at least from the point where that personhood is acknowledged.

Ms FORREST - Mark, on that point, you may or may not be aware of the reality of when terminations occur. About 96-97 per cent of terminations occur before 12 weeks.

Mr BROWN - The first trimester, yes.

Ms FORREST - Yes, so the very small percentage of terminations that occur beyond 20 weeks are generally for gross foetal abnormality, many of which would not be compatible with life.

Mr BROWN - That is not the case in Victoria, where the stats show that about half of later abortions are on healthy babies - the 2009 stats.

Ms FORREST - Where is that evidence? Can you provide that evidence?

Mr BROWN - I've sent that to you but I will send it to you again. 2009 were the latest statistics available.

Mr CHAMBERLIN - Late-term abortions went up 400 per cent.

Mr BROWN - Since early 2000.

Mr CHAMBERLIN - At that time.

Ms FORREST - Define 'late-term' termination here?

Mr BROWN - Post-20 weeks is what they cited in the stats from Victoria. I think it was around about 400 total late-term abortions and at least half of those were on healthy babies. I can send that data to you.

Ms FORREST - Were there maternal indicators for those as well?

Mr BROWN - Sorry?

Ms FORREST - Was the mother's life and/or health at risk? Was that considered?

Mr BROWN - No.

Ms FORREST - Many late-term terminations occur because the mother is at risk. You have to exclude those as well.

Mr BROWN - I don't know how many there are but I've heard that that's very rare.

Ms FORREST - It's not as rare as you might like to think, unfortunately.

Mr BROWN - Even in Tasmania, if you are looking at roughly 1 500 abortions a year, if you take even 5 per cent of that, that is 75 children that we are talking about. Even though it is a very small number, it is a significant number of children. Even if we extrapolate

from Victoria half of 75 are being terminated post-20 weeks when they are healthy children.

Ms FORREST - I would only be convinced if I saw evidence that showed the reason for those terminations and maternal indicators as well.

Mr CHAMBERLIN - I will send you that.

Ms FORREST - In some considerations, and we have heard this from many of the medical professionals in this area, below 23 weeks the child is not going to survive, so it is only from that time that you could have a child who could potentially be born alive and survive, but they can't survive independently.

Mr BROWN - No, neonatal care. I looked it up - at 24 weeks it is two-thirds of children, 66 per cent are able to survive.

Ms FORREST - I'm saying that up until 24 weeks the baby is not going to survive anyway.

Mr BROWN - That is the other point you have to think about. Back in the 1950s the survival rate would have been somewhere probably in the 30-week range, but in 2013 we are considering keeping babies alive at 22 weeks and I think 21 is the minimum. Who is to say that in another 10 or 20 years that will not be below 20 weeks? When most of the people in this room were born, from what I've read, if you weighed under 1 kilo you were considered a stillbirth.

Ms FORREST - There is a limit to the human condition.

Mr BROWN - I'm not denying that, but all I'm saying is that over the last 50 years there has been a huge -

Ms FORREST - I accept and acknowledge that, but we're at a point here where 24 weeks is touch and go. We are dealing with what we have now and the foreseeable future.

Mr BROWN - For sure, but the point I'm trying to make is where we put that line in the continuum of pregnancy. If they are viable at 24 weeks, who is to say that it may not be 22 weeks in 10 years' time?

Ms FORREST - Let's discuss the viability thing, because we're talking about babies here who potentially are not going to survive anyway. These are incompatible-with-life conditions.

Mr BROWN - In some instances.

Ms FORREST - The statistics you quote here say that 73 per cent of people oppose late-term abortions after 20 weeks. If you broke that down and asked who would oppose late-term terminations for women whose life was in danger beyond that point, or their health and wellbeing - a mother might survive but she could have a massive stroke and she has other kids she has to look after, that is not an ideal situation.

Mr BROWN - Obviously those surveys do not capture all of the scenarios.

Ms FORREST - Exactly, so I think we need to use a little bit of caution here and when you make a claim that so many are born as healthy babies beyond 23 weeks I would need some evidence.

Mr BROWN - I will send that down to you tomorrow.

Mr CHAMBERLIN - I was just looking at the actual bill itself at clause (8) where it says:

> Woman not guilty of crimes or offence
>
> Notwithstanding any other act or law, a woman who consents to assisting or performs a termination on herself is not guilty of a crime or any other offence.

I have a question. If there is a scenario where two women are fighting and one of them is pregnant and the woman who is not pregnant injures the other and she loses her child, is this opening up a clause where there might be some problem? Could that lady who was violent get away with it?

Mr MULDER - She might just be charged with assault.

Ms FORREST - This is performing a termination on herself?

Mr CHAMBERLIN - Or assisting. If someone assists with the termination they are not going to be charged. I just wanted to clarify that. Once you define life as important it is the requirement of government to protect that life. Thank you.

THE WITNESSES WITHDREW

PUBLIC

Mr ERIC JOHN LOCKETT, TASMANIAN BAPTISTS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Eric, welcome to this here today. You are familiar with parliamentary privilege because you have been in front of committees in the past. Do you need me to explain to you the protection of parliamentary privilege?

Mr LOCKETT - No, I don't think that's necessary.

CHAIR - We have your submission and have had a chance to familiarise ourselves with it. We are open to you making a presentation to us in support of that.

Mr LOCKETT - I would like to commend the Legislative Council for setting up this inquiry and to thank the committee for the opportunity to present evidence on behalf of Tasmanian Baptists. You have all received a copy of our written submission to this inquiry. We have previously lodged a response to the initial information paper and the draft bill, which is available on the departmental website. They expand on some of the points I would like to emphasise today. Unfortunately the young woman who helped me prepare our submission is unavailable today due to family and work commitments. Lest anyone might feel it is inappropriate for a man, and one for whom having children is a fairly distant but nevertheless vivid memory, to present evidence on this subject, I believe I can honestly state that a majority of Tasmanian Baptists are women.

Although my professional qualifications are as a forest scientist, I gave up my full-time work in forest research in 1996. I have subsequently served for six years on a National Health and Medical Research Council human research ethics committee and for three years on the Australian gene technology ethics and community consultative committee. I have presented papers at two ethics in human research conferences and an Australasian Association for Bioethics and Health Law conference.

For the past 15 years I have been public questions officer for Tasmanian Baptists. Their annual assembly keeps re-electing me, so they must be happy with the way I represent them on public issues.

Now, to our position. Tasmanian Baptists feel a responsibility to stand up for human dignity and to defend the rights of the weak and vulnerable along with other Christians, to defend the defenceless and give a voice to the voiceless and there are none more defenceless or voiceless than those as yet unborn. Unfortunately, clear thinking in this area has been clouded by the use of euphemisms designed to make the unpalatable more palatable.

Termination of pregnancy is itself a euphemism as the normal and natural termination to a pregnancy is a live birth, a joyous occasion. But there is nothing joyous about the sort of terminations we are talking about today and could there ever be a more grotesquely Orwellian misuse of language than the description of themselves as pro-choice by those who support the most final and absolute denial of choice possible - the denial of life itself. Now we see the term 'reproductive health measure' used to describe something that usually has nothing whatsoever to do with enhancing reproductive health but may in fact diminish it.

I first need to emphasise some facts about which the information paper and the bill give no hint at all. It is an inescapable fact that whether it is referred to as a zygote, an embryo, a foetus or a baby, all of which we once were, termination involves the taking of a human life. This is not just an unfortunate growth that arises spontaneously and can easily be got rid of if it becomes troublesome without affecting anyone but the woman, herself. It is a separate and unique human life which, although totally dependent on his mother for its growth and development during its first nine months, is as much a part of its father as its mother.

I sometimes wonder about our priorities when we express great and justifiable concern over the tragic accidental loss of a thousand-plus boat people at sea, yet simply sweep under the carpet the deliberate taking of the similar number of lives in Tasmania and 80 times as many nationwide to the extent that we do not even have publicly available records of the number of terminations carried out and the reasons for them. Any termination directly affects three people - the child, the mother and the father - and may indirectly affect many more including medical practitioners, nurses and counsellors. But this bill does not even acknowledge the existence of the child, much less the father. Of those who argue that a decision whether to terminate should be one for the woman alone, having reflected on the fact that by denying the father's legitimate rights to a say, they are absolving him from his due responsibility for the welfare of the mother and the child he has fathered.

How should a civil rights society address this issue? It is profoundly unjust that whereas we said to provide the best possible prenatal care to some individuals and go to great lengths to nurture others born prematurely, we should deliberately deny yet others the opportunity to achieve their human potential just because their mothers choose not to allow them to be born.

In our society there are only two other contacts where the deliberate taking of a human life is excused - they are in war and in self-defence. In both cases strict criteria must be met or serious charges will be faced. Logically, the determination of pregnancy should be regarded with equal gravity and require a similar level of justification. This bill would deny that gravity and put no value at all on human life. It would require no justification at all for terminations up to 16 weeks and require consideration only of the women's interests thereafter. That is not a sign of a civilised society.

Some may argue about pregnancies that threaten the mother's life or are due to rape or where the foetus is severely malformed, but the reality is that such cases can be dealt with on their merits under current law and they constitute a very tiny proportion of all pregnancies anyway. One must remember the adage that hard cases make bad law. Good law is designed to cover the generality while making adequate provision for the exceptions. Laws designed specifically for the exceptions are generally inappropriate.

Not only does the bill require no justification for terminations up to 16 weeks, it makes a nonsense to any claim to regulating terminations by imposing no penalties whatsoever by those who ignore even its minimal requirements for later terminations. In effect, we declare open slather. Nor does it require counselling, even for, say, a 12-year-old girl who may be ill-equipped to decide on a termination at a time of great stress and possibly coercion.

This bill would also heavy-handedly impose state controls on the information provided to women and trample the rights of conscientiously objecting practitioners and counsellors by requiring them to refer women on to someone holding the view that they may regard as unethical and not in the woman's best interests. A practitioner who had a conscientious objection to providing a termination for purely sex-selection reasons, for example - and that objection is shared by 92 per cent of Tasmanians - would have to find someone with no such objection to refer the woman on to, yet there is no reciprocal requirement for a pro-abortion practitioner to refer the woman to someone willing to counsel against termination and advise on the possibility of adverse repercussions that may haunt her for life.

It is not surprising that the AMA has publicly described the referral requirements as contravening their code of ethics. In the case of counsellors, the penalties of up to $32 500 for a failure to observe this requirement are unconscionable. Such a legally enforced bias in the provision of information should not be tolerated in any democratic society.

We may ask why an original requirement in the proposed amendment to the Criminal Code Act section 1(7)(18) to require the woman's informed consent, surely one of the most fundamental ethical requirements for any clinical procedure, was changed in the final bill to merely 'consent'. Could it have been to guard against the possibility of charges being brought on the grounds that a termination was carried out with the consenting woman being fully informed of all the possibly adverse consequences of such an action?

The bill would also trample the rights to free expression of those calling for restraint by banning even peaceful, non-disruptive protests within an access zone under threat of a grossly excessive $65 000 fine plus 12 months jail. Surely there are adequate laws to deal with genuine cases of harassment or intimidation without the need for this? The establishment of a termination facility in the centre of any of our cities could effectively shut down any protest within their respective CBDs. This would be an unnecessary and unwanted infringement of civil rights such as occurs in no other field.

From a recent Galaxy survey it is clear that although most Tasmanians would find a termination acceptable in some circumstances, and the point at which they would draw the line varies, they virtually all believe that such a line should be drawn. This bill effectively leaves that decision entirely up to the individual. Yet as John Donne said some four centuries ago, 'No man or no woman is an island.' Our decisions inevitably affect others and in this case dramatically so. Hence, a community can no longer deny its moral responsibility by leaving such important decisions solely to the individual than it can leave the decision about what is a safe speed limit to the individual. It is the responsibility of parliament, as the people's representatives, to determine where that line is drawn.

Everything about this bill seems to be designed to reinforce the false notion that the woman is the only person affected by a termination and she should have the sole and untrammelled right to exercise the power of life or death over her child without the need to consult or be advised by anyone else. On the other hand, it heavy-handedly seeks to restrain the rights of anyone who disagrees with this viewpoint to act according to their

convictions. Despite all this, it is hard to find any solid justification for these changes. Any uncertainty about when a termination currently qualifies as legally justified could be removed by simply amending the relevant section of the Criminal Code Act.

It is claimed that the changes would make no difference to the number of abortions, indicating that the current law is anything but unduly restrictive. As far as we are aware, no-one has ever been charged, much less convicted, under the present law and no evidence has been provided that the law, rather than ethical and commercial considerations, have any influence on the number of terminations provided by practitioners, including those who fly in from elsewhere. There is nothing to suggest that these changes would have any effect at all on the current so-called unsafe - for the woman, that is - backyard abortions. They are all unsafe for the child.

In summary, this is an appallingly bad bit of legislation that has been fairly described as one of the most radical bills in the world. I personally believe it is the worst bit of legislation I have seen in my 15 years in this role. Tasmanian Baptists believe that its [inaudible] should not be countenanced in any just, democratic and caring society. It will trivialise the taking of human life by leaving the decision on whether an unborn child should live or die to the untrained and possibly ill-informed sole discretion of its mother, with no requirement to even consider the legitimate interests of the child. In doing so, it fails to even acknowledge the existence of that child, much less its father. It falsely portrays the termination of pregnancy as a reproductive health measure, in blatant denial of the inescapable fact that the vast majority of terminations are carried out on perfectly healthy foetuses who are a living testimony to the reproductive health of their mothers.

Whereas the inclusions of the current provisions covering the termination of pregnancy within the Criminal Code Act properly signifies the gravity with which the taking of any human life should be regarded, their removal would simply equate it with the extraction of a troublesome appendix, something that is nobody's business but the woman's and can only be of benefit to her. Its failure to provide any penalties whatsoever for practitioners who simply ignore even its minimal requirements to justify a late termination makes a nonsense of any claim that it seeks to regulate the termination of pregnancy.

Furthermore, it would take a step towards imposing a state-controlled bias on the information provided to women inquiring about a termination by requiring practitioners and counsellors who have a conscientious objection to a termination to act against their conscience and refer the woman to someone who does not share that view, an action they are likely to consider unethical and contrary to the best interests of the woman. Yet there is no reciprocal requirement for a pro-abortion practitioner to refer on to someone likely to counsel against it. It makes no attempt to ensure that a woman's decision is fully informed.

At the same time, it would trample the civil rights of any hungering for more restraint on terminations and impose draconian penalties on them. The claimed justification for these changes is flimsy indeed. They seem to have been devised purely for ideological reasons. Despite claims to the contrary, most Tasmanians disapprove of the termination of pregnancy other than in exceptional circumstances and parliament ought to be sensitive to those views.

It is very hard to find any redeeming features at all in this bill. Tasmanian Baptists believe that it is unconscionable, unjust, unnecessary, undemocratic and unacceptable to most Tasmanians. The only responsible course of action would be to reject it outright. We therefore strongly urge this committee to recommend that the Legislative Council do just that. Thank you for your attention.

Mr VALENTINE - With respect to your earlier comment about fathers having a say, have you given any thought as to how you would see that being achieved? At the end, someone has to make the decision. Are you suggesting that a father has an equal opportunity to make that decision as it is a woman's body?

Mr LOCKET - The first point to be made is it is not just a woman's body, it is a woman's plus a child's body.

Mr VALENTINE - I understand that.

Mr LOCKET - It is the woman's son or daughter and the father's son or daughter. I think, at least, there should be some requirement to consult with the father and that would make him part of the decision-making process. I recognise that this is a two-edged sword, as there are occasions when fathers coerce the woman into having an abortion but along with the recognition that they should have a say in it goes the responsibility that they have to share for the consequences of that decision and for the welfare of the woman and the child.

Mr VALENTINE - Seeing how that would work through is difficult, to my mind, how you would put that in legislation. I just don't know you could legislate it.

Mr LOCKET - I acknowledge it may not be easy but I think it would be a decided advance if, rather than denying the existence of the father, the legislation at least recognised his interests in the decision that is to be made.

Mr MULDER - Going back to the importance of someone being fully informed in contemplating an abortion, would you be of the view that someone who is contemplating abortion should also have counselling from someone who has a conscientious objection to it?

Mr LOCKET - I think if we want to even-handed and we want to be honest about ensuring that people are fully informed, then it is hard to get away from that requirement.

Mr MULDER - Then you would have no objection in them going the other way, if someone comes to you, they get the counselling about the abortion but to be fully informed they should also then get counselling from someone who doesn't have a conscientious objection to it?

Mr LOCKET - Yes, that's the logical outcome.

Ms FORREST - In your submission you say that this bill removes the requirement for women who are requesting a termination to be fully informed of all implications of such a decision before proceeding. Any medical treatment - and termination certainly is a medical procedure - requires informed consent, otherwise the doctor could be disciplined

including being struck off and deregistered. Informed consent requires, under the NHMRC guidelines as well as the medical code, that the woman patient is told about all the expected benefits, all the side effects and any significant long-term adverse outcomes - physical, emotional, mental, social, sexual, financial or other - so how does this bill, as it stands, do that? How does it remove that requirement for a woman to give informed consent?

Mr LOCKET - The bill does not require informed consent. That's the point. The bill requires consent but not informed consent.

Ms FORREST - A consent in the medical sense is an informed consent as per the medical guidelines and you can't get away from it. Doctors can't operate any other way but under their requirements as they are registered under, or they fear being disciplined in some manner. It's only doctors who are doing it; no-one else is doing it.

Mr LOCKET - I don't question that but should that not be enshrined in the legislation? Why was the word 'informed' removed from the bill? Can anyone answer that question, I wonder.

CHAIR - That is it then, Eric, there are no more questions on that last matter that you raised. Members can raise those points themselves in another forum and not seek to provide an answer here today. Members are aware of the draft which was in circulation and the difference between it and the bill which is currently here. Those questions could be pursued if members are of that mind. Thank you.

Mr LOCKET - Thanks very much.

THE WITNESS WITHDREW.

PUBLIC

Ms CAIT CALCUTT, PRO CHOICE TASMANIA WAS CALLED BY TELEPHONE; AND **Ms JENNY EJLAK**, PRO CHOICE TASMANIA WAS CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome to you both. Jenny will be sworn in and therefore everything she says is protected by parliamentary privilege because she is in this jurisdiction. We cannot swear you in because of not being in Tasmania, so the things you share with the committee today are not protected by parliamentary privilege. The transcripts of the proceedings, which are recorded today and transcribed at a later time, are a matter of the public record and will go onto the parliamentary website.

In terms of parliamentary privilege, anything Jenny has to say is protected by privilege and cannot be legally challenged while ever she is in the jurisdiction of the committee. Outside here, Jenny, if you are asked by the media or you volunteer comment by the media, if you are reflecting on the deliberations of this committee and the things that were said here, if there are matters that could be challenged legally then you are exposed to that.

Ms EJLAK - First of all, thank you for inviting me to come and give evidence. I won't go through the submission stage by stage because I appreciate you have probably all read it. I will focus on a couple of key principles.

First, on the importance of this bill and why the current law needs to change. A lot of the sections of the Criminal Code Act that relate to abortions stem from the old UK bill, the Offences Against the Person Act from the mid-1800s. You may be aware that the UK repealed those sections in 1967, so if we are trying to be consistent with UK law we are about 46 years behind.

One of the main concerns we have is that the current provisions, even though there was an amendment in 2001, still present both a genuine and a perceived risk of prosecution, particularly for health professionals. As to what I mean by genuine risk, if we look back over the history of doctors being charged with criminal offences in relation to abortion, right up until the late 1960s there were quite a lot of medical practitioners and so-called backyard abortionists in Tasmania and mainland states.

In Victoria between 1961-69 there were 16 charges laid against doctors and 11 against lay practitioners. In 1963, the Crown vs Luttrell in Tasmania - Luttrell was a doctor who was convicted and sentenced to four years for performing abortions. In 1967 in Tasmania, the Crown vs McIntosh, also convicted. There is a history of doctors being convicted and sent to jail in Tasmania under these provisions in the Criminal Code Act we have today. In Victoria in 1969, the Crown vs Davidson resulted in the Menhennitt ruling, which was used as a judicial precedent by Victoria and, in an informal sense, by other states and territories. But even then, we have still had Crown v Ward in New South Wales in 1972. We had Crown v Bayliss and Cullen in Queensland and 1986 but 1987 was the last known prosecution in Victoria.

In 1998 in Western Australia two doctors were arrested and charged with unlawful abortion. In 2001, as I am sure many of you will remember, in Tasmania a medical student or registrar complained to police under sections of the Criminal Code Act. The

only reason that police investigation did not go ahead was because parliament was recalled and we ended up with section 164. In 2006 in New South Wales in Crown v Sood, Dr Sood was found guilty. In 2010, only three years ago, in Queensland a young woman was put on trial for procuring an abortion. Once I have finished my points I might ask Cait if she would like to expand on the impact that had in Queensland in terms of health services, doctors being able to practise and women accessing services because, as you can imagine, when someone is charged and has to go to court, there is quite a time delay. It dragged on for quite a long time.

Given that there is quite a long history of doctors being charged in Australia with criminal offences in relation to abortion, it is not unreasonable that a lot of doctors in Tasmania feel that medico-legal risk is too high so do not participate in performing abortion services. They don't often want to sign the papers to meet the requirements under section 164. I have heard from some of the providers who fly in and provide services that some patients who come in have not been able to get a doctor locally to sign the statement that is required so the doctors at the clinic have to do that for them.

It is fair to say that the current provisions are really creating a lot of difficulty for the medical profession. Also, if you look at the wording of section 164, which is similar to the 16-week requirements in the current bill, it is quite redundant. If you look at the wording around the risk of continuing a pregnancy being greater than the risk of terminating it, the weight of medical evidence - and I have detailed that in the submission - is quite clear that a safe, legal abortion is much safer than continuing a pregnancy to term and going through childbirth. In asking a doctor to weigh up those risks, they are going to come to the same conclusion each time if they are basing their assessments on the research evidence.

Having abortion in the Criminal Code Act also creates a lot of stigma for women. It allows a lot of people to make accusations that women are very uncertain of because average members of the community don't know the Criminal Code Act line by line and it is a written in very legalistic terms and can be quite confusing for the layperson to understand. There is a lot of lack of understanding about what is legal and what isn't when it comes to abortion for women in Tasmania.

The current law is contrary to both United Nation and World Health Organisation recommendations, which is quite concerning. The overwhelming community view is that abortion should be legal and that is even including right up to later-term, second- and third-trimester abortions.

I know that you had Lachlan De Crespigny and Julian Savulescu appear previously. I do not know whether they referred you to their journal article of 2010 called 'Australian Attitudes to Early and Late Abortion'. They did a survey in 2008 where they found that, not surprisingly, 87 per cent of respondents supported abortion being legal in the first trimester, but then they went on to ask questions about later-term terminations. One of the things we often find when politicians are looking at the level of community feeling and support for or against different stages of pregnancy is that there seems to be this common belief that people don't support terminations later in pregnancy. They took the time frame of 24 weeks, which was proposed in the Victorian bill at the time, and instead of saying to people, 'Do you think this is a good thing - yes or no?', they presented people with 16 different real-life scenarios of situations a woman might be in and asked them

whether they thought that doctors should face sanctions if they were to perform a termination in these circumstances.

In every single case, the majority of people said that they did not think the doctors should face sanctions. There was no circumstance, from the woman's life risk right through to the family not being able to afford to raise a child, not one of those 16 scenarios there that even close to 50 per cent of people thought should be sanctions against. Surveys are a little bit like statistics; you have to be very careful of looking at how they are done, whether there is a bias in questions, methodology and sampling techniques. This one was published in the *Medical Journal of Australia*, which is a peer-reviewed journal, and I am happy to provide a copy of that if you haven't been provided with that already. My point is that there is a very strong community support for removing sanctions for health professionals who provide this service and it is strongest in the first trimester but is consistent through later phases as well.

The other main point that I would like to make, and I am sure you have heard this before, is that the health sector already has sufficient regulations and clinical and professional guidelines to cover a wide range of procedures, including termination of pregnancy. The other thing I would like to point out is that I have often heard in this debate that this is a very distinct and separate circumstance because it is a life-or-death situation, but I would like to put it to you that there are lots of life-or-death situations in medicine.

There are lots of, shall we say, accidental deaths through medications being used wrongly, surgery going wrong and, to give you an example, I have had two immediate family members die from cancer and in both cases they went to their GPs repeatedly with symptoms and the GPs failed to diagnosis it as cancer, so their treatment was delayed and both of them died quite shortly afterwards. It is very much a life-or-death situation if a doctor does not diagnose a terminal illness in a timely manner, but we do not have anything in the criminal law that says if a doctor does not diagnose this particular illness they are committing a crime. So I think when we are looking at termination of pregnancy in that very serious life-or-death framework, we need to remember that doctors deal with life or death every single day so we need to make sure we are treating this in the same way.

I understand that there is a heavy sense of responsibility in finetuning a bill such as this because it is such a serious issue that everybody takes seriously, but I would like to point out that when you look at the laws across the world there is no correlation between restrictive laws and greater or lesser proportions of terminations. The bottom line is that if a woman desperately wants to terminate a pregnancy she will find a way to do so and what we are doing with the law is not disallowing it or stopping it but providing a framework, and I would suggest the best framework we can provide is one that is consistent with the rest of the spectrum of women's reproductive health experiences and medical practice, with all of our existing health regulations and governing frameworks, and I think that we need to adopt a principle of less is more when it comes to separate or additional regulations in relation to abortion.

I might just add something extra to the later-term gestation abortions because I know that is always an emotional issue. I would ask you to bear in mind that each case is a complex mix of physical, psychological, emotional, psychosocial and circumstantial situations and the law in this case in some ways is a bit of a blunt instrument. It is very

difficult to legislate for all of the unique scenarios women will find themselves in and I think that is something where our medical professions have a range of clinical guidelines and I think that it is more appropriate for multidisciplinary teams of health professionals to assess each case on its merits than for a one-off piece of legislation that must meet yes-no kinds of criteria.

In summary - and then I will hand over to Cait - the key thing I would like to put forward is that this is very much a health issue. I understand that there are a range of philosophical, religious and personal views but fundamentally I think that it needs to be covered within our existing regulatory frameworks that cover all of our other health issues. I wish you luck in coming up with a suitable bill for that purpose.

CHAIR - Thanks, Jenny. Over to you, Cait, if you have some comments to make.

Ms CALCUTT - Briefly, and I would like to support the comments that Jenny has made in her excellent presentation to the committee, I am the vice president of Reproductive Choice Australia, which is a national pro-choice organisation, but I also work for Children By Choice, which is a Queensland-based NGO that provides counselling information and referral services for women experiencing unplanned and unwanted pregnancies in this state.

Picking up from the points that Jenny made regarding the ongoing criminalisation of abortion in Tasmania and also in Queensland and the need for reform was the trial in 2010 of a young woman and her partner. She was charged and prosecuted for an unlawful abortion under our section 225 of the Criminal Code.

The effect of those criminal charges led to doctors withdrawing their services due to the uncertainty that the ongoing criminal provisions around abortion in Queensland still create and many women had to travel interstate to access services and particularly unfortunately, mostly women who were seeking terminations in the public sector following a diagnosis of a severe foetal abnormality. They often were wanted pregnancies that became unviable due to the foetal abnormality diagnosis, so it was quite a distressing time for those women, not only being told that the foetus was unlikely to live much past birth but also that the baby would have significant suffering.

They then had to travel interstate, either to Sydney or Melbourne, to access services and a number of doctors raised the need for the removal of criminal sanctions in Queensland and around Australia to enable better practice to occur in the area of abortion provision.

I wanted also to raise the issues of national consistency around abortion laws. Doctors and women repeatedly raise concerns around the misunderstanding and lack of clarity because of the different laws in different states and the need to have more national standards around abortion. I think they proposed Tasmanian legislation that fits in a world with what is already in Victoria and also in the Australian Capital Territory, and enable a woman and doctor to better understand when they are able to provide or access pregnancy termination.

Another reason why I believe that the Tasmanian law needed to be updated and why I support this bill is that the introduction of medical termination of pregnancy into Australia has been a fairly new development and mifepristone for early medical

termination up to seven weeks' gestation or 49 days since the last natural period, was approved by the Therapeutic Goods Administration in September last year and has just been listed on the PBS - the Pharmaceutical Benefits Scheme - as of last month or August 2013.

I think most of us would agree that when a woman is facing an unplanned pregnancy that for her was unwanted and she doesn't wish to continue with, for enabling her to be able to implement that decision at the earliest is the best both for her mental and for her physical health. I think the current law in Tasmania that requires the two doctor approvals certainly would create delays in enabling a woman to access that termination before seven weeks' gestation, whereas I think the proposed new law would enable women to access pregnancy termination, particularly early medical pregnancy termination, as early as possible once they had made the decision to end the pregnancy. They are the key points that I would raise.

CHAIR - Thanks very much, Cait. Vanessa Goodwin has the first question for either of you.

Dr GOODWIN - It is on that issue of mifepristone or RU486 - I would prefer to use RU486 because it is easier to say. In your submission, Jenny, you do mention that you think there is a likelihood of a medical termination occurring in breach of the act increasing, presumably as a result of the increased availability of RU486. Can you just take me through why or how you think that might occur?

Ms EJLAK - I think the example that I gave was that there is a long history of women choosing to go to Melbourne or to other cities to access pregnancy termination services. Partly that is historically because Tasmania hasn't had a lot of service provision, but also it's often a privacy issue. I am sure you can appreciate how small Hobart is and to walk into a hospital, a doctor's surgery or a pharmacy to get a prescription without running into your next-door neighbour or your mother-in-law can be quite difficult. In the example that I gave if let's say I live in Hobart, I go to Melbourne, see a doctor, obtain the medication and say, 'Doctor, I would really rather be in my own home when this takes place,' hop on a plane, come back to Hobart and take the medication. Because I have not consulted a doctor within Tasmania and I haven't had the two doctors' signatures that are required currently, my understanding is that I would be committing an offence under section 134.

That's exactly what happened in Queensland and the young woman, as Cait has described, was charged. She went through a full trial, their house was fire-bombed by protestors, they had to move and they went through absolute hell. I certainly would not wish that on anybody. That is one example.

If, for example, a GP decides that they are going to prescribe the medication and they don't feel they need to get a second doctor's signature, both the doctor and patient would be at risk. I think that requirement for two doctors is quite a barrier. As I have said before, we are already finding from the providers who fly in from other states to provide the surgical service, that the patients are saying that they can't get doctors to sign a statement to say that under section 164 this termination is legally justified. Whether it is a surgical or a medical procedure, that law would still be in place if it isn't changed, so it would still be very difficult to get those two doctors.

The other risk is if the providers who fly down to provide a service for whatever reason stop doing that. Even with the capacity to prescribe the medication, if doctors still aren't prepared to take that medico-legal risk of signing the statement to meet the requirements of section 164, then they're still not going to be able to prescribe the medication. Again, we're going to have women in a situation without access, which of course is quite dangerous and causes delays and costs. Some women will be able to fly interstate and some won't; there is an equity issue there and it could create lots of problems.

Dr GOODWIN - Just in terms of the case in Queensland, which I'm not familiar with, I didn't know about the circumstances there and the fact that it was a medical termination as opposed to surgical. How was that discovered? Who was the one who -

Ms EJLAK - There's a book written by Caroline De Costa, who I believe has also provided evidence to the committee, and there are a range of books and DVDs. The young woman and her partner in Cairns found out she was pregnant, agreed to terminate the pregnancy - I am a bit hazy on the exact details, but I think what happened was her partner was from an Eastern European country and a relative either brought the drug in or posted it from the Ukraine because it is far easier to access in Europe. It has been used quite widely in Europe for approximately 40 years.

Mr VALENTINE - Is that 14 or 40?

Ms CALCUTT - Misoprostol has been used, but mifepristone has been used only in the last couple of decades.

Ms EJLAK - Sorry, I might have exaggerated that. The woman took the medication and terminated the pregnancy and everything was fine. A few months later police were investigating a completely separate incident and for some reason they searched the house this couple was living in. They found nothing in relation to the crime they were investigating but they found a blister pack in a foreign language. They didn't know what it was, they thought it might have been illicit drugs so they investigated it and found out it was an abortifacient drug. The young woman, being Gen Y, had no idea abortion was a crime, so she freely acknowledged and told the police what the drug was and what she had taken it for, and therefore she was admitting to a crime. The police and public prosecutors chose to pursue that and she went to trial.

As I understand it, it came down to whether - there is an idiosyncrasy in the Queensland law; they have kept the original UK wording that says it is a crime to terminate a pregnancy whether the woman is pregnant or not. In the 1800s there were no pregnancy tests, you did not know you were pregnant. You could suspect if you had symptoms but it wasn't until quickening, which is about halfway through the pregnancy, that a doctor could confirm the pregnancy.

Ms CALCUTT - The question in the criminal trial and the prosecution of the young woman and her partner, who was also charged with assisting her to procure an abortion, was whether the medication she obtained and took, the mifepristone, was a noxious substance. Under the Queensland law you cannot use a noxious substance. Medical experts gave evidence that mifepristone was not noxious to the woman and therefore the judge directed that the woman should be found not guilty and the jury followed that direction.

Mr MULDER - They should have charged her with drug importation, you're suggesting?

Ms CALCUTT - She wasn't charged with unlawful drug importation. She was charged under the criminal provisions around abortion in Queensland.

Ms EJLAK - The question came down to whether the definition in the act of the word 'noxious' was noxious to the woman or the foetus, but because the law says 'whether she is pregnant or not' then obviously it is to the woman.

Ms FORREST - A technicality really.

Ms EJLAK - She may be in jail if it hadn't been for that technicality. I would hate to see any woman go through that kind of public trial.

Ms CALCUTT - I think it was the uncertainty that prosecution caused, the fact that doctors and also women had believed that the law, because it had not been used since the 1980s by the police or the prosecuting authorities, was essentially dormant. Because it was then utilised by the police, there was a great feeling of nervousness in the medical profession and women. It caused a great deal of anxiety and confusion that continues today.

Dr GOODWIN - It raises an interesting issue, that the importation of RU-486 could well be going without on us realising it anyway. It could already be more widespread than we know.

Ms EJLAK - Very much so. There are organisations set up specifically for that purpose where you have a consultation via Skype or over the phone and the medication is posted. That does happen in a lot of countries where abortion services are not available.

Ms FORREST - Is it done without any supervision at that point?

Ms EJLAK - Yes.

CHAIR - You said that it is good we are proposing to align our law with the Victorian law. Victoria doesn't go down the path of the counsellors and their conscientious objection, like our bill does. Do you have a view about that?

Ms EJLAK - I do. The legislation is a step forward towards national consistency, which I think is important. I do support that additional conscientious objection clause being placed in the Tasmanian legislation.

CHAIR - Specifically relating to counsellors?

Ms CALCUTT - Yes. I am putting my Children By Choice hat on. We have counsellors here and we receive frequent reports of women calling our service having encountered health workers and also pregnancy counsellors who had a particular view against abortion and did try to dissuade the woman against making that decision. Unfortunately, sometimes some misinformation and false information can be provided to women about the abortion procedure. It can often cause great distress to women and cause them to

rethink and delay their decision and also delay their finding a service that is nearby. Particularly in Queensland, where we have large distances and very few providers - as in Tasmania there are limited providers - that can delay women being able to access services. It is in the best interests of women's health if they have made the decision, that they can access safe medical or surgical termination of pregnancy as early in the gestation as possible.

CHAIR - Thanks very much.

Ms FORREST - Following on from Vanessa's question, at the end of your submission, Jenny, you make the point that proposed section 14 of the bill which puts in 178D, Termination by person other than medical practitioner or pregnant woman, is a hangover from the days of backyard terminations. In view of the fact that mifepristone or misoprostol may be administered by a nurse, and midwives certainly administer them in maternity units all the time for induction of labour and other purposes, if it stayed as it was - and maybe this is not a question for you but a lawyer - and the doctor prescribes it and the midwife merely hands it to the woman because she can't prescribe it, unless we get to the point where nurse practitioners are prescribing it, which may mean we need an amendment to the legislation to facilitate that, then this could present a challenge in another way. Is that what you are saying on this section?

Ms EJLAK - I think so. Going back to the earlier principle about clinical guidelines, hospital guidelines, prescribing rights, the scope of practice of different health professionals, all of those things are evolving continually and they can happen far more quickly than the law can change. They are based on experience and evidence in research. If we are going to treat this as a health issue, that is where those kinds of decisions should be made. At the moment, for example, with mifepristone, my understanding is that only doctors who have completed the training with Marie Stopes International Australia are allowed to prescribe it because it is a slightly restricted drug. Pharmacists can dispense it. It's not something you can buy at the corner shop.

In hospitals, as you pointed out, there are a lot of situations where medications are given that would normally only be able to be prescribed by a doctor and dispensed by a pharmacist. But because there are protocols in place within that hospital setting that would only be able to be prescribed by a doctor and dispensed by a pharmacist but because there are protocols in place within that hospital setting, often nurses or midwives are able to actually give a patient medication without necessarily having to go through the prescription or the doctor's consult in some cases if there is a protocol for the use of that drug.

Ms FORREST - Following from Vanessa's question, a 20-plus week termination and there would appear to be an induction of labour at that point and the midwives will often put in vaginal medication. We are not talking about the woman swallowing a tablet and she is giving it to herself if she is conscious, obviously, but she is unlikely to dispense a vaginal medication herself - she could but she would need to get it in the right spot. That may be something we need to look at in facilitating - I am not talking about the induction of labour for an expected live birth, I am talking about termination of a baby that is not expected to live, perhaps.

Ms EJLAK - I think, as you said, it is probably a question more for a clinician or a lawyer. I am not sure that I am really qualified to answer that in the detail in which you are presenting it, but I do think that there is potentially a risk there as you have described that. One would hope that a judge would use common sense - why have the risk if you have the opportunity to change it?

Ms FORREST - In your submission on page 3 you said that there are many reasons why a woman may not recognise or acknowledge a pregnancy until after 16 weeks and that is why we have late terminations here and that a tiny percentage, 0.7 per cent, of terminations after 20 weeks represents a personal tragedy and you go through a range of reasons there. Where do you get those figures of 0.7 per cent being after 20 weeks and are you able to provide those?

Ms EJLAK - It is in the Victorian Law Reform Commission report and they obtained it from the National Council on Obstetrics and -

Ms CALCUTT - The National Maternal Neonatal Morbidity - is that the one, or it might be the Australian Institute of Health and Welfare who make that publication.

Ms EJLAK - I might need to refer you back to the Victorian Law Reform Commission report and to find the original source of that. My understanding is that from 20 weeks onwards there needs to be a report to the relevant state authority and that is how they collect that data. Accurate data on terminations is notoriously difficult to get right, particularly on earlier terminations, but my understanding is that that is a more robust number. I think it is a few years old and I won't quote the year.

Ms FORREST - The data collection for Victoria - I am not sure how it compares with the Tasmanian data collection. After 20 weeks you have to put out a report to the parent data collection but in that, whether that termination has occurred, do we have the figures of how many are related to gross foetal abnormality, particularly those that wouldn't survive and maternal indicators?

Ms EJLAK - I do think that data is available but I cannot tell you off the top of my head but I can chase that up for you.

Ms FORREST - That would be helpful and for the terminations occurring beyond 20 weeks and beyond 24 weeks and the indications for those? We did have a witness suggest earlier today, and I have forgotten the actual percentage that they said, but it was a significant percentage of those were for healthy babies.

Mr MULDER - My first question relates to the proposition and you identified a number of prosecutions for abortions of Tasmanian doctors. What you didn't mention, I think, was that they were all before the amendments to the criminal code which came in. Have there been any prosecutions under the Tasmanian criminal law as it now stands?

Ms EJLAK - Since the addition of section 164, not that I am aware of but my understanding is that doctors and particularly in the public hospital system have done a risk assessment and still assessed the risk as being too high.

Mr MULDER - From your legal opinion. what is the risk of getting a prosecution, given that fact that section 164 is there and that these terminations are occurring, at least in early term and late term abortions are still occurring due to foetal abnormality?

Ms EJLAK - I don't have a legal background, so I'm not really in a position to make that kind of assessment. If we go back to the scenarios that we were talking about earlier with Vanessa's question about medications being used, perhaps being obtained over the internet or from interstate, if the woman doesn't receive two doctors' signatures in writing and the relevant assessment is required, I think that's still a possibility. I can't speak on behalf of Tasmania Police as to whether they would or would not follow a complaint, but they did so in 2001, so there is no reason to think they wouldn't do the same thing if someone went and complained to them in 2013.

Mr MULDER - I think they're duty bound to follow up a complaint. What they do about it is the issue and what advice and whether the DPP, for example, would launch a prosecution in the public interest. The other question I wanted to ask was there is a constant theme in here which says the rights of the child under UN Charter don't occur. There are no rights until birth.

Ms EJLAK - I'm not sure of the particular charter that you are referring to, so I will take your word for that.

Mr MULDER - That is the state. You would also concede that we never talk about the rights of the unborn child in this procedure.

Ms EJLAK - At the level that you're working at it is about a legislative framework. We could have a philosophical discussion about relative rights, about the woman versus the unborn or born and obviously that is something that you are considering and will take into account. I'm not quite sure what else I can add other than -

Mr MULDER - As part of that philosophical discussion, has anyone turned their mind in the principles in the Rowe vs Wade decision, which you are probably familiar with, which talks about an increasing right relating to the gestation period of interference with the child? I wonder whether anyone has tried to factor that into the law reform going on in Tasmania?

Ms EJLAK - First, that is something that doctors take into account with every case that they have to assess. In terms of how that fits in with law reform, I suspect that was a factor leading to the Victorian model, which has requirements around 24 weeks and my understanding was that 24 weeks was chosen because there is a significant amount of medical evidence that says that the foetus isn't viable prior to that. That point of viability is where they started to weight up those concerns. I think when you have a case of weighing up the rights of a living adult human being versus a potential life, I would suggest that the rights of the person who is already living take precedence. As I said, that is a philosophical discussion. It is not something you can be very clear about in law, but I appreciate that it is something that you need to take into consideration.

Mr MULDER - Why would you have different procedures for late term abortions if it wasn't for that factor?

Ms EJLAK - What do you mean by different procedures? Legal requirements?

Mr MULDER - This bill proposes a different requirement, and we can pick a term; it was 24 weeks, it is now 16. Obstetricians and gynaecologists have argued for 12 or 14, but I wonder why would we need to pick a term at all unless the viability or the rights of the foetus had some play in it.

Ms EJLAK - Again, there are lots of different reasons why you might look at different requirements for different gestations, the rights of the foetus being one of those. Again, I come back to saying that I think that that's something that fits within the clinical guidelines of the medical profession and it is very difficult for the law to have an absolute cut-off point. That is best left to those who are at the coal face dealing with the case in front of them with medical research and a team of health professionals to assess each case on its merits.

Mr MULDER - So balancing the rights of the mother versus the rights of the child is a medical issue, not one the law should dabble in? Is that what I am hearing?

Ms EJLAK - I wouldn't say the law shouldn't dabble, but I am not sure that the law is the best mechanism.

CHAIR - Cait and Jenny, thank you. We are grateful to you both for your time and evidence today. It will help form part of where we proceed from here.

THE WITNESSES WITHDREW.

PUBLIC

Ms RACHEL BALL , HUMAN RIGHTS LAW CENTRE; AND **Ms TANIA PENOVIC** AND **Ms RONLI SIFRIS**, CASTAN CENTRE FOR HUMAN RIGHTS LAW, WERE CALLED, BY TELEPHONE, AND WERE EXAMINED.

CHAIR (Mr Harriss) - Given that you are participating via teleconference and therefore not able to take the oath here with us, you are not afforded parliamentary privilege which is afforded to people who appear before the committee in Tasmania and take the oath. Nonetheless, the evidence you give to us today is being recorded and will be subsequently transcribed and will form part of the public record. Transcripts of the evidence will go onto our committee website and therefore accessible by anybody who takes an interest in these proceedings. If there are matters you would wish us to consider in camera, we can take that into consideration.

Given you do not have parliamentary privilege, if there are things which you might choose say to the committee when they go into the public domain on the *Hansard* and anything might be actionable, we suggest caution in how you provide that evidence to the committee. There is no great drama when people are giving factual information to committee of the parliament whether they are under oath or not. We have your written submission, so we are happy to hear from each of you.

Ms BALL - I am Rachel Ball from the Human Rights Law Centre. Thank you very much for the invitation to speak to the committee today. The Human Rights Law Centre submission focuses on the [inaudible] compatibility with Tasmania's human rights obligations. If you have a bill for a human rights [inaudible] should assist to identify different rights and interests and strike a fair balance in cases of conflict. Human Rights Law requires the conflict between rights are resolved so that any limitations on human rights are reasonable and proportionate. It is a commonsense evidence-based approach to dealing with complex policy issues.

[inaudible] in reference to issues in the bill that invokes Tasmania's human rights obligations: conscientious objection and access zone. On both of these issues the bill limits rights, most significantly freedom of religion and freedom of expression. The limitations imposed are intended to protect women's rights to health, privacy, liberty and equality among others.

On our analysis the conscientious objection provisions strike a fair balance between competing rights. Doctors can and do restrict or prevent women from accessing lawful reproductive health services. Legislatively the intervention is necessary to ensure that women's rights can access the services and are not subordinate to their doctor's personal belief. This aim should be achieved in a way that it is least restrictive of religious rights and we feel that the bill does this.

On the question of access zones, there should be no doubt that there is a need for access zones because of the significant harm that protesters can cause when they intimidate and harass patients and staff coming in and out of clinics. However, we feel there may be some scope to amend these provisions if there is a way in which they can be less restrictive than they currently are.

More broadly, we commend the Tasmanian Parliament's move to decriminalise abortion. Decriminalisation is an essential step towards the realisation of women's human rights and the elimination of the confusion and stigma in the current law. Thank you.

Ms PENOVIC - It is Tania here. I would like to make a brief opening statement. We are on my behalf and on Roli's, we are from the Castan Centre for Human Rights Law. We are grateful for the opportunity to address you today. We wish to express our strong support, overall, for the bill. Removing abortion from the Criminal Code and regulating the procedure as a health matter is an essential step in promoting the autonomy, dignity and rights of women.

Assertions are often made to the effect that decriminalising abortion and providing access to reproductive health services is a breach of Australia's human rights obligations on the basis for the right to life commencing at conception or some other point prior to birth. This is not the case. Despite attempts by various nations to extend the ambit of human rights treaties to the unborn child at the time those treaties were drafted and debated such proposals have always failed to achieve consensus. They have never been adopted.

In negotiations around key human rights instruments, such as the international covenant on civil and medical rights and the convention of the rights of the child, the Australian Government has taken the view adopted by a preponderance of nations. That is, the obligations it would assume to ratify those treaties applied from the point of birth.

The bill is compatible with the standards of human rights law which were enshrined in instruments Australia has ratified including, as I have mentioned, the international covenant of civil and political rights, also, significantly, the convention on the elimination of all forms of discrimination against women and the international covenant on economic, social and cultural rights. There is a growing body of jurisprudence that recognises that the international human rights laws support women's reproductive autonomy including the right to choose to terminate pregnancy and the right to access safe termination procedures.

Reproductive health is fundamental to women's health and wellbeing. Access to safe abortion is essential to securing women's equality in society, generally, and securing women's health. International treaty bodies have found that the right to the highest attainable standard of health incorporates the right to control one's health and body. This includes sexual and reproductive freedom. The realisation of women's rights to health requires the removal of all barriers interfering with access to sexual and reproductive health services. Furthermore, the criminalisation procedures which were only required by women have been found to constitute discrimination.

The United Nations body have observed that mortality caused by unsafe abortion is associated with restrictive abortion laws. The refusal to allow access to abortion has been found by both the UN body and the European Court of Human Rights to breach the rights of privacy and to constitute cruel inhuman or degrading treatment. It has, furthermore, been found to amount to a failure to eliminate prejudices and practises based on gender stereotyping and constitute discrimination against women in the field of health care.

It has been argued that the bill is unnecessary because of the current absence of investigation and prosecution by the Criminal Code but the potential for prosecutions under the existing law is not fanciful. The current legislative framework is clear and uncertain; women and doctors are therefore operating in an environment in which they may not fully understand what is required for an abortion to be performed legally. The lack of certainty has the effect of limiting access to reproductive health services and stigmatising women. We believe that the bill's passage would bring clarity and certainty to the law and have the effect of strengthening respect for the law.

We support the introduction of access zones to protect vulnerable women from harassment and to ensure that the bill's objectives are achieved. We appreciate that access zones may limit protesters' freedom of expression and must therefore be tailored so as to restrict that limitation to what is necessary to protect the rights of women seeking reproductive health services. In light of the problems associated with protest action outside other Australian abortion clinics, we believe access zones are a valuable initiative which could be usefully adopted in other jurisdictions.

We similarly believe that the obligations imposed on medical practitioners by clause 7 strike an appropriate balance between a woman's right to terminate her pregnancy and a practitioner's freedom of conscience and religion. It is consistent with the juris prudence and observations of the UN Treaty body including the Committee on the Elimination of All Forms of Discrimination Against Women and the Human Rights Committee.

We furthermore commend the drafters for recognising the autonomy of women as competent decision-makers concerning their own reproductive health, and introducing abortion on request up to 16 weeks of gestation. We nevertheless believe that the requirement of third party approval after 16 weeks is problematic. It perpetuates gender stereotyping and the existing stigma surrounding abortion contrary to the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women. It furthermore denudes women of autonomy and is in practice likely to limit access to abortion services.

We submit that Tasmania should follow the example of the ACT in which a woman's ability to access abortion on request is not predicated on the period of gestation, or at the very least increase the gestational limit to 24 weeks, as is currently the case in Victoria.

Subject to these concerns, we strongly support the bill and believe that its passage would introduce clarity and certainty to the law and significantly advance the rights of Tasmanian women. Thank you.

CHAIR - Thanks very much, Tania. I just have one question, in both your written submission and the evidence which you have provided just now, you have suggested that the radius for the protest process could be reduced, and also the penalties attaching to protests within that area. Is there any particular overarching reason why you are suggesting that could be a consideration?

Ms BALL - One of the important principles when you apply human rights analysis to limitations on rights is that the limitation should be the least restrictive that is necessary to achieve the aim. If the aim of the access zone is to ensure that women are able to enter and leave clinics safely and free from intimidation and harassment, and likewise

staff, then the question that needs to be asked is what is the minimum restriction on protesters' rights, if necessary, to achieve that aim.

I am afraid I don't have all the background so I am not certain why the access zone of 150 metres was chosen, nor the level of the penalty. If there is evidence and a good reason that can be given for justifying the extent of the radius and the penalty then that would be permissible under human rights law. However, if the aim of protecting women's rights and also the rights of staff could be achieved through lesser restrictions, then those restrictions should be considered.

Ms FORREST - Both of you may wish to address your minds to this. We have had a lot of concern raised, particularly by church groups, about the rights of the unborn baby. I made the point this morning to one of those groups that the rights only extend to after the baby has been born. That seems to be a misunderstood area. We acknowledge the baby exists before that because it is obvious, but can you explain more fully the rights of an unborn baby and then the rights once they are born.

Ms SIFRIS - You have asked a very difficult, challenging issue. From the perspective of international human rights law, there has been a lot of debate on this particular issue. In fact, there was significant debate when the Convention on the Rights of the Child was originally drafted as to whether the notion of a child in that convention started at birth or beforehand. It was very clearly decided that it started at birth, not beforehand. So from the perspective of international human rights law it is quite clear that when we are talking about the rights of children we are talking about from birth and that there are no specific rights that attach to a foetus per se.

This is not to say that if, for example, injury is caused to a foetus, say, by negligent conduct by someone, or by assault and battery, that has absolutely no consequences. But, the consequences are conceptualised as being related to the harm that has caused to the woman as opposed to the foetus having independent rights from the woman carrying that child. I am not sure if that answers your question.

Mr MULDER - The American judgment in Rowe vs Wade concurs with the view that it is not the rights of the child, but it identified a right of the state to protect the unborn and that that right became more significant or had a heavier duty of responsibility on the state to protect it was matched with the gestation. So the right or the duty of the state to interfere in those terminations was larger in the latter stages of pregnancy than it was at the beginning. What is your comment on that?

Ms SIFRIS - Again, a really difficult question addressing a very difficult issue. When it comes to period of gestation, there is no right line. It is not that you can say there is such a clear differentiation between each day of pregnancy as the pregnancy progresses. It is a very difficult issue which is precisely why, in my view, the issue should be given to the woman to make the decision. I do not believe it is the role of law or the state to intervene in an individual woman's life in this way. I accept that for a number of people this is a very serious moral and ethical question, and for many women for that precise reason they would choose not to have an abortion. Equally, I don't believe it is the role of the state or of law to dictate what an individual's morals or ethics should be on this particular question.

Mr MULDER - The issue was with the state's right to intervene and basically you are suggesting it is such a difficult question that right should not be considered in legislation.

Ms SIFRIS - Precisely. I think that is a moral and ethical question which should be outside of law's domain.

Ms FORREST - Both submissions refer to the human rights compatibility of key aspects of the bill, one being access to abortion and the other conscientious objection. I would like to talk about both of those a little bit further. I would like you to expand a bit further on how you see changing the law as is being proposed here, will have a positive human rights outcome on access to abortion.

Ms PENOVIC - Introducing clarity and certainty into the law will remove barriers to access which currently exist. It will also remove the current stigmatisations of women that exists in this area and therefore protect women's human rights.

Ms BALL - To respond to the element of the question directed towards conscientious objection, I understand that the committee has heard evidence that without legal provisions, directing doctors to make a referral where they have a conscientious objection, there are cases where doctors simply tell women that abortion is illegal and that they will not provide that service. That is a concrete example of where not having these provisions in the law can result in restrictions on women in accessing lawful services.

Ms FORREST - On that point, it has been suggested by some that the conscientious objection is way too onerous. I made the point a number of times that it is in line with the medical codes and codes of practice and codes of ethics that requires a doctor who has a conscientious objection to ensure the woman does not have access to treatment blocked or appropriate legal treatment blocked or to refer her on, depending on the code you look at. Is this as much a protection for those medical practitioners, such that they are not required to proceed down a path they don't want to go? It enshrines in the law as well as in the medical codes where it normally sits, the fact that it is okay to have a conscientious objection because this is how you deal with it.

Ms BALL - Yes, I think that is definitely the case that this bill also provides protection of doctors who have a conscientious objection and protects their right to religious freedom in that way.

Ms FORREST - Some of the doctors have expressed a concern that the use of the word 'refer', and we have had a lot of discussion about this, makes them complicit. If they refer a woman to another medical practitioner who doesn't have a conscientious objection, regardless of whether or not that doctor undertakes terminations, they seem to have this fear that their complicit in that and on their conscience, the fact that this one may end up having a termination. Even going to a family planning clinic, for example, where terminations aren't conducted, they have expressed some concern about that because more than likely they end up having a termination, but not on that referring doctor's advice but on some other doctor's advice. Do you have a comment on that?

Ms SIFRIS - The issue with conscientious objection is that you are dealing with a conflict of rights. You dealing with, on the one hand, the rights of a doctor to freedom of religion

and freedom of conscience and then, on the other hand, the right of a woman to be able to access adequate health care in a timely fashion. One option is to have a law which says that all doctors have to perform an abortion. In that way you safeguard the rights of the woman, but you potentially infringe the rights of the doctor with that conscientious objection.

The other option is to go to the other extreme and to say that no doctor has to provide abortion services or refer anyone to have an abortion. Then the other ground, which I think is the middle ground that is really reached by this bill, is to reach a middle point and say doctors are not obligated to perform abortions unless it is in a life-saving situation, but that they are obligated to refer.

I do understand that that may make some people feel uncomfortable, but I do think that really is the only reasonable middle ground. Particularly when you consider the fact that there may be some places, like some country towns, for example, where the only doctor in town has a conscientious objection and without an obligation to refer, a woman who is seeking to terminate her pregnancy will simply have no vehicle for even really finding out where she can go to access those health services.

Ms FORREST - The point you are making then that is impinging on her rights to access to information of a service, is that what you are saying?

Ms SIFRIS - Yes, that's right. I'm saying that the way that the bill is currently framed is such so as to protect both the right of the doctor to conscientious objection as well as the right of the woman to access the health care that she requires.

Ms BALL - I understand that there is a suggestion that is made around referring to Family Planning Clinics, was that part of the question you were asking as well?

Ms FORREST - That was one of the suggestions that has been made, that rather than referring to a doctor who does not have a conscientious objection. You may or may not know who that is potentially, but if you refer to a service such as Family Planning where they are known to give a full range of options, including continuing the pregnancy, adoption and termination, where they also have medical practitioners who work there and you have fulfilled your obligation without actually referring directly for a termination.

Ms BALL - So that would be an extra step that women were required to take potentially. The question I would have about that is - and it may not be one that the committee is in a position to answer - but is that a plan that would alleviate the concerns of doctors who have a conscientious objection, or would it just be imposing an additional step that would not help anyone necessarily?

CHAIR - We will just take that as rhetorical, so we will think about that proposition that you put to us. We don't have any further questions for you, so for the three of you, thank you, and also for the submission you provided earlier.

THE WITNESSES WITHDREW

PUBLIC

Dr HELEN LORD, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Helen, thank you for your written submission; it is substantial and we are grateful for that.

Dr LORD - Thank you for inviting me to appear today and to speak to my written submission. I am a Tasmanian-trained medical practitioner and I have been working in general practice for 30 years. In my training I worked as an obstetrics and gynaeocological resident at the Royal and I continue to provide medical care to young women, pregnant women and women in later stages of life.

I have a specialist qualification in palliative medicine and a masters degree in primary health care. At present I have a teaching position in the University of Tasmania Medical School and I work as a senior medical educator for the general practice training program.

In presenting today, I have sought the views of a number of my GP colleagues and they have encouraged me to speak on their behalf as many of them have similar concerns as my own. I am confining my comments mainly to the care of women. I think it is obvious that this proposed bill neglects completely the care of or even thought of care of the unborn child, but I am sure that others will have addressed issues such as the rights or expectations of care related to unborn children.

I consider that abortions should be safe and legal and rare. Termination of pregnancy is more than just another medical or surgical procedure. This is made quite apparent by the strength of community discussion and the concern that this issue generates. Pregnancy itself causes an enormous upheaval in women's life - physically, emotionally, socially and economically - as it involves taking on the responsibility of another life.

Women contemplating a termination have the added burden of dealing with the existential issues of potential grief, regret, and loss for both themselves and others that may ensue from the decision that they make. A termination of pregnancy does have long-term consequences relating to the circumstances that actually lead to the pregnancy, the pregnancy itself and then life afterwards. I am going to talk a bit about helping decision-making, limits and criteria related to the bill, clauses about duty to treat, the conscientious objection clauses and health aspects of access zones.

Helping-decision making: I suggest that the two most important factors in a woman's decision-making when it comes to considering a termination, and which any progressive legislation should address, are the availability of good information and lots of support. I am well aware of women who, having gone through a termination, in later months and years state that they would not have gone ahead if they had known more and had more information beforehand. So first, good information or, put another way, proper informed consent. This needs to be addressed in any progressive bill related to termination.

Informed consent is commonly understood to be the provision of the information to a person in a manner which they can easily understand about the nature and process of the procedure which is being proposed, the likely outcomes of the procedure - good and bad - the likely outcomes of not having the procedure - good and bad - in other words, the risks

and benefits involved and other alternatives to the proposed procedure. In this case it would termination of pregnancy, continuing the pregnancy or adoption. I'm well aware of women undergoing termination of pregnancy here in Tasmania who are not currently being given such informed consent, even though the current bill has requirements for referral, enabling that to happen. These steps have effectively been circumvented by the current termination practice in Tasmania and I think more specific steps need to ensure that informed consent occurs. I suggest that the Health department provide an information brochure along those lines.

Second, support for pregnant women facing a termination decision is essential. I want to emphasise research which does show a significant association between termination of pregnancy and psychological distress. The published work of Fergusson and Coleman with respect to the effect of termination has been discredited in these hearings, yet their work is widely and authoritatively quoted in the obstetric field when it comes to issues of mental health, alcohol, drugs and smoking, as these have major effects on the outcomes of pregnancy. Their work, and the work of a number of other researchers, has been collated and is quoted in the definitive 2011 UK Academy of Medical Royal College's report and the definitive 2008 American Psychiatrists Association Review. These reports all make recommendations that women need to be better supported during their pregnancy, particularly with regard to decision-making around termination. Particular groups of women are noted in these reports as being at increased risk of adverse outcomes from terminations. They are those women with co-existing life stresses, negative emotional reactions or previous mental health problems. That is the UK report summary.

The APA report is similar: stressful life events such as violence and sexual abuse, foetal abnormalities where that has been the sole concern leading to the termination, environmental issues such as lack of resources, lack of partner support or if they have had previous mental illness. Progressive legislation in this area really needs to include provision of support and counselling for all women facing any of these decisions. I note as I was reading through the key indicator report published by the Health department, as part of my other work, Tasmania has a higher rate of difficulties with health literacy than the national average, so health literacy, support for women and proper information really needs to be considered as being part of any proposed legislation.

I will go on to speak about limits and criteria for abortion. I refer members of the committee to my written submission for a more detailed discussion and for the references to the medical literature, which I mentioned in discussing these issues and which I would like to summarise here.

Foetal development is a continuum from birth to conception. There is no real natural cut-off point as far as the foetus is concerned. I mentioned before I would like abortion to occur rarely, but it is going to happen and for a variety of reasons. I think there is also a community expectation for some degree of control over the procedure and the process. I have suggested about five categories of termination of pregnancy that need to be considered.

Earlier terminations performed before 13 weeks of pregnancy are safer for the mother both physically and psychologically than termination in a later stage in pregnancy. I have references to support that. For this reason I am suggesting an upper limit of

13 weeks for terminations. However, you need to retain some of the checks and balances in that and I suggest retaining the two independent doctors to sign and a requirement for referral for counselling. I am particularly concerned that these checks and balances are in place. It prevents people being coerced into having an abortion by the threat of emotional blackmail or physical abuse. There needs to be some opportunity to further care for women who are in difficult circumstances. That doesn't happen if it is just a procedure and then it is finished.

Mid-trimester abortions: I am suggesting that after 13 weeks there needs to be a process of assessment and consultation that takes place that may involve more than just medical staff. It may involve allied health staff to address the reasons in delay of presentation. The reasons for delay in access to termination in Australia are known to be related to poverty, lack of transport, mental illness, drug abuse, not realising that you are pregnant, and violence. These are the issues that are related. These were published in a study from Melbourne in 2009. This is recent work that has been done. All these issues should be addressed in a comprehensive manner in order to improve women's health, not simply to provide an abortion.

I would like to suggest an upper limit set by foetal viability in terms of abortion beyond which no abortions should probably be performed. I have referred in submission to the 2010 study from the MJA from de Crespigny and the 2013 Tasmanian Galaxy Poll which showed that the majority in our community are not happy with late-term abortions occurring. I consider a phrase something along the lines that 'a termination of pregnancy should not be performed if the foetus is considered viable'. This is generally considered to be somewhere between 22 to 24 weeks. It is a bit hard to know. An upper limit of the stage of foetal viability would remove the dilemma of a late-term abortion resulting in the delivery of a viable, live, living baby.

That is supported by other jurisdictions. It is 24weeks in the United Kingdom. It is suggested at 22 weeks in the United Kingdom that the foetus be killed prior to an abortion occurring. That is in the UK guidelines. A 20-week foetus has been determined to be able to feel pain by the US Supreme Court. They are considering bringing legislation back in across the US in terms of what occurs there. I notice there is a similar cut-out of about 20 weeks in Western Australia and 28 weeks in South Australia. There is a range of options there being considered. If you put in the legislation that a termination should not occur if the foetus is considered viable, that may well be an appropriate position considering a lot of community concerns.

Abortions for foetal abnormality: Tasmanian law does not, at present, allow for termination of pregnancy for foetal abnormalities per se. Instead, these are done on the grounds of causing potential maternal distress, a situation which other submissions have mentioned as being problematic. Current practise in Tasmania is often for a woman to be offered a termination for any foetal abnormality at all which is picked up, life threatening or not, just because of this potential. This offering of terminations for even minor abnormalities in itself may cause maternal distress. For example, a mother was recently offered a termination because her unborn child simply had plagiocephaly, a variation in the shape of the skull which is known to be benign and does not cause any problems.

The UK has a separate clause for dealing with foetal abnormalities which is not gestation-bound. Their grounds are that the termination may occur for severe foetal abnormalities which may result in severe handicap, if done with formal consent of the mother and father. I am suggesting a similar category of allowable termination may be appropriate in Tasmania.

My fifth category is abortion for sex selection. At present, abortions are allowable in Tasmania for just about any reason at all. This includes abortions for sex selection at any stage of pregnancy, right up until term, under the current 'any other matters' clause in the 2001 bill. Since writing my submission I have become aware of GPs being approached to refer to sex selection in Tasmania. Fathers, in particular, want to have a boy and pressurise their pregnant wives to have a termination of a baby girl. This issue has not been raised so far, so it does need to be considered in its own right, either in this legislation or in a separate bill. In the Galaxy Poll I referred to earlier, 92 per cent of Tasmanians want were opposed to a termination of pregnancy occurring for selecting the sex of the baby. I am suggesting that sexual selection termination should be banned, perhaps except for those where you have medical conditions possibly known to be sex-linked.

I am going to talk about duty to treat. I would like to mention clause 6 - the duty for those with a conscientious objection to treat for emergency termination. I would like to submit to the committee that this clause is actually unnecessary. It is based on a bit of unclear thinking about what actually constitutes a termination if this is actually part of a health bill. Firstly, there is really no such thing as an emergency termination when that termination is actually meant to lead on to the death of the child. Having a compulsion to take part in a termination may in fact lead to nurses and doctors developing mental health problems as a result. Doctors' and nurses' codes of conduct already cover treatment in an emergency situation and all medical staff and everyone are always willing to help out if the life of a patient is in danger. Cases where a pregnancy must be prematurely ended because of threat to the woman's life are very rare; for example, pre-eclampsia or where you have severe heart or lung failure. The primary aim is not to kill the child. Indeed, if the child is born alive you make every effort to resuscitate that child. That is in keeping with the O&G College guidelines.

Second, having a compulsion to participate in a pregnancy termination will not only apply to those who have a moral or religious objection to the procedure. It is also going to apply to those who may have themselves experienced a foetal death in utero or have been adopted, and so experience distress of what might otherwise happen. This is an emergency termination; the baby is going to be killed. There is some unclear thinking here. There is actually no such thing as an emergency termination. There is an emergency end to the pregnancy but it is not necessary in most cases to actually kill the child. If it is an emergency situation you do not inject potassium chloride before you actually do the termination. You will deliver the child and so save the mother's life that way. It is about intention.

Conscientious objection and doctors: I submit to the committee that this clause is actually unnecessary. This clause is essentially the same as what was introduced into the abortion law in Victoria in 2008. It is meant to remove a significant problem of access to termination of pregnancy. However, there is no research evidence available showing that access to termination is impeded to any significant degree by doctors of conscience.

There is no mention of it being done in the Victorian study. It was actually undertaken in 2006 and was published in the MJA in 2009. They found, as I mentioned before, what the delays were. Doctors of conscience impeding access were not mentioned as a cause. At present under the guidelines from the Australian Health Practitioners Regulatory Authority and the AMA, if a doctor has a conscientious objection to termination then the doctor has to inform the patient that they have such an objection, and then allow the patient to go elsewhere and not to impede access. There is no compulsion to refer to another doctor. If access is impeded, AHPRA has the power to investigate and discipline or sanction.

In this debate, reference has been made to the obstetricians and gynaecologists code of conduct, which does contain a compulsion for referrers as a duty of care issue. However, this is only applicable to members of that college. It is not applicable to GPs. The College of O and G's submission to this inquiry, however, does support compulsory referral against conscience by GPs. Given that a significant part of these specialists' workload is in termination, probably about a third of a gynaecologist's workload according to data published in the United Kingdom and we have similar legislation here and a similar occurrence here, then it is difficult to escape the inference that self-interest may be playing a part here.

I do not refer for terminations. I consider that referring a woman to another doctor whom I know will refer makes me complicit in that process. A number of my colleagues also practice in a similar way and have instructed me to be a voice for them.

I understand that with this proposed bill because of my position of conscience if I see a woman for any pregnancy options advice - that could be anything relating to the pregnancy like where do I go and deliver this baby, let alone if a woman is seeking an abortion, I am liable to be sanctioned by AHPRA if I do not immediately stop talking to her and refer her on, even though I may be providing good medical care, independent medical advice, aiding a woman in understanding her options, and ensuring that the components of informed consent are met.

This is not to be taken lightly. AHPRA's good medical guidelines do allow doctors to have a conscientious objection and do not need that referral. However, if there is a future contract between the provisions of this bill and the AHPRA code then the law takes precedence. I am aware of two doctors who have already been investigated by AHPRA in Victoria for this. AHPRA has no option but to take action against a doctor, even though the doctor is abiding by AHPRA's own code of conduct.

I have been in contact with some Victorian doctors about how they have coped since the 2008 compulsory referral clause was introduced there. Several GPs have left that state as a consequence of this clause being enacted. One paediatrician went from an area of need, and now only sees children under 12. Several have moved from general practice into geriatric practice. Some have closed their books and will not see any new patients. Several retired straight away. One O and G trainee moved to New South Wales rather than stay in Victoria. All have had to make changes to the way they practice. Many have signs in their surgery saying that they are not prepared to see any women for pregnancy options advice or about terminations.

I am considering my own options for medical practice should this law be enacted. This clause is discriminatory, will force me out of caring for women of childbearing age, a large component of my current practice, should I in fact decide to stay in Tasmania.

I am also concerned about the effect this clause is having on younger doctors who are deciding upon a career. I teach at the University of Tasmania and I teach with General Practice Training Tasmania and I am aware of some doctors in training who are considering their option to move elsewhere to work, change their choice of specialty should this clause be enacted. It is an asymmetric law that discriminates against me as a doctor of conscience and will impact on the provision of medical services in Tasmania.

The Hon Michelle O'Byrne in her second reading speech was dismissive of the current AHPRA guidelines pointing out that they were in the process of being reviewed. The draft revision AHPRA code was released last month in August and the relevant clause, section 246, has not been changed, so there has been no change to the AHPRA code. If it is found by the committee that this issue is causing a significant [inaudible] terminations in Tasmania and that some legislative intervention is in fact required, might I suggest you use the AHPRA own guidelines as a basis for regulation and actually insert:

> A doctor with a conscientious objection must inform the patient and, if relevant, colleagues of their objection and not impede access to any treatment that is legal.

I think that may well be the thing that would get around and that would be in keeping with the guidelines. It would mean that AHPRA isn't forced to go against its own guidelines. That is what my suggestion would be seeing that it is necessary.

I will just briefly mention some of the health aspects of access zones. I do consider that women really should be free from harassment or any form of intimidation. I understand that the access zone idea is designed to prevent psychological harm in those attending a clinic for an abortion. However, this legislation does curtail freedom of speech and it is a matter for the wider community to discuss.

The only other jurisdiction I am aware of in the developed world at all, which has such legislation in place, is in British Columbia which has a 50 metre exclusion zone. I understand the creation of the access zones was considered necessary to prevent psychological harm to women accessing termination and a small, unpublished Australian survey has been quoted to support this. However, peer review, published research, suggests this is not necessarily the case and the impact of protestors would appear to be much less than might otherwise be expected.

A large study on the effect of protestors on the emotions of women seeking abortions, published in the peer review journal, *Contraception*, earlier this year, 2013, with results which were unexpected by the researchers, there were 950 women, 30 abortion clinics across the US where women, seeking abortions, were regularly interacting with protestors. On interview, about half could not recall seeing protestors even though they had been present; half of those who did recall seeing the protestors were not the least bit upset; and one-sixth reported they were a bit upset or extremely upset at the time. Those people who were upset were those who had the most difficulty in making the decision to

abort. The difficulty in the decision-making is a significant problem and these are the women who really do need support in this area.

However, the presence and the intensity of reaction had no effect on emotional wellbeing at one week after and it was a similar finding to a 2000 study by [inaudible] in the US which measured the effect of protestors at two years as being negligible. While some women may be upset at the time, this does not appear to be long-lasting and it is important for women to have support at the time of their abortion. The issues of protestors having a significant effect on women attending for termination may have been overstated.

CHAIR - With regard to your submission, on page 3 where you are addressing your mind to informed consent, you suggest that removing the opportunity for general practitioner and independent counselling input makes the consent provisions, et cetera, I want to question, yes, section 164 of the Criminal Code currently indicates informed consent consistent to components. But just because the bill doesn't specifically set out what informed consent means, nonetheless, is it true that various medical codes require that informed process? I think you indicated that in your verbal contribution. Do we need to specifically set it out in legislation and the code too?

Dr LORD - I think you do. I think informed consent is really important because I know of women who have not had informed consent, who have not been given it, and that is why I think it needs to be in there.

CHAIR - That then suggests that there has been a breach of the medical codes by doctors who are providing advice as to termination or not?

Dr LORD - Yes. If this is going to be in a health bill, it really needs to be very clear.

CHAIR - Staying with your submission, on page 8, and you addressed this a moment ago as well - what constitutes an emergency termination? I want to be clear there, when I read the bill, it makes it clear to me because it talks about the necessity to save the life of a pregnant woman. That is the trigger point for performing the termination.

Dr LORD - Yes. But in terms of the wording, if it is a termination of a pregnancy, but it depends whether it is a termination of a pregnancy to mean the death of the unborn child. That is where the difficulty comes in because most emergency situations arise later on in pregnancy. The only one that it occurs under would perhaps an ectopic pregnancy. But most emergency situations - you may have a car accident or a ruptured uterus or something like that earlier on but in most cases it is about the intention of what happens with the unborn child. That is my issue with the emergency provisions there. You are not actually terminating that pregnancy and terminating the child and that is where some work needs to be done because viability is 22 weeks these days. Most of these emergency situations happen later in pregnancy and that is the area where the difficulty is.

CHAIR - I was interested in pursuing that a little further particularly given your verbal contribution today - and I have struggled with this particular principle if you like, and you have just mentioned it - whether a termination - and this is relying on your expertise as a medical professional - of pregnancy is a different proposition than injecting

potassium chloride such that a live child is killed. I scribbled that on my copy of the bill only a couple of weeks ago when we were taking evidence at that time. What of that, from a medical perspective, in you judgment?

Dr LORD - I think you are killing an unborn child if you have to do that, if it is viable. If a child is viable and you are killing that. That is why I think viability is really important and that gestation is really important. Some of this is historical. All the original abortion bills had the 'save the life of the unborn mother' and termination having to occur. I actually have a patient who had to have a termination and she was about 23 weeks, and this is some years ago. She, to this day, can't actually hold a baby because she wasn't given consent - there was no consent, but she had to have a termination. Nowadays it would be different. It is because things have changed, things have moved on. Nowadays it is possible with good neonatal intensive care, that 22 weeks is possible for that viability to occur. It used to be 28 weeks in the UK and they brought it back to 24 weeks. I am not sure whether they will bring it back even further. It is that upper limit that is where the problem is.

CHAIR - Finally, from me, again right now you have indicated to the committee your concerns about conscientious objection and as I best recall you saying that if a woman comes to you for pregnancy options advice you are obliged to immediately refer. We have had various deliberations about that with other witnesses -

Dr LORD - That is what I believe has happened in Victoria. They have just said you can't even discuss it. This is depriving me of a lot of experience, and a woman of that experience and that discussion. I think, especially if it is a patient of mine, they would probably want to discuss it with me.

CHAIR - And the matter of the Victorian disciplinary action, we do have copies of that. It would seem that based on that, you are right, but the committee has addressed its mind with other witnesses to the effect that there is no prohibition as it is set out here in actually proceeding to provide pregnancy options advice to your patient, and then get to the stage that you have provided that advice and then you could identify your conscientious objection and say, 'Look, I do have an objection to terminations. I can't and I won't give you advice about terminating but then I'm obliged to refer you to somebody else. I am sure the committee will need to clear up whether what we are suggesting is right or not, and the second reading may give us some clue on that.

Dr LORD - It strikes me the AHPRA guidelines have been in play for a long time and it is that I don't impede access. I actually point them in the right direction. If that is what I am satisfied that is what they're going to do, but I will not refer. Everybody has a bit of a different -

Dr GOODWIN - This is 'refer' in the medical sense of the word?

Dr LORD - Yes, and 'refer' - I suppose lawyers might understand it better. Say if I have a patient and I refer for a medical procedure, I am actually condoning that. This might be helpful - if a patient sees a chiropractor and they say end up with a spinal injury and the lawyers are looking for who to sue. If I as a medical practitioner have verbally said to them, 'Look, there is a good chiropractor there, go and see them,' I am liable for that advice that I am giving. Medical people are responsible for the advice that they give, I

think. We are responsible for the advice we give. That's what medicine is all about; we are responsible for the advice that we give.

Mr VALENTINE - Even if you are only handing a pamphlet that has a level of services.

Dr LORD - This is actually quite interesting. Everybody has their different level at which they are happy with. Some would be happy with that, some may not be. I have a receptionist who will not handle anything which has abortion written on it and I respect her views on that. There is a range of views and there is a range at which those options are. The other thing is the information is very freely available. You can look up abortion in the phone book and the clinics are there in the Yellow Pages. The information is freely available in terms of the abortion clinics. It is not difficult to get a termination in this state.

Mr VALENTINE - To follow up on that. It might be, though, that a woman wants to be able to discuss that rather than get an abortion. Seeing services in there talked about as being an abortion service might actually put her off from going there. She may want to know more information first.

Dr LORD - They actually call them reproductive health services.

Mr VALENTINE - There you go, so that's good.

Dr LORD - I think it is fertility centres.

Mr VALENTINE - I am just interested in your submission on page 2 you talk about the 16 week cut off and you are not sure how that limit was decided upon but it appears quite arbitrary. Therefore, wouldn't it be better that there is not a limit, or that indeed at least it was after say the 18-week scan?

Dr LORD - I have considered this a few times now. The thing is that abortions done earlier are safer. There is no doubt about that. That is what all the evidence is. The earlier the abortion is done it is safer for the woman, so that is what is known. At 12-13 weeks is a little bit of a cut off in that that is when the surgical terminations can be done fairly safely. After that it is more complications in terms of the cervical incompetence. I think there is a move towards doing them more medically these days with mifepristone and the other agents, medically.

Mr VALENTINE - But you don't have the fullest information available to you at that point.

Dr LORD - We would know you are pregnant.

Mr VALENTINE - At 18 weeks you are going to have the scan and all of the information.

Dr LORD - I think that's why I have separated them into two things. That is why I suggest it needs to be looked at for two different reasons. Most women who want a termination for whatever reason, I think usually decide fairly quickly. That would be my understanding just from what I have seen and that happens fairly early on. The ones who delay in their seeking a termination, as I mentioned, are often in the more difficult life circumstances - poverty, isolation and those sorts of things - so they delay it or else they are just really

not sure about what is happening. They may be homeless, they may be really not sure, and there are a lot of other issues going on there. Those women need support before they can decide what they want to do realistically.

Work is only just starting to be done on this so you have a group who know pretty much what they want to do early on, or if there is a bit of a delay in the diagnosis of the pregnancy, I suppose you would put it, but the realisation that it is a pregnancy and then they decide fairly early on. But, as I said, most women who have the scan and find that there is something wrong, a lot of the time they decide they will go through and continue the pregnancy because they are committed to that pregnancy. It is a much harder decision to make if you are having to go through a termination if there is a problem. That is what the psychological evidence and everything is. These women have significantly more problems if there is a foetal abnormality with the decision making and that sort of thing and the whole process in that. It is a bit of a different process, I would suggest, in terms of their decision making.

Mr VALENTINE - Given the fact that we have a bill that has a gestational limit in it, for whatever reason, it would be better if that gestational limit was further out rather than where it is at the moment, which is arbitrary?

Dr LORD - The other thing is, it is probably not a bad thing to have a limit in there in that encourages people who may well be not deciding to actually - yes, I know I have to get it done by then. Certainly, the majority that I see who have decided have decided pretty quickly and it may well be just from what I have seen I think that having that. At the moment we have effectively got that limit because of the way things are done in this state with the abortion clinics really only operating up until about 13.5 weeks and gaining easy access to them. People know that and people know that they actually have to decide whether this is what they are going to do or not. In effect that is what we have and really that is probably actually safer.

Dr GOODWIN - Dr Lord, I just wondered if you could clarify for me from a practical perspective how you would respond to a patient coming into your practice today saying, 'I think I'm pregnant. I'm not sure what I want to do. I might want to have a termination but I'm not sure', how would you respond to them practically to be compliant with the APHRA guidelines?

Dr LORD - I am really trying to find out what their thoughts are about this. The first question when anyone comes in who is pregnant is always finding out if they are happy about it. That is the first question I ask anyone who is pregnant. That is the first question I ask, 'How do you feel about it?' and you explore the feelings and that is where you start off from: how does this affect you? How is this going to affect your life? What are your thoughts about it? Looking for support - who is around to support you especially if they are in an unsupported situation. Who have you talked to about this? They are the sorts of things that you go through in this initial phase. You are trying to gather who is going to be around to support them whichever decision they make and I am very keen to not impose my views on other people.

I am well aware of that so I am very keen to not do that. I really just try to work out who is around to support, have you thought about this are you aware, how are you feeling, and

give some good advice. I usually try to get them to go and have a scan if they need to. That is where I usually take it from. I try to end up the consult with them having a scan.

One woman really didn't want to have a scan because she said, 'I know if I see the scan, I will want the termination', so you go for a beta HCG because that gives you the information without having had a scan. There is a whole lot of things that you take into consideration and it takes about an hour, I find, these consultations.

Dr GOODWIN - If at some point during that they are pretty firm about saying, 'Look, I really think I want a termination,' what do you do then?

Dr LORD - I really try to suggest that they talk about it with someone that they trust, just to make sure that they are fairly firm. Then I will give them a form to get a scan done because you need to have a scan done so that you know what gestation you're at. I make out a scan in her name so that she gets a copy of it. Then I usually say you have a range of options: you can either look up in the phone book, you can go to Family Planning because I know that they are also the main -

Dr GOODWIN - You are already essentially giving them the information that was talked about in the AMA guide for Victoria. So you are really doing what would be expected of you.

Dr LORD - Yes, but I will not refer.

Dr GOODWIN - No, okay. It is that 'refer' word that is the real problem.

Dr LORD - It is the word 'refer' that is the real crux of the problem.

Mr MULDER - But you don't have a problem with providing an access to people who will give them further advice.

Dr GOODWIN - What you are doing is providing information.

Dr LORD - Yes.

Mr MULDER - In layman's sense you are referring people not for the procedure but for further information relating to pregnancy options.

Dr LORD - Yes. Sometimes if a woman is just saying to me, look I really need support, then I will go with Pregnancy Support. I will suggest them if that is the support that is where you need to talk to. I suggest a range of options to them and I let them choose.

Really it depends a bit on how it has happened. Sometimes they will have done a pregnancy test and come in; sometimes I will be the one who has done the pregnancy test and it is a bit of a shock. So it depends a bit how much and how far. That is my approach. I will not impede access. I will point them in the right direction, but I will not refer. The other thing I say, 'Look, I'm here if you want to come back and talk to me.' My understanding is what happened in Victoria is that the way the legislation is written and that is why I think you need to really look at the way the legislation is written. If I have a conscientious objection I really have to stop the consultation then and there. That

is what has been my understanding and that is why I think you really need to look at the way it's written.

Dr GOODWIN - I just wanted to ask another question around this issue of sex selection and you mentioned that a few doctors have said they have been approached. What have they done about that, and how have they responded to it?

Dr LORD – It is mainly within the course of a conversation because the woman is being pressured. It has actually been an issue of the woman being pressured.

Dr GOODWIN - What have they said to the woman when she has come in? Put yourself in that situation, what would you say to them?

Dr LORD - I would really be wanting to say, 'Your options are very limited.' It has actually been the refugee population. When people come here as a refugee one of the first things they want to do is get pregnant, because this is a free country and they are so pleased to be here and they want to start or increase their family. That is one of the things that refugees do. Then you get the woman coming in and saying but my husband wants a boy this time. That is where you have the issues arising. I am not sure how I would handle it because I have not had that position myself. I am not exactly sure of the outcome but it has been said we are seeing this arise as an issue.

Dr GOODWIN - I am not sure how, by changing the legislation, it would be worse than it is now.

Dr LORD - I am not sure how it changes either. But, as an inquiry, this action needs to be considered and you might have to put in some different legislation for this. I notice with the IVF provisions, IVF is not allowed to do sex selection unless it for a medical reason. That is Australia-wide. It is not a law, it is convention, but that is the position with IVF at the moment.

Dr GOODWIN - It is not covered by your AHPRA guidelines at all, this issue of sex selection?

Dr LORD - It is covered under NH&MRC-type guidelines because it is IVF. That is my understanding of where it fits at the moment. They said we are going have a moratorium on this. There is a ban on this at the moment - that is for IVF. That is where it is at the moment. That is Australia-wide and is my understanding of where that is. It may be that is something separate, but I think Victoria is looking at having some separate sex-selection legislation being brought in because this has become a problem.

Dr GOODWIN - I imagine it would be if it has a cultural dimension to it.

Dr LORD - This is something that may have to be considered as a separate issue. I am bringing it up because I was a bit surprised. As part of this, I have asking my colleagues what they think.

Ms FORREST - You said something around the termination of pregnancy not being available if the foetus was considered viable; that was your view?

Dr LORD - Yes.

Ms FORREST - Viability is an issue that is a moving feast. You mentioned the UK. I understand in the UK it has a gestational limit, not a viability limit. The science and technology committee in the House of Commons basically said viability was highly contested because of these issues. You are also talking about babies who may be born alive, such as a trisomy 18 or encephalic baby or whatever, and we are including those as viable. I am not sure what you are trying to achieve by saying it should not be available if the foetus is considered viable.

Dr LORD - I am saying there needs to be consideration for an upper limit and where you draw that.

Ms FORREST - How do you set that?

Dr LORD - You need to consider that.

Ms FORREST - How do we consider that when you have all these different situations that occur so you cannot make hard and fast rules? Since when did we stop trusting doctors to make good clinical decisions?

Dr LORD - If you have to inject potassium chloride -

Ms FORREST - No, I am asking a question. You are saying that there has to be a limit somewhere.

Dr LORD - Yes. I would suggest 22 weeks.

Ms FORREST - So after that you can't have a termination?

Dr LORD - That is what I would suggest. However, in the UK they have said for foetal abnormalities there is no gestational limit.

Ms FORREST - What about a pre-eclampsia at 36 weeks?

Dr LORD - That would be covered by an emergency. You are terminating a pregnancy but it is not with the intention of killing the unborn child.

Ms FORREST - I am talking about obstetricians and gynaecologists, not general practitioners because they will not be doing this, so at what point do we stop trusting their clinical judgment in determining when is an appropriate time to conduct a termination and how they do it in the best interests of their patient?

Dr LORD - I am suggesting that if you have to ingest potassium chloride, perhaps you should not be doing it, and the UK says 22 weeks.

Ms FORREST - For what?

Dr LORD - For terminations. I am suggesting that if you have to do a termination and you are having to use potassium chloride to cause the death of that child before it is terminated, then perhaps it should not be happening.

Ms FORREST - Not all cases are like that. You have terminations where you don't use potassium chloride or any other medication.

Dr LORD - That is what they are saying at 22 weeks, and 22 weeks is the stage, so that is where I would put viability if you had to put a gestational age on that.

Ms FORREST - Clause 6 of the bill you said was unnecessary. This is about the emergency treatment to. You said subclauses (3) and (4) were not necessary because -

Dr LORD - It is because of the intention -

Ms FORREST - Can I just finish the question - because you have an obligation to treat. You have a contentious issue, as you have rightly identified. Isn't this more a doubts-removal clause to ensure that people know that they are protected if they are called on to undertake a procedure that saves the life of a woman -

Dr LORD - Sorry, a doubts-protection?

Ms FORREST - To remove doubt. Your duty to perform or care or provide treatment is enshrined in this, as it is in the medical codes, because it is the woman who is the patient here.

Dr LORD - I think those things are enshrined in the codes. I don't think it needs to be in there because there is actually no such thing as an emergency termination. Termination is an elective procedure to terminate that pregnancy. If this is a health bill and it is covered under the codes then I don't think it needs to be there.

Ms FORREST - I am asking whether it does need to be there because it is a health bill. If you have an emergency termination and it is the woman's life in danger here, and if it is a 23-24-week foetus, generally these are very much wanted pregnancies, so every effort would be made to save the baby, unless of course there had been a discussion and decision made with the mother that palliation and comfort measures were all that was required because there may be other issues at play.

Dr LORD - I think that actually makes it really hard for that mother.

Ms FORREST - That's why this protection is there, isn't it?

Dr LORD - If it is an emergency procedure, my understanding is there is often not consent and there is often not even the discussion about what we do here. If it is an emergency situation you should save life, therefore there is no discussion about do we or do we not palliate, because in an emergency you go and save life. If it is an emergency situation and a baby is born, if it is a true emergency situation then there will not be that discussion about whether we palliate or not. The decision will be, it is an emergency situation and we will save that child if possible.

Ms FORREST - There are some emergency situations where the mother would be unconscious and, of course, you can't get any -

Dr LORD - Yes, therefore you go with life; you don't go with death.

Ms FORREST - You have an emergency situation where the mother is unconscious and unable to give informed consent. In that case there is a process around that, as for any unconscious patient, but sometimes there are real emergencies, such as a woman with severe pre-eclampsia who is conscious. There is still a period of time when the anaesthetist comes to see her and you have the obstetrician there discussing the outcome and the paediatrician will be there to talk about the options. This all goes on. I have been there.

Dr LORD - I have been there, too.

Ms FORREST - You know that you can have a discussion while everything else is going on in preparing that woman for theatre or whatever you are doing with her, inducing the labour or whatever, so that is still an emergency situation to save the mother's life but there is sometimes time to have those discussions.

Dr LORD - I'm suggesting I don't think that's a good time to be saying to that woman, 'Do you want us to kill the baby?'.

Ms FORREST - No, that's not what I'm saying.

Dr LORD - That is what this is about. That is what this termination is about.

Ms FORREST - No, it's not.

Dr LORD - In fact, that is not what is covered under these situations.

Ms FORREST - A number of times you have made the comment that consent has not been given. You have had a number of patients who have told you that they didn't give consent.

Dr LORD - They weren't given the proper information. A few patients have said to me, 'If I'd actually known at the stage at which that development was, I wouldn't have done this'.

Ms FORREST - Have you reported those cases to AHPRA?

Dr LORD - No, I haven't because it's too late. You cannot undo what is not done. This is about trying to make sure this is done now.

Ms FORREST - If it is a recurrent thing, and you are saying there are a number of cases, isn't there a duty there?

Dr LORD - That is why I'm trying to make sure now this goes in this legislation.

Ms FORREST - Consent is required in the legislation, and after 16 weeks the consent of two doctors.

Dr LORD - I'm really concerned that when consent is mentioned here it is only 'consent'. I think 'informed consent' needs to be put in the bill. It is very important.

Ms FORREST - You also gave an example where if you referred a patient to a chiropractor and then the patient suffers a spinal injury as a result of their treatment. If you referred a pregnant woman to an obstetrician and she ended up having a FDIU from some mismangement of the obstetrician - or not even mismanagement because sometimes these things happen - unless there had been gross negligence or you knew that that obstetrician was deregistered or some other issue, would the lawyer come after you?

Dr LORD - This is a question for the lawyers, but that is becoming increasingly apparent in a litigious society. If something does go wrong you don't just involve the surgeon who is involved. You involve the people who have referred. That is starting to happen. This is for surgical procedures.

Ms FORREST - But if the surgeon was negligent, unless you knew they were an unfit practitioner -

Dr LORD - That is what is happening.

Ms FORREST - Do you have cases where you can illustrate that is actually happening?

Dr LORD - No, this is theoretical possibility.

Ms FORREST - It's not actually happening?

Dr LORD - No, but it is theoretical. It is in terms of that referral liability. If something goes wrong with the surgical procedure, who do the lawyers actually want to look at?

Ms FORREST - First you have to demonstrate negligence.

Dr LORD - They look at everybody. They draw an enormous net; that is what I'm saying.

Ms FORREST - No-one is going to be sued if they haven't done the wrong thing.

Dr LORD - It is not just the suing. It is the whole process that is particularly unpleasant.

Ms FORREST - You obviously do a lot of lecturing at UTAS. When you are talking to medical students about this, because you say you don't refer and you are talking about a conscientious objection - whether it is termination of pregnancy or some other procedure like male circumcision of newborns or sterilisation procedures, because some people have objections to those as well - what do you tell your students about referring?

Dr LORD - About referring for what?

Ms FORREST - If they have a conscientious objection to termination.

Dr LORD - I use the AHPRA guidelines because they are the ones we use. If people have a conscientious objection, they don't have to refer, but you must not impede access if people want to do that.

Ms FORREST - In our rural communities you might only have one or two doctors in the area -

Dr LORD - It is actually fairly rare. Most towns have more than one.

Ms FORREST - Some of the places I represent don't. In small rural communities we sometimes have only one doctor, sometimes two, but one could be away and only one around at the time -

Dr LORD - There are a number of avenues towards getting into a termination.

CHAIR - It is important, Helen, that you let Ruth complete the question. I would afford you protection if any one of us was badgering you, so it is important to get the context in the question.

Ms FORREST - If you have an approach where you will not refer, isn't that inadvertently -

Dr LORD - I have actually said I don't refer, but I will point them in the right direction. There are a range of services that I would refer her to.

Ms FORREST - So there are services you will refer her to?

Dr LORD - Not refer in the medical sense.

Ms FORREST - The Victorian AMA put out a commentary on a policy document in their journal v*icdoc*. It said:

> It concluded the word 'refer' under the legislation requires at a minimum a practitioner send or direct a patient seeking an abortion to another practitioner who does not have a conscientious objection to abortion, or otherwise facilitate access to such a practitioner. In the panel's view this duty will be discharged if a doctor provides the patient with the name of a non-objecting medical practitioner or health service, such as an established family planning centre or an appropriately accredited abortion clinic.

Is that what you do, you send them to Family Planning or somewhere?

Dr LORD - I will say, 'You can find the phone number here in the book'. I point them in the right direction, but I am not going to refer.

Ms FORREST - But the AMA is saying -

Dr LORD - I am saying there are a range of views out there.

Ms FORREST - The AMA here is saying that is a referral and they are happy that is a referral, not actually having to write a referral, 'Can you take on the care of this woman's

pregnancy and ensure that she does not have a termination'. It is saying here is somewhere else she can go for the information. If you are satisfied that is a referral, as AMA Victoria has said, then isn't that enough?

Dr LORD - AMA Victoria has written that in response to what this has been all about over there.

Ms FORREST - To clarify, you do not need to provide a formal referral in the strict medical sense.

Dr LORD - That is why this word 'refer' is a problem in this legislation. That is why I suggest you use the AHPRA guidelines.

Ms FORREST - We have rural communities where there are limited numbers, and the AHPRA guidelines say you must not impede access. Simply by not providing them with a clear direction of where to go in a timely manner, because they all have to travel and may have to arrange other children, then they -

Dr LORD - I've told you what I do.

Ms FORREST - Isn't this action of not providing a clear direction of where they can go, impeding access?

Dr LORD - I think if you were taking proper care of the woman, and again it is down to that doctor/patient relationship, you would do something similar to me. That is what I would do in the situation, but I cannot speak for every doctor.

Ms FORREST - No, I'm talking in general terms.

Dr LORD - These guidelines have taken a long time to develop and that sits both things together. I am very unhappy about having my conscientious objection provisions eroded.

Ms FORREST - But isn't it providing protection here? It is saying it is okay to have a conscientious objection and that is why it is there - to provide you with a framework.

Dr LORD - Yes, but it impedes my practice; that is what this is doing.

CHAIR - Helen, thank you for being here.

THE WITNESS WITHDREW.