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Parliament of Tasmania

LEGISLATIVE COUNCIL

GOVERNMENT ADMINISTRATION COMMITTEE "A"

REPORT

ON

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013

Members of the Committee:

Hon Ruth Forrest MLC
Hon Vanessa Goodwin MLC
Hon Paul Harriss MLC (Chairman)
Hon Leonie Hiscutt MLC
Hon Tony Mulder MLC
Hon Rob Valentine MLC

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Establishment and conduct of the Inquiry

Government Administration Committee "A" (the **Committee**) was established by resolution of the Legislative Council and its operation is governed by Sessional Orders agreed to by the Council.

By resolution of the Legislative Council on 12 June 2013, *the Reproductive Health (Access to Terminations) Bill* 2013 (No. 24) was referred to the Committee for further consideration and report (the **Terms of Reference**).

At its meeting on 13 June 2013 the Legislative Council Government Administration Committee "A" granted leave in accordance with Sessional Orders 4(15)1 and 4(15)2 for the Hon. Rosemary Armitage MLC to be replaced as a Member of the Committee by the Hon. Tony Mulder MLC as her substitute for the purposes of its inquiry and report on the *Reproductive Health (Access to Terminations) Bill 2013*.

The Committee called for submissions in advertisements placed in Tasmania's three daily newspapers on Saturday, 22 June 2013. The closing date for receipt of submissions was 22 July 2013. In addition invitations were sent to key stakeholder groups and individuals. In total 148 public submissions were received during the course of the Inquiry. The full list of written submissions is attached at Appendix A.

The Committee held public hearings in Hobart on seven occasions from 29 July 2013 to 14 October 2013, taking evidence from a total of 55 individual witnesses, 47 of whom represented 25 organisations. A full list of witnesses is attached to the report at Appendix B.

The Committee wishes to thank the witnesses for their time and valuable contributions to the Inquiry.

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Committee Findings

Clause 3 - Interpretation

Finding 1:
The Committee finds that a definition of midwife may be required in this clause and in other clauses in the Bill where the term “nurse” is used.

Finding 2: The Committee finds that, while the words “to birth” are of concern to some medical practitioners and legal experts, it is very difficult to propose amendments to the Bill to clarify the legislative intent.

Finding 3:
The Committee finds an amendment is required to the definition of “terminate” to clarify the role of nurses and midwives in the legal administration of drugs associated with terminations.

Finding 4:
The Committee finds that no alteration is required to the definition of “woman”.

Clause 4 – Terminations by medical practitioners at not more than 16 weeks

Finding 5:
The Committee finds that there is an increasing medical risk to the woman in carrying out terminations the further the pregnancy progresses.

Finding 6:
The Committee finds that terminations beyond 16 weeks gestation are uncommon and those beyond 24 to 28 weeks are extremely rare.

Finding 7:
The Committee finds that the use of the term “consent” in this clause is appropriate.

Clause 5 – Terminations by medical practitioners after 16 weeks

Finding 8:
The Committee finds that it is unclear whether the use of the term “must”, in sub clause 2, limits the medical practitioner to only consider the woman’s current and

future physical, psychological, economic and social circumstances, when assessing the risk of injury to her physical or mental health.

Finding 9:
The Committee finds that, while some medical practitioners suggested that foetal abnormality should be included as a relevant circumstance for termination, the definition of such a circumstance is unnecessary as the implications of foetal abnormality are already provided for in the Bill.

Clause 6 – Conscientious objection and duty to treat

Finding 10:
The Committee finds that the issue of conscientious objection is an area that is also covered by codes of practice as established under the *Health Practitioner Regulation National Law Act 2009*.

Finding 11:
The Committee finds that a consequential amendment may be necessary to include "nurses and midwives" in this clause.

Clause 7 – Obligations on medical practitioners and counsellors

Finding 12:
The Committee finds that medical practitioner conscientious objection is also covered by codes of practice as established under the *Health Practitioner Regulation National Law Act* 2009.

Finding 13:
The Committee finds that this clause differs from the AHPRA codes of practice as it obliges practitioners to facilitate access to further care rather than not impede access to treatments that are legal.

Finding 14:
The Committee finds that the Bill, as drafted, prevents a medical practitioner, with a conscientious objection to terminations, from referring a woman to anyone other than another medical practitioner.

Clause 7 (cont.)

Finding 15:
The Committee finds that it would be appropriate for a medical practitioner to be able to refer a woman to other prescribed services.

Finding 16:
The Committee finds that "counsellors", as a collective group, are not regulated under any national or state-based regulatory body.

Finding 17:
The Committee finds that the definition of "counsellor" is broad and, despite assertions to the contrary, unintended classes of persons may fall within its parameters.

Finding 18:
The Committee finds that the maximum penalty applying to counsellors, as currently prescribed, may be excessive.

Finding 19:
The Committee finds that the Bill, as drafted, prevents a counsellor, with a conscientious objection to terminations, from referring a woman to anyone other than another counsellor.

Finding 20:
The Committee finds that it would be appropriate for a counsellor to be able to refer a woman to other prescribed services.

Finding 21:
The Committee notes that the comparable Victorian legislation, the *Abortion Law Reform Act* 2008 (Vic), does not regulate counsellors in any way.

Finding 22:
The Committee finds that the word "refer" has a particular meaning for medical practitioners, but the word "refer" in this Bill has the ordinary meaning of the word.

Finding 23:
The Committee finds that the obligation to refer would be satisfied by a counsellor or a medical practitioner providing the contact details of a service or provider, for example, in the form of a prescribed list or pamphlet.

Clause 7 (cont.)

Finding 24:
The Committee finds that the obligation to refer does not require such referral to be made immediately upon the woman raising the issue of termination. Accordingly, the medical practitioner or counsellor is not precluded from discussing other pregnancy options with the woman prior to referring her.

Clause 9 – Access zones

Finding 25:
The Committee finds that access zone provisions are justified because women and staff have been subject to harassment, physical violence, vilification and intimidation when attending premises at which terminations are provided.

Clause 10 - Proceedings

Finding 26:
The Committee finds that the appropriate timeframe in which to allow the institution of proceedings is that generally allowed for health complaints, being two years.

Clause 17 – Administration of Act

Finding 27:
The Committee finds that terminations of pregnancies could be available in the public sector, or purchased from the private sector, through a Ministerial Policy Direction or by decision of a Tasmanian Health Organisation.

Finding 28:
The Committee finds that a barrier to early terminations being performed in the public hospital system is the fear of a criminal prosecution currently felt by some medical practitioners.

Finding 29:
The Committee finds that there is a lack of comprehensive data regarding terminations in Tasmania.

Finding 30:
The Committee finds that there is limited publicly available data regarding terminations in Tasmania because of privacy concerns.

Paul Harriss MLC
Inquiry Chairman
12 November 2013

Ruth Forrest MLC
Committee Chair
12 November 2013

Introduction

The *Reproductive Health (Access to Terminations) Bill 2013* was introduced into the Legislative Council on 17 April 2013 and the Second Reading Debate began on 12 June 2013. During the Second Reading Debate on that day the Member for Huon, the Hon. Paul Harriss MLC moved that the Bill be referred to the Legislative Council Government Administration Committee "A" for further consideration and report. The Motion moved by Mr Harriss was agreed to by the Legislative Council and the Committee met for the first time in relation to this Inquiry on 13 June 2013.

This Report has been prepared following consideration of all the evidence provided to the Committee in the form of written submissions and also given in person at public hearings held between July 2013 and October 2013.

The Committee wishes to emphasise that the Report must be read in conjunction with the Hansard Transcripts of verbal evidence presented to it and the written submissions it received. It was not feasible to reproduce or refer to every piece of evidence or opinion put before the Committee during its Inquiry. It is therefore strongly recommended that those with an interest in the subject of the Report also familiarise themselves with the documents mentioned above, especially the Hansard Transcripts of the Committee's public hearings.

The evidence presented to the Committee in relation to the *Reproductive Health (Access to Terminations) Bill 2013* was largely specific to the clauses within the Bill. There were, however, some broader matters raised in evidence that were relevant to the Committee's deliberations. Among the more significant of these matters were the contention that one of the main purposes of the Bill was removing the termination of pregnancies from the *Criminal Code Act 1924 (*the ***Criminal Code****)*; the competing contentions that terminations should, or should not, be treated as purely a medical procedure like any other; the competing rights of the mother and the unborn child; and, the role of codes of conduct and of ethics that apply to the medical profession and the inclusion in the Bill of some, but not all, relevant issues already covered by these codes. All these matters, in one way or another, overlap in their impact on the Bill, particularly on the question of whether it goes too far or not far enough.

Some witnesses highlighted the removal of the termination of pregnancies from the Criminal Code as being a central element of the Bill. For example, Dr Beth Mulligan stated *'I think the whole point of this legislation is that we take it out of the criminal code, isn't it?'*[1]

[1] B. Mulligan, *Transcript of Evidence*, 23 August 2013, p. 41.

Senior Law Lecturer at the University of Tasmania, Ms Terese Henning, told the Committee that:

> '*The purpose of the bill is to take the law in relation to terminations of pregnancy as far as possible out of the criminal calendar, so to decriminalise terminations of pregnancy except in very narrow circumstances*.'[2]

Associate Professor Jo Wainer from Monash University's Faculty of Medicine, expressed a similar view:

> '*The critical point of this legislation is to remove abortion from the Crimes Act and give women the authority in their own lives to make the decisions that are going to affect them more than anybody else*.'[3]

Many other witnesses highlighted the importance of decriminalising the termination of pregnancies. For example, Ms Rachel Ball from the Human Rights Law Centre told the Committee that:

> ' … *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*.'[4]

Professor Boon Lim, the Director of Obstetrics and Gynaecology at Tasmanian Health Organisation South (**THO South**), gave evidence to the Committee on behalf of Women's Adolescent and Children's Services at THO South:

> '*We welcome the proposal to change access to termination to a reproductive health act rather than under the Criminal Code, because it gives doctors certainty in a situation where termination of pregnancy is to be considered, rather than being under the Criminal Code where the doctors will consider that he or she may be under disadvantage and worry about being prosecuted*.'[5]

Representatives of Family Planning Tasmania were also among those who supported the principle of removing terminations from the Criminal Code. The General Manager of the organisation, Ms Georgie Ibbott, told the Committee that:

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[2] T. Henning, *Transcript of Evidence*, 30 July 2013, p. 1.
[3] J. Wainer, *Transcript of Evidence*, 19 August 2013, p. 45.
[4] R. Ball, *Transcript of Evidence*, 3 September 2013, p. 77.
[5] B. Lim, *Transcript of Evidence*, 30 July 2013, p. 58.

> '*At Family Planning we believe that termination of pregnancy needs to be regulated as a health issue and not as a criminal issue in the twenty-first century. We also respect that doctors are working in an environment of uncertainty and risk and this legislation helps clarify that so that we can provide termination services in Tasmania to women who choose that option. We very firmly believe that it is not a criminal matter, it is a health matter that should be dealt with between a woman and her medical practitioner*.'[6]

However, it must be noted that not all witnesses supported this view.

For example, Mr Mark Brown, representing the Australian Christian Lobby, said that *'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.'*[7]

There were also divergent views expressed to the Committee about the issue of whether or not terminations should be regarded as purely a medical procedure like any other.

Professor Julian Savulescu, Uehiro Professor in Practical Ethics, University of Oxford and Editor of The Journal of Medical Ethics told the Committee '*I think it is important not to single out abortion as different from other medical procedures*.'[8] The Tasmanian Anti-Discrimination Commissioner, Ms Robin Banks, expressed a similar view: '*It's a medical procedure and should sit within the scope of medical procedures*.'[9]

Tasmania's Chief Medical Officer, Dr Craig White, also supported this view, but noted that, unlike other medical procedures, community perceptions varied in relation to terminations:

> '*I think it is just another medical procedure, it's just that different people have a range of views about it and tend to judge it in ways they don't judge other medical procedures. I don't think it's the procedure itself that is so different*… '[10]

The Public Health Association of Australia, through its Chief Executive Officer Mr Michael Moore, presented a similar position.

> '*It is a political issue. You probably don't feel you can take it out of the criminal legislation without doing something else with this particular*

[6] G. Ibbott, *Transcript of Evidence*, 30 July 2013, p. 87.
[7] M. Brown, *Transcript of Evidence*, 3 September 2013, p. 49.
[8] J. Savulescu, *Transcript of Evidence*, 29 July 2013, p. 6.
[9] R. Banks, *Transcript of Evidence*, 30 July 2013, p. 49.
[10] C. White, *Transcript of Evidence*, 30 July 2013, p. 35.

> *issue. We know there are significant portions of the community that consider this a completely separate issue medically. The Public Health Association doesn't; we think it should be part of normal medical procedure*.'[11]

In her evidence, Dr Beth Mulligan also highlighted community attitudes, stating that '*this is hugely about community values, this whole perception of termination and what it means, and how it's managed*.'[12]

Interestingly, it was also on this issue of community perceptions and attitudes that other witnesses based their view that pregnancy terminations were, in fact, different from other medical procedures.

Tasmanian General Practitioner, Dr Helen Lord, for example, stated that:

> '*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. …. 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*.' [13]

The President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**), Professor Michael Permezel, expressed a similar view when he addressed this issue in more detail:

> '*The college view would be that the community would want greater reassurance in this difficult ethical area of practice, greater reassurance that proper - I need to think of the right wording - certainly there is a community expectation that termination of pregnancy will not be treated like Panadol for a headache nor even treated like the management of cancer. For the community there is an expectation that this will be treated differently, this is a big issue - …. I think that as a medical procedure, while clinically it is very similar to managing cancer or managing childbirth or many of the other things that an obstetrician does in practice, the community perception is that it is something entirely different and I think that is why you are all here*

[11] M. Moore, *Transcript of Evidence*, 23 August 2013, pp. 53-54.
[12] B. Mulligan, op. cit., p. 42.
[13] H. Lord, *Transcript of Evidence*, 3 September 2013, pp. 82 & 83.

> *today because the community doesn't regard it in the same medical context as those other procedures*.'[14]

The Very Reverend Richard Humphrey, the Dean of Hobart, representing the Anglican Church of Tasmania, argued that the existence of the Bill itself indicated that terminations were unlike other medical procedures. He told the Committee that:

> '*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*.'[15]

Mr Darren Carr, the Chief Executive Officer of the Mental Health Council of Tasmania, in arguing that terminations should be regarded as a medical procedure like any other, indicated that medical codes of conduct are the appropriate means of regulating terminations rather than legislation:

> *'We were supportive of removing fines for doctors from the legislation because abortion should be regarded as a medical procedure like others and governed by the rules around that. Where a doctor does not adhere to the appropriate standards of their profession, they should be held accountable according to the relevant body. Likewise, for counsellors and psychologists, they should be held accountable according to the standards of their body.'*[16]

This overlap between the legislation and relevant professional codes of conduct was raised many times in evidence presented to the Committee. Sometimes, witnesses would argue that legislative measures were not necessary because the codes of conduct were sufficient in regulating particular aspects of medical practice. At other times the same witnesses would argue that, in relation to other matters, the legislation was necessary to reinforce the codes of conduct or to ensure they were complied with.

This dichotomy is best illustrated in the following two extracts of verbal evidence given to the Committee by Mr Michael Moore:

> '*….The reality is that the legislation just makes it clearer. I would say - and I am not a lawyer - but the* [medical] *code* [of conduct], *and you refer to particular cases in other states, effectively does require the same as the legislation* [in relation to conscientious objection]*. The*

[14] M. Permezel, *Transcript of Evidence*, 19 August 2013, p. 97.
[15] R. Humphrey, *Transcript of Evidence*, 3 September 2013, p. 82.
[16] D. Carr, *Transcript of Evidence*, 29 July 2013, p. 33.

> *legislation makes it much clearer. …. I think the whole intention of the legislation is to make it really clear so that medical practitioners know what they ought or ought not do and where they do have room to move and they do not. That is one of the strengths of the legislation*.'[17]

> '*…. Our perspective is that this* [requiring the involvement of a second doctor after 16 weeks of a pregnancy] *is something that should be regulated within the normal medical procedures and processes that doctors abide by and making their medical judgment which is covered by a whole range of codes of conduct, rather than having this in the legislation*.'[18]

The relationship between the Bill and the various medical codes of conduct, which are already underpinned by national legislation, is addressed later in this report in discussion of issues related to specific clauses of the Bill.

The final broad issue in the Bill raised by some witnesses related to the rights of the unborn child. Dean Humphrey stated that:

> '*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?*'[19]

On the other hand, Ms Jenny Ejlak, representing Pro Choice Tasmania, told the Committee that:

> '*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*.'[20]

This question was also addressed from a broader human rights perspective by Dr Ronli Sifris, from the Castan Centre for Human Rights. Dr Sifris stated that:

> '*From the perspective of international human rights law, there has been a lot of debate on this particular issue. In fact, there was*

[17] M. Moore, op. cit., p. 52.
[18] Ibid., p. 53.
[19] R. Humphrey, op. cit., p. 11.
[20] J. Ejlak, *Transcript of Evidence*, 3 September 2013, p. 74.

> *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 [been] caused to the woman as opposed to the foetus having independent rights from the woman carrying that child*.'[21]

However, the Committee notes the following extract, which clearly refers to the child before birth, the United Nations Declaration of the Rights of the Child (emphasis added):

> *'… WHEREAS the child, by reason of his physical and mental immaturity, needs special safeguards and care,* ***including appropriate legal protection, before as well as after birth****, …*
>
> *…. Now, therefore, The General Assembly Proclaims ….*
>
> *4. The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health;* ***to this end, special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post natal-care****. The child shall have the right to adequate nutrition, housing, recreation and medical services. ….'*[22]

Dean Richard Humphrey expressed his concern that the Bill appeared to place no value on the unborn child:

> '*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*

[21] R. Sifris, Transcript of Evidence, 3 September 2013, p. 79.
[22] United Nations, *DECLARATION OF THE RIGHTS OF THE CHILD*, adopted by UN General Assembly Resolution 1386 (XIV) of 10 December 1959.

> *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?*'[23]

Ms Robin Banks told the Committee that the rights of the unborn child was a contentious issue that had been considered extensively.

> *'It has been considered extensively because it's not just an issue of contention here in Australia and Tasmania. Consistently in all of the international and multinational human rights areas the right to life is considered to commence at birth. The one exception is in the American system. There is a human rights framework for all of the Americas and they include from conception, but even there they don't say it overrides the right of the mother to reproductive health and her own right to life; it is a balance in that circumstance but consistently the right to life is held to commence at birth. The way in which that question has been dealt with in international law, the woman's self-determination has been held to be the central question. Obviously, if she is able to have that conversation and consider it with the person who has fathered the unborn child, then that is a good thing but the consistent approach is that the father's view doesn't override the woman's autonomy.'*[24]

The Committee notes the following information provided by the Victorian Law Reform Commission about United States legislation in relation to terminations.

> '*Abortion is regulated by a combination of federal and state law in the United States (US). While criminal law and health law are primarily state matters, there have been many US Supreme Court decisions about abortion over the past 35 years. These have concerned the extent to which a woman's right to terminate her pregnancy is protected by the right to privacy in the Bill of Rights and, conversely, the extent to which state law may regulate abortion without infringing that right.*
>
> *In the well-known case of Roe v Wade, the Supreme Court decided that the right to privacy, drawn from the 'due process' clause in the US Constitution's 14th amendment, allowed a woman to have an abortion in the early stages of her pregnancy without state interference. The court held that the reach of this privacy protection diminishes as the*

[23] R. Humphrey, op. cit., p. 11.
[24] R. Banks, op. cit.,p. 54.

> *pregnancy progresses, thereby permitting some legislative regulation of late abortions. The principles to be drawn from Roe v Wade were described in a subsequent case:*
>
> > *"It must be stated at the outset and with clarity that Roe's essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal* [sic] *viability, if the law contains exceptions for pregnancies which endanger a woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus* [sic] *that may become a child."* [*Planned Parenthood of Southeastern Pennsylvania v Casey* 505 US 833, 846 (1992).]
>
> *Subsequent cases have dealt with the extent to which the state may impose preconditions upon access to abortion services and regulate abortion procedures without violating the Roe v Wade principles*.'[25]

The Committee also notes the following commentary in the footnote related to the above information:

> *'Roe established a trimester approach, whereby the State's interest becomes more compelling the further the pregnancy advances. It also held that in matters of bodily integrity the court must have a high degree of scrutiny*.'[26]

The following sections of this Report deal with specific clauses in the Bill about which the Committee has made particular findings.

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[25] Victorian Law Reform Commission, Law of Abortion: Final Report, Melbourne, March 2008, pp. 27-28.
[26] Ibid., Footnote 143, p. 29.

The Bill

Clause 3 Interpretation

3. Interpretation

(1) In this Act, unless the contrary intention appears –

nurse means a registered nurse or an enrolled nurse;

The Hon. Ruth Forrest MLC highlighted the need for this clause to also include a definition of "midwife". Ms Forrest noted that:

> '*With later-term terminations, it is often the midwives who administer the Misoprostol or the Mifepristone, or whichever medications are used. The obstetricians obviously order that medication but they do not always administer it - sometimes they do, but often they do not. I think the midwife needs to be included in the definition as well because midwives are involved, particularly in later-term terminations*.'[27]

Subsequently, the Committee raised this issue with Dr Craig White and Ms Cherie Stewart, Legal Policy Officer with the Department of Health and Human Services (**DHHS**). The following extract from the Hansard transcript of the public hearing on 23 September presents the main aspects of that discussion:

> **'*CHAIR*** *- Casting back to the start of this conversation with regard to the definition of nurse in our section 3, where Ruth drew our attention to the Victorian act which sets it out quite specifically, did you say, Craig, that there may be a need to revisit that definition of nurse, as set out in our section?*
>
> ***Dr WHITE*** *- No. I think nurse stands as [is]. But we need to add midwife in that section, don't we?*
>
> ***Ms FORREST*** *- My view is that it needs to be as we have defined nurse in other acts in recent times. Since the passing of the National Health Practitioners Registration Act, we tend to define nurses and midwives as registered under that act.*
>
> ***Ms STEWART*** *- The Acts Interpretation Act has the definition of medical professional, medical practitioner and nurse and that sign-post to the national laws.*

[27] R. Forrest, *Transcript of Evidence*, 23 September 2013, p. 2.

***Ms FORREST** - It does.*

***Ms STEWART** - If that is the policy articulation, OPC* [Office of Parliamentary Counsel] *can give you guidance on how to get there.*

***Dr WHITE** - We agree with you*.'[28]

Finding 1:

The Committee finds that a definition of midwife may be required in this clause and in other clauses in the Bill where the term "nurse" is used.

3. Interpretation

(1) In this Act, unless the contrary intention appears –

…

terminate means to discontinue a pregnancy so that it does not progress to birth by -

(a) using an instrument or a combination of instruments; or
(b) using a drug or a combination of drugs; or
(c) any other means –

but does not include the supply or procurement of any thing for the purpose of discontinuing a pregnancy;

A number of witnesses raised concerns about the inclusion of the term "to birth" in this definition. Among these were Mr Michael Stokes, Senior Law Lecturer at the University of Tasmania, who stated that:

'I have serious concerns with the way this legislation is drafted; it is increasing the possibility of successful prosecutions for either murder or manslaughter for late-term terminations. There is already that possibility there but this increases it because you have this definition in section 3 of 'terminate': 'terminate is to discontinue a pregnancy so that it does not progress to birth' - drawing a distinction between termination and birth. If a termination ends in a birth, particularly a live birth, it falls outside the scope of this act completely. At that point it falls under the Criminal Code, section 153. If you have a live birth, under section 153(4) and (5):

[28] P. Harriss, C. White, R. Forrest, C. Stewart, *Transcript of Evidence*, 23 September 2013, pp. 10-11.

> *A child becomes a human being when it has completely proceeded in a living state from the body of its mother. ... The killing of any such child is homicide if it dies in consequence of injuries received before, during, or after birth.*

> *So if you have a live birth as a result of a termination, it seems to me it is not a termination for the purposes of the act. Then you have the real possibility of homicide under section 153.'*[29]

Another Senior Law Lecturer at the University of Tasmania, Ms Terese Henning, also addressed this issue in her evidence:

> *'The other objections to the bill that have been raised relate to difficulties in some of the interpretive provisions, particularly in relation to the definition of terminations of pregnancy. The argument around that has been that because a termination of pregnancy is defined as the discontinuance of a pregnancy in such a way that it does not proceed to birth - and the problematic words appear to be 'to birth' - then that may expose doctors more than they currently are to charges of murder or manslaughter if they perform a late-term pregnancy by inducing a birth, and the foetus survives that procedure. I will make two points about that. We do not believe that is a concern because we think doctors would be protected by the defence in section 51 of the Criminal Code, which is the defence relating to surgical operations. We think that doctors would be protected by that provision. Nevertheless, if it is a concern there is a very simple remedy - simply delete the words 'to birth'.'*[30]

Ms Henning went on to say later in her evidence:

> *'I would make very few changes to the bill. The only one that I would suggest for insurance would be to lop off 'to birth' from the definition of 'terminate'. Otherwise, I think it can stand. I think it will work very well.'*[31]

Other witnesses expressed a similar view, including Prof. Michael Permezel.

> '*… I think the wording 'so that it does not progress to birth' is ambiguous and doesn't clearly describe what is meant by termination of pregnancy. Just as you have said, the wording you used was, 'there is no intention to proceed to a live birth.' When we induce labour for an FDIU [foetal death in-utero] it is still a birth. A severe pre-eclamptic*

[29] M. Stokes, *Transcript of Evidence*, 29 July 2013, p. 13.
[30] T. Henning, op.cit., pp. 2-3.
[31] Ibid., p. 5.

> *who is induced at 22 weeks, is that a termination of pregnancy? …. I think so, because there is no intention to have a live birth and yet nobody opposes that maternal life-threatening physical condition. I am concerned that the wording of that definition doesn't encompass - birth is the wrong word; it is better - the wording that you used 'there is no intention to procure a live birth'*.'[32]

Prof. Permezel went on to explain in some detail the dilemma that 'to birth' poses for doctors:

> '*Could I just say, though, because a termination, say at 23 weeks or 24 weeks, might progress to birth, a termination of pregnancy could progress to birth. Say there were a severe a cardiac malformation and for whatever reason, as we said before, the impact on the mother is such that she and the practitioner make a decision to have the process of termination of pregnancy, that foetus would be born or could be born alive, therefore it is birthed but it is still a termination because the neonatologist in this context -the foetus cannot survive - is not going to put the baby through a whole lot of traumatic cardiac surgery at 24 weeks if it has no hope of success so it has been birthed, it is a termination of pregnancy and this wording does not work. …. The baby is taken up to the nursery and given all comforts and is treated, but it is not put through the trauma of surgery, which is painful and unpleasant if there is no hope of survival*.'[33]

Tasmanian obstetrician, Dr James Brodribb, representing the Council of Obstetric and Paediatric Mortality and Morbidity told the Committee:

> '*I think you could take out the words 'so that it does not progress to birth'. Termination means to discontinue a pregnancy, whatever gestation. …. The termination of pregnancy might very well be at 28 weeks, and that is an induction of labour, so I do not think that is an issue. We are terminating a pregnancy by drugs at that stage. To say that it does not progress to birth, but it will progress to birth*.'[34]

Others, however, argued that including the words "to birth' provided greater clarity in defining "termination". Ms Cherie Stewart said:

> '*I think the words 'to birth' are useful because they help to distinguish between an intended termination versus the ending of a pregnancy that is intended to deliver a live birth. For that reason we would*

[32] M. Permezel, op. cit., p. 100.
[33] Ibid., pp. 101-102.
[34] J. Brodribb, *Transcript of Evidence*, 23 August 2013, p. 30.

> *support them continuing, and I think that those words coupled with the statutory interpretation around clause 5 would be enough for a court to say this bill doesn't apply to a caesarean or vaginal delivery, it is about an intended termination. …. If we lost the words I don't believe it would be fatal to the bill in that I don't think it would draw in the examples we're trying not to draw in. I do think that having those words there helps in making it clear that we're not about drawing them in because it is about discontinuing a pregnancy so that it does not progress to birth. …. The usual step for a court is if there is no definition in the legislation itself that can inform that the next step would be to consider the ordinary use of the term 'birth'. If we look at the Macquarie Dictionary its definition of birth refers to independent being or life so you are effectively then drawing in that line or difference, if you like, between an intended live birth versus not.*'[35]

In his evidence to the Committee, Dr Craig White, said:

> '*I suppose what we're debating is the difference between a legal mind and a clinical mind, so legally when you sit with Cherie* [Stewart] *and hear that explanation it all makes perfect sense, but when you're out in the clinical world it's possible that saying something does not progress and deleting to birth still makes the point more reassuringly perhaps. …. I suppose the other factor that a court is likely to take into account is the intent of the legislation, which is to provide an updated framework to consider terminations, so they will be focused more on the definition of 'termination' as leading to a different end point than the birthing end point, so if you do a caesarean section or a vaginal delivery there is a different intention from the Reproductive Health Bill that we are discussing; that is a different outcome than is intended from the process described in here. I suppose that is the other way that a court may differentiate.*'[36]

Ms Susan Fahey, representing the Women's Legal Centre Tasmania, also supported the inclusion of the words to birth in the definition of termination. She told the Committee:

> *'It is clear that it is meant, for the purposes of a termination, to provide clarity, which it does. I have thought about it and you could take it out but that would cause some confusion. If you have 'does not progress to birth,' that does take that confusion out and provides clarity as to what it is meant to be. Effectively, if you put it before a court it is understood that the sole intent of a termination is to deliver a dead*

[35] C. Stewart, *Transcript of Evidence*, 19 August 2013, pp. 3-4.
[36] C. White, op. cit., p. 4.

> *foetus or a dead baby - however you want to put it. If someone challenged it, having 'to birth' in there does provide that clarity, particularly when you look at [it] in view of what the understanding of 'terminate' is.*[37]

Finding 2:

The Committee finds that, while the words "to birth" are of concern to some medical practitioners and legal experts, it is very difficult to propose amendments to the Bill to clarify the legislative intent.

Also in relation to the definition of "terminate", the Committee raised with witnesses concerns about the words "*but does not include the supply or procurement of any thing for the purpose of discontinuing a pregnancy*", especially in terms of their relationship with the *Poisons Act* 1971 (***Poisons Act***) and of their impact on nurses and midwives.

In response to Committee questions about the former, Dr Craig White said:

> '*There is a question about how it is intended that the Poisons Act will interact with the provision. The short answer to that is: it isn't intended that there is any particular interaction, any more than with any other legislation. The Poisons Act stands alone and it controls the supply and manufacture, administration, and prescribing of all types of poisons, including pharmaceuticals and medicines, in Tasmania. We felt this was fine as it was, and it didn't raise any issues*.'[38]

Ms Cherie Stewart provided further clarification, telling the Committee:

> '*I guess the definition of termination in that last sentence is drawing a distinction between the performance of the termination and the supply of something that might be used in a termination. So whether that supply is lawful or unlawful is, I guess, irrelevant for the purposes of this bill, because it is regulated under different legislation. I wouldn't mind exploring the thinking behind introducing the terms 'administration' and 'lawful' and 'unlawful'. This definition refers to somebody handing over something that may be used in a termination, but that act, in itself, is not a 'termination', so it doesn't come under this bill*.'[39]

[37] S. Fahey, *Transcript of Evidence*, 19 August 2013, p. 87.
[38] C. White, op. cit., 23 September 2013, p. 1.
[39] Ibid., p. 1.

In relation to nurses and midwives, both Departmental representatives acknowledged that there were shortcomings in the "*supply and procurement*" wording of the definition of termination.

As Dr White explained:

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

Finding 3:

The Committee finds an amendment is required to the definition of "terminate" to clarify the role of nurses and midwives in the legal administration of drugs associated with terminations.

3. Interpretation

(1) In this Act, unless the contrary intention appears –

…

- ***woman*** means a female person of any age;

The Committee raised concerns about the definition of a woman in relation to how minors were able to give consent to medical procedures. Evidence was received about the use of the Gillick competency test in determining whether or not a minor was capable of providing a properly informed consent to a procedure.[40]

[40] The common law position relating to a minor's competency to consent to treatment was established by the English House of Lords decision in Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, which was approved by the High Court of Australia in Secretary, Department of Health and Community Services v JWB and SMB (Marion's case) (1992) 175 CLR 218. In Gillick, it was held that the authority of a parent decreases as their child becomes increasingly competent. Gillick prescribes that the parental right to determine their child's treatment terminates once a child under the age of 16 is capable of fully understanding the medical treatment proposed. Whether a particular child has the requisite intelligence and understanding to give a valid consent is a question of fact. While Gillick holds that a minor who has a requisite level of understanding may consent to treatment, this does not amount to a corresponding right to refuse treatment. Hence, an adolescent who is competent according to the principles established by Gillick, will generally lack the capacity to refuse life-saving treatment if his/her parents are prepared to consent to it. See Thomson Reuters (Professional) Australia Limited, *FindLaw Australia website*, http://www.findlaw.com.au/articles/432/age-of-consent-to-medical-treatment.aspx, accessed 2 September 2013.

For example, Senior Nurse and Midwife with Family Planning Tasmania, Ms Kate Wilde, described how that organisation deals with minors seeking terminations.

> '*We have something called the Gillick competency. It is how we assess a minor's understanding of a clinical procedure or test. We talk to them about the procedure of the test, about the good and bad things, the complications and the benefits, and we assess their understanding of it. If we think they are mature enough to understand what we are saying, we say they are Gillick competent. If I am unsure I will get another colleague to assess them as well, which we did to someone last week. It comes up fairly frequently that we see a minor on their own - …*'[41]

In cases where a minor is not Gillick competent a parent or guardian is required to give consent to the procedure. However, this is not always a straightforward exercise, as Hobart paediatrician Dr Michelle Williams, representing the Council of Obstetric and Paediatric Mortality and Morbidity, noted.

> *'A parent is considered a guardian of a child until they have achieved majority or are deemed to be independent under the Gillick case competency. However, when you have someone who isn't Gillick competent - and Gillick competent means someone who has been deemed to be able to make appropriate decisions with a view to the future, et cetera - it's important that somebody acts in that child's stead. For some of the children we deal with and I deal with, we have children who are not yet wards of the state, and do not have a responsible guardian who is able to give consent. We need to be aware that we do have a problem with people, particularly under the age of 16, who are not Gillick competent, that we don't have an easy system of appointing an advocate for that person in the decision-making process. We have spoken about how traumatic this* [terminations] *can be for mothers. For people with altered capacity that is even more so. We would like the parliament to be aware of that when this legislation is debated.'*[42]

Dr Craig White told the Committee that:

> '*The intent was to not create any special considerations around the process of consent beyond that which is required by AHPRA through its code of conduct, which is based on the NHMRC consent guidelines and which is relevant to the next set of questions as well. The usual process to consent in a setting of someone who is under the age of*

[41] K. Wilde, *Transcript of Evidence*, 30 July 2013, p. 92.
[42] M. Williams, *Transcript of Evidence*, 23 August 2013, p. 31.

majority is based on a couple of court cases: there was the Gillick case in the UK, which was followed by the High Court of Australia in Marion's case, which established what we call a 'mature minor assessment' and that is where the - I will read from the note - the court said that: 'Parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and this rate of development depends on the individual child.' In practice usually the cut-off is about 14; below 14-ish you would require a mandate, effectively the parental consent, but between 14 and 18 it depends on the specific child you have in front of you.'[43]

Finding 4:

The Committee finds that no alteration is required to the definition of "woman".

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[43] C. White, op. cit., 23 September 2013, p. 3.

Clause 4 Terminations by medical practitioner at not more than 16 weeks

The pregnancy of a woman who is not more than 16 weeks pregnant may be terminated by a medical practitioner with the woman's consent.

Early Gestational Period

The question of setting a change of process at a gestational period of 16 weeks was a major issue in the evidence given to the Committee about this clause and also Clause 5. The discussion in this section of the Report relates mainly to the increased medical risk factors beyond the first trimester and the number of terminations that take place in that earlier period. Further consideration of the 16-week gestational period is included in the following section about Clause 5[44].

The issue of the meaning of "consent", which appears in a number of clauses in the Bill, is also considered in the following discussion relating to Clause 4. The issues raised in this discussion are relevant to the meaning of "consent" throughout the Bill and should be read as such.

Clear and unequivocal evidence was received by the Committee indicating that the overwhelming majority of terminations were performed in the first trimester of a pregnancy. The evidence also showed that these terminations can be performed medically, i.e. with the use of drugs, but are more commonly carried out surgically.

Professor Caroline Da Costa, Professor of Obstetrics and Gynaecology and Director of the Clinical School at James Cook University School of Medicine, Cairns Campus in North Queensland, told the Committee that '*about 94 per cent of terminations are going to take place before 16 weeks, about 6 per cent after that and only about 1.5 per cent after 20 weeks*.'[45] Assoc. Prof. Jo Wainer said '*the clinics where I worked, overwhelmingly women have their terminations before 12 weeks of pregnancy, overwhelmingly. So 80 per cent, it is huge*.'[46]

According to the evidence given to the Committee by specialist medical practitioners the medical risks of a termination increase as a pregnancy progresses. Prof. Permezel provided detailed evidence about terminations and their risks when he appeared before the Committee.

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[44] See page 31.
[45] C. Da Costa, *Transcript of Evidence*, 29 July 2013, p. 3.
[46] J. Wainer, op. cit., p. 47.

Professor Permezel outlined the usual procedures for terminations during the first trimester:

> '*Early termination can be performed medically or surgically - medically by RU486, and we heard that mentioned before, followed by prostaglandin therapy which is relatively recently introduced to Australia. The traditional method is by curettage, which is surgically evacuating the contents of the uterus. …. In a small town it would very commonly be curette; remember that in having this conversation we are talking about miscarriages as well. Quite commonly a foetal death in utero, an embryonic death, will be diagnosed at 10 weeks, 12 weeks, exactly the same circumstance as a termination of pregnancy and there need to be sensible measures around the management of that. Clearly, up to 12 weeks it could be done in a relatively small centre. The likely complications are going to happen at any time with any medical procedure, as you know, but the likelihood is so low that you would be comfortable about it happening in a relatively small town without specialist back-up. A curette for a miscarriage, a curette for a termination of pregnancy*.'[47]

He then went on to discuss the increased risk involved in terminations later in a pregnancy:

> '*Beyond 12 weeks it is increasingly complex and you would like to be in a town that could manage complications. As the gestation gets advanced beyond 16 weeks, then curettage ceases to become a possibility. Between 12 and 16 weeks some doctors have the expertise to manage by what is called dilatation and evacuation, but relatively few and I do not know whether anyone in Tasmania has that expertise. My expectation would be increasingly after 12 weeks that it would be managed medically, for instance, by inducing uterine contractions and resulting in spontaneous expulsion. …. The risk remains small, but undoubtedly there is an increase in risk with advancing gestation and one hears in - I said that dilatation and evacuation is uncommon after 16 weeks, but there are centres where it is done up to 22 or 24 weeks, but certainly I would be very surprised if that were to happen in Tasmania. The risks are very small, but they will increase with advancing gestation. A six-week curette for a miscarriage is - I wouldn't like to say it is amongst the safest surgical procedures, but six weeks miscarriage - there would be hundreds done every day, maybe thousands. It is a very common procedure.*

[47] M. Permezel, op. cit., p. 98.

> *As the gestation advances the risks go from one in 300 000 to one in 100 000*.'[48]

Prof. Permezel also gave evidence about the risks involved in medical terminations:

> '*As you move into medical terminations, administering medication and waiting for the uterus to contract, then the probability of an adverse outcome, a haemorrhage or whatever, increases to a matter of 1 or 2 per cent instead of 1 in 100 000. They still are very uncommon with mid-trimester termination, but it does progressively increase as the gestation increases until you get to term birth, when it becomes very risky. The likelihood of a haemorrhage with a term birth is 4 per cent unless you are under a natural third stage and it is 8 per cent. As the gestation increases the risk of haemorrhage will increase*.'[49]

He also made a significant point about late term terminations:

> '*People wonder why you would ever do a termination late in pregnancy and practically you do not ever do terminations - or extremely rarely would you do a termination late in pregnancy; there are these very peculiar, rare situations, but you have to write legislation that works for the whole community, not just for a few individuals*.'[50]

Finding 5:

The Committee finds that there is an increasing medical risk to the woman in carrying out terminations the further the pregnancy progresses.

Finding 6:

The Committee finds that terminations beyond 16 weeks gestation are uncommon and those beyond 24 to 28 weeks are extremely rare.

Consent

Many witnesses used the term "informed consent" throughout their evidence even though the Bill itself only uses the term "consent."

[48] Ibid., p. 99.
[49] Ibid.
[50] Ibid., p. 104.

The Medical Board of Australia also refers to “informed consent” in its code of conduct for doctors when discussing the issue of patients agreeing to medical procedures or treatment.[51]

Within this context some witnesses raised the question of the actual meaning of “consent” in this clause and throughout the Bill, particularly suggesting that the term “informed consent” would be more appropriate.

For example, Dr Helen Lord told the Committee:

> ‘*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*.’[52]

Mr Michael Stokes also wanted the definition of consent to be clarified in the Bill.

> ‘*I would much prefer to see a more concrete definition of 'consent'. My own view is that, before you have a fully informed consent in this area, you need to have an understanding of all the options which are available to you. They need to be presented to you in an impartial way and I would like to see that made clear in the legislation*.’[53]

Mr Eric Lockett, representing Tasmanian Baptists, pointed out to the Committee their concern that the original draft of the Bill included the term “informed consent” and this had been later changed to “consent” only.

> ‘*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?*’[54]

The Committee raised with DHHS representatives the question of why “consent” was preferred over “informed consent” and why it had been changed from the earlier draft of the Bill.

Dr Craig White told the Committee that:

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[51] See Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, 1 July 2010, Section 3.5 Informed Consent, pp. 5-6.
[52] H. Lord, op. cit., p. 97.
[53] M. Stokes, op. cit., p. 23.
[54] E. Lockett, *Transcript of Evidence*, 3 September 2013, p. 61.

'*Not through having been involved in earlier drafts but just from talking with people it appears that it was seen as a tautology, it was redundant to have the word 'informed', there was no change or shift in policy, it was just seen as 'consent' is by definition, 'informed' in the context of what we are talking about, and if you draw on the Criminal Code definition of consent, that implies free agreement, and if you look at the medical understanding you do not have consent unless it is informed. It is a key feature of the consenting process. The Medical Board's code of conduct takes you to the National Medical Research Council's guidelines on consent, and all about being informed*.'[55]

Finding 7:

The Committee finds that the use of the term "consent" in this clause is appropriate.

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[55] C. White, op. cit., 23 September 2013, p. 6.

Clause 5 Terminations by medical practitioner after 16 weeks

(1) The pregnancy of a woman who is more than 16 weeks pregnant may be terminated by a medical practitioner with the woman's consent if the medical practitioner –

(a) reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and

(b) has consulted with another medical practitioner who reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.

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

Late Gestational Period

As noted in the discussion of the previous clause, the Committee received considerable evidence about the issue of the change of process beyond a gestation period of 16 weeks.

In the original Bill Clause 5 required the involvement of a second medical practitioner after 24 weeks of pregnancy, but this was reduced to 16 weeks during consideration in the House of Assembly. As Dr Craig White acknowledged in his evidence, the 16-week period was chosen as a compromise position.

> '*There has been, as you are well aware, considerable debate about whether there even should be a threshold like that, and if there should be one, where it should lie. We have taken a view that 16 weeks is a bit of a middle-ground approach. It's not as short as some would like and it's not as long as others would argue. You would probably have had some submissions from others, particularly obstetricians and gynaecologists about that. We thought that it was a pragmatic position to take at 16 weeks*.'[56]

Dr White also acknowledged that the original 24-week gestational period was based on the provisions of the Victorian legislation on terminations.

[56] C. White, op. cit., 30 July 2013, pp. 35-36.

> '*The 24-week position is based on that which was landed on in Victoria, which went through an exhaustive process of assessing the situation. So that was the basis of an original proposition that landed at 24 weeks. That would certainly be acceptable to the department. We would have no exception at all, in fact we would support restoring the 24 weeks, but we would rather have it at 16 weeks than how it is at the moment, if that's the option*.'[57]

He went on to say:

> '… *our assessment was that that would have the benefit of lowering some resistance to the bill and it was seen as more important to decriminalise and to get the threshold to 16 weeks than to come in saying, 'We have to have everything or nothing', because we recognise that we live in the real world*.'[58]

The evidence presented to the Committee reflected the breadth of debate about whether or not any change of process based on gestation should be included in the Bill and, if so, what that gestational period should be. Those who supported a change of process suggested periods ranging from 14 weeks to 28 weeks. There was strong support for the current 16-week period to be maintained in the Bill, but a significant number of witnesses also supported a period between 18 and 22 weeks. Many of those with reservations about the current, or any, change of process stated that a gestational period of 16-weeks was acceptable if it allowed the Bill to pass.

For example, Victorian General Practitioner, Dr Sally Cockburn, told the Committee:

> '*I support the bill in its current form with one small reservation about the 16-week change of access protocol as this pre-dates the 18-week ultrasound. I feel the Victorian protocol of 24 weeks is more practical, but having said that, if it means the difference between passing or failing of the bill I believe that clinically it's workable as it stands*.'[59]

Ms Mary Anne Ryan, representing the Tasmanian Women Lawyers organisation, did not support any gestational period, but was prepared to accept the change of process at 16-weeks if it meant the Bill was agreed to.

> '*Our preferred position is that it is not there at all. We don't believe it is necessary. However, like everything, we are a pragmatic group of*

[57] Ibid., p. 36. The Victorian legislation is the *Abortion Law Reform Act 2008* (No. 58 of 2008). Sections 4-7 of that Act include references to 24 weeks.
[58] Ibid., p. 37.
[59] S. Cockburn, *Transcript of Evidence*, 19 August 2013, p. 49.

> *women and we see the big picture is that the bill is passed and we were prepared to compromise on the question of weeks of gestation*.'[60]

Those who supported a different gestation usually linked it to the times when pregnant women were given diagnostic scans to assess the health and viability of the foetus. For example, Professors Boon Lim and John Daubenton, who supported a 14-week gestation, linked it to a scan or diagnosis usually undertaken at around 12 or 13 weeks. In their written submission on behalf of the senior medical staff of the Women's, Adolescents' and Children's Service at the Royal Hobart Hospital, they said:

> '*We note that terminations by medical practitioner at not more than 16 weeks may be performed with the woman's consent under the new Act. We feel that this should be lowered to 14 weeks after which there should be two doctors supporting the request*.'[61]

In verbal evidence to the Committee Prof. Lim expanded on the reasons for supporting the 14-week gestation change of process.

> '*Some of these abnormalities are not necessarily diagnosed on scans, some would have had an invasive test at 13 weeks - and we would get the result at 14 weeks. …. the majority of these terminations are carried out at 12 to 14 weeks under the clause where it affects the maternal mental health - that is the group we are talking about - the group of women with lethal abnormalities or chromosomal abnormalities will invariably be, as you said, diagnosed from 13 or 14 weeks. In our set-up it is not difficult to access doctors to assess the situation*.'[62]

Others, like Prof. Permezel speaking on behalf of RANZCOG, suggested a 20-week gestation based on the diagnostic scan usually undertaken around 18 weeks, but did point out that the change of process concept was based on community expectation.

> '*I am speaking on behalf of the college. The view of the college was that 20 weeks would work better than 16. We appreciate that there is not a huge difference between 16 and after 16, so why would it matter if it was 16 or 20? There is symbolism but not a huge difference. …. the threshold is really a community expectation. It is not really going to be a change in practice that is going to make the woman feel under pressure to make a hurried decision. The two-tier system has not got the college worked up*.'[63]

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[60] M. Ryan, *Transcript of Evidence*, 23 August 2013, p. 65.
[61] B. Lim & J. Daubenton, *Written Submission*, 22 July 2013, p. 2.
[62] B. Lim, op. cit., pp. 59-60.
[63] M. Permezel, op. cit., pp. 105-106.

Ms Terese Henning supported a change of process at 22 weeks gestation:

> '*We certainly have an opinion and it is based on what doctors have said. It is preferable, we would say, to extend the period for terminations by consent to 22 weeks, rather than to have it at 16 weeks. One of the reasons we say that is because if you do extend it out to 22 weeks - and this isn't the medical reason but it is our view - then you are not placing women under such pressure to make a hasty decision. You are giving them more time to reflect. That is one of the reasons why we say to extend it out to 22 weeks. I think that doctors' position would be, and I hope I am not verballing them, that if you extend termination by consent to 22 weeks then again you are additionally protecting them from being dealt with by the law, imposing what they would consider to be unreasonable constraints on the doctor/patient relationship. Thereafter they can see that perhaps other controls may be valid*.'[64]

The other question of concern raised in evidence about this clause was the need for the involvement of a second medical practitioner and whether that practitioner should be an obstetrician or gynaecologist.

Some witnesses suggested that the requirement for the second doctor to be a specialist would limit access to terminations for women in rural or remote parts of Tasmania, while others believed the Bill should be more specific about requiring a specialist obstetrician or gynaecologist as the second doctor. However, a number of witnesses also claimed that in current medical practice there would almost always be a second doctor, usually an obstetrician or gynaecologist, involved in a pregnancy termination after 16 weeks and therefore the clause was not needed.

In her verbal evidence Assoc. Prof Jo Wainer told the Committee:

> '*Almost all the doctors in the private sector in the specialised clinics that provide terminations are general practitioners that have been trained to do that. I have a lot of concern about parts of the bill that require the intervention of a gynaecologist and/or obstetrician because even the second trimester terminations in Victoria and in Queensland were provided primarily in the private sector by general practitioners who have been trained specifically in the technique. When you say it has to be an obstetrician-gynaecologist, I'm concerned about that. That will limit access to services. The reason for that is you only have 16 obstetricians and gynaecologists in Tasmania and a proportion of them - and I don't exactly how high but it could be as high as a quarter of them, or even more than that - don't want to be involved in providing*

[64] T. Henning, op. cit., p. 11.

> *termination services, so who's going to do it? When you put those sorts of limits in, the only possible consequence can be not better care for women but restrictions on access, which I presume is the reason it's in there*.'[65]

A similar view was expressed by Ms Glynis Flower, the Executive Officer of the Hobart Women's Health Centre.

> '*The truth is … by [that] 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*.'[66]

Prof. de Costa told the Committee that in most cases the second practitioner would be a specialist obstetrician or gynaecologist so the requirements in this clause would not pose any particular difficulties.

> '*A termination of pregnancy after 16 weeks must take place in a hospital or in a very appropriate clinical situation, so women in that situation do need to travel. Earlier pregnancies, up to nine weeks, can be terminated in any situation where it is possible for a doctor to look [after] a spontaneous miscarriage. So I would see that termination after 16 weeks in Tasmania would be taking place in Hobart, Launceston, Burnie and perhaps a few other hospitals, so women will have to travel. The other thing is that termination after 16 weeks is usually going to be conducted by a specialist obstetrician gynaecologist anyway, who is going to have a clinical environment where that can be done, so I wouldn't see it as a problem*.'[67]

She went on to say that the 16-week gestation change of process and the requirement for a second doctor was not an issue.

> '*I wouldn't have thought practically that it was, because about 94 per cent of terminations are going to take place before 16 weeks, about 6 per cent after that and only about 1.5 per cent after 20 weeks. They are done for major reasons, usually foetal abnormality because we just can't diagnose these abnormalities, although there are changes there. In about 10-15 years' time, many things we can only diagnose now after 16 weeks will be diagnosable at six or seven weeks, but it needs*

[65] J. Wainer, op. cit. pp. 38-39.
[66] G. Flower, *Transcript of Evidence*, 3 September 2013, p. 6.
[67] C. de Costa, op. cit., p. 2.

> *to be done by an experienced obstetrician-gynaecologist with commitment to the techniques*.'[68]

Dr Michelle Williams referred to the increased risk involved in terminations later in a pregnancy. She told the Committee:

> ' *… there is a difference in potential medical risks in terminations in the early and latter parts of pregnancy and that we believe terminations at more advanced stages of pregnancy should be carried out in a recognised medical facility, in a hospital preferably, particularly when the mother has other risk factors that would make the risk of a termination of pregnancy higher, such as previous caesarean section …* .'[69]

Dr James Brodribb told the Committee that some risk factors or complications beyond 10 weeks in a pregnancy were such that two doctors should be involved in terminations beyond 11 or 12 weeks:

> '*Given that we know that cervical incompetence is a known complication beyond 10 weeks, it would seem sensible that, certainly from 11 or 12 weeks on, if a termination is going to be undertaken that should be reviewed by two medical practitioners, one of whom should have training in obstetrics and gynaecology so that that woman can be advised appropriately about what risks exist and also to advise about the pre-treatment of the cervix before the procedure is undertaken*.'[70]

He went on to add that counselling by a practitioner trained in obstetrics and gynaecology was very important as a pregnancy progressed.

> '*One of the suggestions initially was that we should recommend that up until maybe 12 weeks that a single practitioner might be able to consent the woman in the way that an ordinary procedure can be done. From the period of 12 weeks through to what we might loosely call viability for the moment, it's very important that a woman is counselled appropriately by someone who has training in obstetrics and gynaecology, particularly as the pregnancy advances. The complications and risks increase dramatically and then you start to put potentially the life of the woman at risk*.'[71]

Family Planning Tasmania supported the requirement for a second medical practitioner to be involved after 16 weeks and that one should be a specialist:

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[68] Ibid., p. 3.
[69] M. Williams, op. cit., p. 26.
[70] J. Brodribb, op. cit., p. 33.
[71] Ibid.

> '*We also believe that the two medical practitioners, one of them being a specialist, are very well placed to work with that woman to form an opinion on whether it is appropriate to continue with the termination. We are comfortable that is an appropriate inclusion in the legislation*.'[72]

The Royal Australian and New Zealand College of Obstetrics and Gynaecology also supported the retention of the clause:

> '*I think there are issues there to do with service provision and I think the college would prefer that that clause remain; it was something that the board of the college discussed but increasingly, and outside termination of pregnancy, just practice in women's health, there are issues of patients unexpectedly being referred to hospital with complications of varying sorts, whether it be from home birth or delivery in small units, and late termination of pregnancy would be another potential situation and the board quite liked that potentially, given an obstetrician-gynaecologist's involvement, potentially the person to whom a complication would be referred who had some involvement in the decision-making processing at an early stage*.'[73]

Prof. Permezel went on to suggest that the wording of the clause be changed to ensure beyond any doubt that it required the involvement of a specialist obstetrician or gynaecologist.

> '*Perhaps better wording for that might be 'who is a medical practitioner who is a specialist in obstetrics and gynaecology' as opposed to who specialises in it as specialist defines somebody who is a Fellow of the college and would be experienced in the management of mid-trimester pregnancy loss, whether it be no experience at all in termination of pregnancy but looking after unexplained foetal death in utero in middle pregnancy and having to terminate a foetal death so it is the spontaneous mid-trimester labour. They are quite difficult pregnancies to manage and it is good to have the expertise around these potentially complex cases*.'[74]

Dr Craig White told the Committee that such a change was not necessary, even though it would reflect the current requirements for terminations under the *Criminal Code*.

> *'The reason, on balance, my preference is' specialises in' is that it does include people who are Fellows of the College of Obstetricians*

[72] G. Ibbott, op. cit., p. 79.
[73] M. Permezel, op. cit., p. 95.
[74] Ibid., p. 96.

and Gynaecologists, but it would also include someone who is a very experienced medical practitioner who had a diploma of obstetrics, who spent half their time for the last 20 years just doing terminations , they were known to do it safely, they work in family planning, they do not have a fellowship should they be excluded from being the second person. On balance probably not. You could argue it either way but I think having the flexibility, specialises in, is a valid thing …. I think that in the vast majority of cases, and I am confident certainly in the public sector and I dare say in the private sector, it is going to be a specialist O&G. I am thinking of other scenarios where that may not be essential.'[75]

Circumstances to be considered

Physical, psychological, economic and social

Another aspect of this clause that had been subject to some controversy relates to the circumstances that must be taken into account by medical practitioners when assessing the risk to the pregnant woman of a termination after 16 weeks.

Ms Susan Fahey outlined the rationale for the inclusion of the requirement for doctors to take into account a woman's current and future physical, psychological, economic and social circumstances.

'*Section 164 of the Criminal Code says that in assessing medical practitioners may take account of any matter which they consider to be relevant. My understanding is that the reason that it was drafted listing those four fairly broad terms is because doctors did not understand that social and economic circumstances, for example, could be deemed relevant. In a bid to make this clearer, it has sparked a bit of a debate by having those four provisions in there but those provisions - mental health, physical health, social and economic factors - were determined in court cases starting in 1971 and 1972, …. it is accepted that those are the four factors because they are used in a lot of assessments that doctors make, not just on this - they are the four common things that are taken into consideration*.'[76]

Prof. Julian Savulescu also referred to previous court decisions in supporting the inclusion of the four circumstances that must be taken into account.

[75] C. White, op. cit., 23 September 2013, pp. 8-9.
[76] S. Fahey, op. cit., pp. 83-84.

> '*I think that terminology came from Michael Kirby in another decision. He sought to introduce the idea that the broader wellbeing of the woman besides purely medical wellbeing is a relevant consideration in considering the reasonableness of an abortion. Lachlan* [Dr Lachlan de Crespigny] *mentioned before people with drug addiction or severe intellectual disability. In a particular case those may be relevant considerations in justifying the reasonableness of a procedure. It is important to remember that doctors can always refuse to perform terminations of pregnancy so there are many barriers that women face and I think in this area the law should not be making those barriers unethically obstructive*.'[77]

Dr Lachlan de Crespigny, a retired Obstetrician and Gynaecologist, also supported the inclusion of the four circumstances.

> '*Particularly the social circumstances, but economic as well, I believe absolutely should be there because it should be flexible, and to suggest that people will take these in a trivial way I would reject. We can all think of many social circumstances in the community where we would think it's reasonable to consider that in terms of a late abortion*.'[78]

Prof. Permezel expressed some caution about the wording of the clause, suggesting a preference for the wording used in the equivalent Victorian legislation.

> '*With the four items - I think there are four items that are listed currently - there is an implication that it is on one or A, B, C or D and that then becomes a ground, whereas I think that as a clinician and certainly as a teacher - an enthusiastic university teacher - one tries to teach the global appreciation of clinical, psychological and total patient welfare as a broad concept. So I think the wording, as I have heard it from Victoria, does look more globally at the entire patient encompassed and all the circumstances pertaining to that patient. So in some ways I think, just as you have worded it, that the Victorian wording does seem to be more along the lines of what the college would like to see. …. you have to make a global assessment of all the relevant circumstances pertaining to that patient and together make a decision as to what medical treatment would be in the best interests of the patient, which is more or less as that Victorian legislation espouses … to make an assessment of the patient and in so doing you need to consider all the relevant facts.*'[79]

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[77] J. Savulescu, op. cit., p. 9.
[78] L. de Crespigny, *Transcript of Evidence*, 29 July 2013, p. 9.
[79] M. Permezel, op. cit., pp. 92 & 93.

The relevant clause in the Victorian legislation states:

> '***5. Termination of pregnancy by registered medical practitioner after 24 weeks***
>
> *(1) A registered medical practitioner may perform an abortion on a woman who is more than 24 weeks pregnant only if the medical practitioner-*
>
> *(a) reasonably believes that the abortion is appropriate in all the circumstances; and*
>
> *(b) has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances.*
>
> *(2) In considering whether the abortion is appropriate in all the circumstances, a registered medical practitioner must have regard to-*
>
> *(a) all relevant medical circumstances; and*
>
> (b) *the woman's current and future physical, psychological and social circumstances.*'[80]

The Committee notes that, unlike the Tasmanian Bill, the Victorian legislation does not include a specific reference to the woman's economic circumstances.

Mr Michael Stokes questioned the requirement in the clause that says the doctors must take into account the woman's current and future physical, psychological, economic and social circumstances.

> '*What the proposal does, which I find slightly odd and I haven't quite been able to get my head around what it would mean in practice, is when we look at that section 5, medical practitioners 'may' terminate and that would seem to be a fairly discretionary thing and they may not terminate. But if they go down the path of considering termination then they are under this duty to take into account the social and economic circumstances. If that were retained, certainly from my perspective, I would understand it a lot better if it was not a duty - 'must', but simply 'may have regard' because that seems to be more consistent with the whole discretion of whether to proceed or not in subsection (1). In making a decision, we may terminate and in making that decision you*

[80] State of Victoria, *Abortion Law Reform Act 2008*, s 5.

may have regard but I'm not sure how the duty - 'must' - there relates to the overall discretionary nature of it.'[81]

Ms Cherie Stewart told the Committee that:

'*That provision sets the minimum that has to be taken into account. There's nothing stopping a doctor from taking other matters into account, but it's quite clear - here is the list of factors that have to be taken into account. …. Because there has been a history of lack of understanding of our current framework, this makes it very clear which factors have to be taken into account. The current wording is - and I will grab the criminal code so I am quoting exactly: "... the medical practitioners may take into account any matter which they consider to be relevant." This legislation sets the standard and says, 'This is what you must have regard to'. If there are other things a medical practitioner wishes to consider, there's nothing in here that stops them from doing that, but this sets the minimum. It also provides clarity from the woman's perspective - about what she can expect to be asked, going through this process. These are the factors that are taken into account*.'[82]

She was supported by Dr Craig White who said:

'*It's meant to be prescriptive as a baseline and you can go as far as you want but here are the minimum things. It is a purely technical assessment of whether someone will survive the anaesthetic. In a sort of narrow minded medical way, you have to understand all of the woman's circumstances, including, but not limited to, these four areas. That was the intent of the framing of it, so it was a bio, psycho, social, contemporary approach.*'[83]

Finding 8:

The Committee finds that it is unclear whether the use of the term "must", in sub clause 2, limits the medical practitioner to only consider the woman's current and future physical, psychological, economic and social circumstances, when assessing the risk of injury to her physical or mental health.

[81] M. Stokes, op. cit., p. 17.
[82] C. Stewart, op. cit., 23 September 2013, p. 32.
[83] C. White, op. cit., 23 September 2013, pp. 32-33.

Foetal Abnormality

The other issue that was raised with the Committee in relation to this clause was the suggestion that foetal abnormality be included as a basis upon which a termination may be carried out.

Dr Michelle Williams explained the view of the Council of Obstetric and Paediatric Mortality and Morbidity as to why such an amendment should be made to the Bill.

> *' … we think lethal and severe foetal abnormalities should be grounds for termination earlier as well, because a severe foetal anomaly is the most common cause for a request of termination in the second trimester. That is certainly our involvement in the neonatal unit where an infant would either succumb soon after birth, in the first year of life or early years, or carry a very severe disability with very little chance of quality of life. These are not minor abnormalities that we are talking about. The South Australian legislation prescribes that the child who suffers from such physical or mental abnormalities as to be seriously handicapped is one of the conditions for lawful termination in South Australia and we think that is a very sensible addendum to the legislation. It is a minority of cases. …. I think we should look at the child's quality of life as well, that is, part of our right to life is the right to quality life and to exist without suffering and I think that this is all mother focused, which is good because the mother is carrying the pregnancy; however, the potentially disabled foetus is not mentioned and I do think that should be a separate category within this area. I hear what you are saying about the vagueness of serious physical and mental handicap, but I think each case does need to be evaluated differently …'*[84]

Dr Helen Lord supported this view, telling the Committee that:

> *'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*

[84] M. Williams, op. cit., pp. 20 & 21.

> *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.'*[85]

Ms Marilyn Beaumont, Chairperson of the Australian Women's Health Network, told that decisions about terminations related to foetal abnormality were very difficult for those involved.

> '*The issue of lethal foetal abnormality and whether or not it is best for the woman's mental health for that to be terminated is, I think, a very difficult decision. She should be supported in the number of weeks she is pregnant; she should have the time she needs. Our health system should be skilled and experienced in supporting women in those decision-making processes. The idea of foetal abnormality and what is acceptable as a disability to some people is different with others. We had extensive discussion with the Victorian Women with Disabilities network during the period of the Victorian law reform process and they came down very strongly on the side of it being the woman's decision because her circumstances and the circumstances she finds herself in are what should prevail. I believe there are situations where that can happen along a spectrum.*'[86]

Ms Susan Fahey, on the other hand, expressed concerns about how to define the term foetal abnormality.

> *'I would be really opposed to getting into things like gross foetal abnormality and, as someone asked this morning, 'What is gross foetal abnormality?' There would be people who think a club foot is that just because their child is not perfect, whereas I would [say] that that would be a really bad way to go. I understand that some doctors say they would like to be able to tick something other than mental health if they are dealing with one of those women who is in the 0.7 per cent where there is a really gross foetal abnormality and they do not want to tick mental health for the mother; frankly, that is a factor. If you have a baby that you desperately want and you find that it is going to die shortly after birth you are going to have a mental health ramification.'*[87]

[85] H. Lord, op. cit., pp. 84-85.
[86] M. Beaumont, *Transcript of Evidence*, 19 August 2013, p. 32.
[87] S. Fahey, op. cit., p. 84.

Prof. Permezel also opposed the inclusion of foetal abnormality as grounds for a termination.

> *'One important thing for the foetal abnormality is that foetal abnormality per se isn't a reason for termination. I am sure you've heard many people say we have to value all human beings and it is really the woman's perception of the foetal abnormality that the college would regard as the issue, not the foetal abnormality itself. I believe it is wrong to list foetal abnormalities as an indication for termination. If something such as that were to be listed, it has to be related to the woman's perception of the impact of the foetal abnormality. The foetal abnormality is not grounds for termination. The college would believe it is the impact of that abnormality on the woman that becomes the issue, but not necessarily to the extent of psychological disease. It is a bit concerning that there is an implication that foetal abnormality necessarily causes psychiatric disturbance. Nevertheless, there can be impact without psychiatric disturbance and I will leave it to the clever lawyers to work out how to best phrase that.'*[88]

Dr Craig White explained the rationale for not including foetal abnormality in the Bill as a reason for undertaking a termination.

> '*The reason we didn't go down that path was because it fundamentally shifts the test from being about the woman, to setting up a bit of competition with the baby, with the foetus, about foetal abnormality. It was not seen as a useful addition in terms of decision making*.'[89]

Finding 9:

The Committee finds that, while some medical practitioners suggested that foetal abnormality should be included as a relevant circumstance for termination, the definition of such a circumstance is unnecessary as the implications of foetal abnormality are already provided for in the Bill.

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[88] M Permezel, op. cit., pp. 93-94.
[89] C. White, op. cit., 23 September 2013, p. 32.

Clause 6 Conscientious objection and duty to treat

(1)	Subject to subsection (2), no individual has a duty, whether by contract or by any statutory or other legal requirement, to participate in treatment authorised by section 4 or 5 of this Act if the individual has a conscientious objection to terminations.
(2)	Subsection (1) does not apply to an individual who has a duty set out in subsection (3) or (4).
(3)	A medical practitioner has a duty to perform a termination in an emergency if a termination is necessary to save the life of a pregnant woman or to prevent her serious physical injury.
(4)	A nurse has a duty to assist a medical practitioner in performing a termination in an emergency if a termination is necessary to save the life of a pregnant woman or to prevent her serious physical injury.

Evidence provided in relation to this clause centred largely on the issue of conscientious objection and the meaning of "termination", especially in relation to the intention involved in any procedures that resulted in the termination of a pregnancy in a life-threatening situation for the woman. Some witnesses questioned whether this clause was even necessary, as Mr Michael Stokes explained:

> '*Section 6 is totally unnecessary. In a real emergency every doctor's moral obligation in this situation is clear - that is, you do what is necessary to save the life of the mother. Normally if it is relatively late term, you bring in the paediatrician and you attempt to save the life of the child as well. There are not too many situations which we could imagine where it would be necessary not only to end the pregnancy but to terminate the life of the unborn child as well, which is what is involved in an abortion in this emergency situation. We found it fairly difficult to come up with that sort of idea where the emergency is so immediate that it could not wait until another medical practitioner. First of all assuming a medical practitioner with an objection to terminations found this unconscionable, and probably not a lot would if it was necessary to save the life of the mother, but it is difficult to conceive of an emergency where that person would have to immediately be involved rather than being able to wait to get in someone who did not have that objection. So it seems to me that in most of the situations which would be covered by section 6, medical ethics, including the position of conscientious objectors, it is quite clear you save the life of the mother. You attempt to save the life of the child if you can. The*

> *only relevance is in that situation where for some reason it is necessary to not attempt to save the life of the child*.'[90]

Dr Helen Lord also suggested that this clause is not needed in the Bill.

> '*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*.'[91]

Dr Lord went on to explain the importance of "intention" in relation to such circumstances.

> '*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*. …. *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*.'[92]

The question of "intention" in an emergency situation was also raised by Catholic Church representatives. For example, the Director of Calvary Health Care, Ms Belinda

[90] M. Stokes, op. cit., p. 12.
[91] H. Lord, op. cit., p. 85.
[92] Ibid.

Clarke referred to the provisions of the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, in particular Section 2.28 which states:

> '*In some cases a woman may develop a life- or health-threatening condition for which the only effective and available treatment is one that would endanger the life or health of her unborn child. Such treatment is permissible provided the risks to the woman's life or health posed by her condition are at least comparable to the risks the treatment would pose for the life or health of her child, and provided any harm to the unborn child is neither the intended goal nor a means to the treatment goal. Every effort must be taken to minimise the adverse effects of the mother's treatment on her child, both before and following birth*.'[93]

As the Catholic Archbishop of Hobart, the Most Reverend Adrian Doyle, further explained:

> '*It is known as the principle of double effect. What we cannot accept is that the intervention to terminate the life of the child is the means by which you resolve the medical problem. But if you address the medical problem and it has as a consequence, it is a terrible consequence but it could be in some ways acceptable to treat the medical problem of concern at the time*.'[94]

It seems clear that, according to this evidence, the question of a conscientious objection would not arise in an emergency situation threatening the life of a pregnant woman.

However, some witnesses did suggest that the inclusion of the clause did make the duty to treat unambiguous.

Ms Georgie Ibbott, for example, told the Committee that:

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

[93] Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia,* June 2001, p. 25. See also B. Clarke, *Transcript of Evidence*, 23 August 2013, p. 3.
[94] A. Doyle, *Transcript of Evidence*, 23 August 2013, p. 4.

this part of the legislation is very welcome to clarify this requirement in the legislation.'[95]

Finding 10:

The Committee finds that the issue of conscientious objection is an area that is also covered by codes of practice as established under the *Health Practitioner Regulation National Law Act 2009*.

Finding 11:

The Committee finds that a consequential amendment may be necessary to include "nurses and midwives" in this clause.

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[95] G. Ibbott, op. cit., p. 80.

Clause 7 Obligations on medical practitioners and counsellors

(1) In this section –

counsellor means a person who holds himself or herself out as a provider of a counselling service, or conducts himself or herself in a manner consistent with a provider of a counselling service, whether or not that service or conduct is engaged in, or provided, for fee or reward;

pregnancy options advice means advice or information relating to pregnancy options including continuing a pregnancy or terminating it.

(2) Subject to subsection (4), 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 the woman to another medical practitioner who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations.

(3) If a woman seeks pregnancy options advice from a counsellor and the counsellor has a conscientious objection to terminations, the counsellor must refer the woman to another counsellor who the first-mentioned counsellor reasonably believes does not have a conscientious objection to terminations.

Penalty: Fine not exceeding 250 penalty units.

(4) Subsection (2) does not apply to a medical practitioner who has a duty set out in section 6(3).

Medical Practitioners

Concerns about this clause were expressed in relation to the obligations it imposed on medical practitioners. Questions were raised about the meaning of the word “refer”, on the basis that it has a particular meaning within medical practice. There was also the issue, as with counsellors, as to whether a doctor with a conscientious objection to termination must refer immediately they become aware that the patient is seeking pregnancy options advice or advice about a termination.

A basic question was whether these obligations in the Bill were necessary in light of the fact that medical practitioners worked under comprehensive codes of practice that were legally enforceable by AHPRA and Medical Boards in each State.

Ms Audrey Mills, a Tasmanian lawyer practising in the health law field, explained how the AHPRA regulatory system operates:

> '*The procedures set up for the regulation of doctors and their practise under that national law, which came into place in 2010 and complementary legislation has been passed in every state, is that AHPRA deals with any complaint that is made to it. It has a very detailed process to investigate and deal with the complaint. It goes through a number of stages in its investigation, seeking responses from the doctor, having it peer reviewed, then tribunal hearings if necessary. At the end of the day there are very significant sanctions which can be placed on doctors as a result of a breach which results in a prosecution. Those sanctions can be anything from a requirement to do retraining, all the way up to suspension of practise, practise with conditions imposed, or to not practising at all. Unlike the criminal law it actually gives a range of sanctions which are much more particularised to the matter and can take into account exactly what has occurred. …. AHPRA is required, when considering standards which apply to a certain procedure, to take into account the law - this bill, if passed, would be the law used - and then take into account the code that exists in relation to their conduct*.'[96]

She went on to explain further in terms of conscientious objection and her view that the clause was a necessary part of the Bill:

> '*I have specifically referred to conscientious objection, because I am aware that is a contentious issue, and the relevant principles that AHPRA would take into account in relation to conscientious objection. My view is that doctors are currently under an obligation, where they have a conscientious objection, to refer to another practitioner who they are aware does not have that same conscientious objection. Therefore, requiring them to do so in the bill is really confirming and making very clear that obligation which is part of their current obligations*.'[97]

A number of witnesses presented similar evidence, including Ms Glynis Flower, the Executive Officer of the Hobart Women's Health Centre:

> '*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.*

[96] A. Mills, Transcript of Evidence, 30 July 2013, p.12.
[97] Ibid.

> *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*.'[98]

Ms Flower went on to elaborate on the benefits of the clause:

> '*I don't want to give the impression, particularly since this will be published, that we have no faith in the medical 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*.'[99]

Prof. Permezel told the Committee that RANZCOG also supported the clause:

> '*We absolutely support the provision under the proposed legislation that practitioners with a conscientious objection are respected and not compelled to participate in the process, but we recognise that that needs to be balanced against the right of women to obtain the information they need*.'[100]

The Castan Centre for Human Rights Law also supported the inclusion of the clause in the Bill:

> '*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 jurisprudence 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*.'[101]

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[98] G. Flower, op. cit., p. 7.
[99] Ibid., pp. 7-8.
[100] M. Permezel, op. cit., p. 90.
[101] T. Penovic, *Transcript of Evidence,* 3 September 2013, p. 78.

Dr Sally Cockburn told the Committee that it was reasonable to require a medical practitioner with a conscientious objection to terminations to refer to another without such an objection.

> '*Surely it is reasonable that when a doctor can't provide a lawful, clinically indicated service, the ethical thing to do is to refer this patient to someone who can. I don't mean can provide an abortion because there is lots of confusion out there in the medical profession and I get the feeling there may be confusion elsewhere that the bill does not require a doctor to refer to an abortion provider, merely to a doctor who can give an all-options discussion*.'[102]

The Australian Medical Students Association (**AMSA**) also supports the requirements in the clause. Its *Conscientious Objection and Access to Care Policy* states:

> '*AMSA believes that a doctor should have a right of conscientious objection, however the exercise of an objection must not, directly or indirectly, impede a patient's access to care. Consequently, AMSA believes that where a course of management for a patient is legal (including that of termination of pregnancy), any doctor who holds a conscientious objection to the provision of such management must declare such an objection to their patient, and provide an effective referral to another health practitioner who does not hold such an objection*.'[103]

However, other witnesses told the Committee that such a requirement in the Bill was not necessary as the issue is fully covered in the medical codes of practice that are already legally binding and enforced by AHPRA.

One such witness was Dr Helen Lord who said:

> '*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 [Medical Journal of Australia] 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*

[102] S. Cockburn, op. cit., p. 50.
[103] Australian Medical Students Association, *Conscientious Objection and Access to Care Policy,* October 2013, p. 3.

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.'[104]

Dr Lord also pointed to the AHPRA guidelines for doctors, suggesting that similar wording could be incorporated in the clause instead of the current wording:

'*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.'[105]

Dr Beth Mulligan presented a similar point of view:

'*The issue of the conscientious objection I find quite interesting. I am not really sure whether it is something that needs to be legislated for. Doctors are very much driven by professional code. If, for example, I am unable or unwilling to provide a service to a patient, the minute that patient walks into my room and talks to me about an issue, or the minute I enter into any contract of care - the minute I say, 'I am a doctor' and someone interprets me to say, 'I can therefore care for you', I have entered into a duty of care - I am obliged by my professional code to say, 'I can't provide that service but I will ensure that someone will provide it for you'. It is not just a case of saying, 'I can't provide that service. Go away and find somebody else'. That is not adequate or appropriate. Therefore, if there is any reason I don't do the right thing by my professional code, the consequences to me are brought back to me by my professional organisations. They don't need to be brought back by some sort of legal obligation because I*

[104] H. Lord., op. cit., pp. 85-86.
[105] Ibid., p. 87.

> *have my professional obligation that is predicated by my professional code of behaviour. The whole issue of conscientious objection, I find, may be unnecessary in this legislation*.'[106]

Mr Michael Stokes suggested that the clause was inconsistent with medical codes of practice.

> '*… it seems to me that it is inconsistent with the codes of medical ethics that I have looked at, including the AMA code. The one under the national health practitioners' law also seems to be inconsistent. That one imposes a duty on the conscientious objector not to impede treatment. That is a negative duty not to impede, which this has converted into the positive duty to refer. The only one which might give some support to this is the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. They have two relevant provisions. One is that in general the conscientious objector should refer, which seems to support this position, but there is another provision that you should not have to do anything to which you have a conscientious objection. It is not quite sure which prevails because you could read the two as saying if you have a conscientious objection to referring then you do not have to do that. So I do not see too much support for this provision. It seems to go beyond the codes of ethics that I have looked at*.'[107]

There was some concern expressed about the meaning of the word "refer", with some witnesses suggesting it meant a formal written referral would be required. Archbishop Adrian Doyle outlined the basics of this issue when he told the Committee:

> '*The common understanding of referral when you get a referral from your doctor is that he is referring you on to somebody who is going to do the kind of thing that he accepts and that you believe you need. This seems to be just tinkering around a bit and saying it is 'refer', but in another sense. The common sense, I think, is the understanding that you get referred to a specialist because he or she is going to do the things that you specifically are looking for and need*.'[108]

Dr Beth Mulligan also raised concerns about this issue.

> '…. *I cannot refer patients to another GP, for example. I can advise that they go and see another GP, but I cannot refer a patient in that situation. The term 'referral' probably has been applied fairly loosely*

[106] B. Mulligan, op. cit., pp. 35-36.
[107] M. Stokes, op. cit., p. 12.
[108] A. Doyle, op. cit., p. 10.

> *historically, and if the term is to be put into any sort of legislative framework it will need to be defined*.'[109]

On the other hand, Dr Sally Cockburn suggested that the Bill does not require a formal written referral in the traditional sense used by medical practitioners.

> '*I also think there may have been misunderstanding about the word referral. From my reading of the bill it does not require any formal, clinical structured sort of referral. More importantly, it is not required that doctors, as I said, refer to abortion providers - just to a practitioner who can give all-options information*.'[110]

Ms Susan Fahey stated that the meaning of "refer" in the Bill was not the formal medical meaning of refer.

> '*Maybe the word 'refer' is one of those things where medicine and law have collided a little bit. 'Refer to' means to give them a pamphlet, if that's how you want it. I do not think you need to put a definition in there but you could say 'hand them a pamphlet.' Talking to a few doctors, they see 'referral' as pulling out the pad or getting on the computer. I think it might be the AHPRA code - I know Audrey Mills gave everyone a copy at the briefing - that spells out what 'refer' can mean, and it would not be outside of that. Maybe it is a bit of education saying, 'You understand "refer" as breaking out the referral pad and writing something down. You don't need to do that. You simply need to give someone this brochure and that would be a referral for the purposes of the legislation*.'[111]

Ms Fahey went on to expand on the issue, while confirming her view that it should remain in the Bill.

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

[109] B. Mulligan, op. cit., p. 45.
[110] S. Cockburn, op. cit., p. 51.
[111] S. Fahey, op. cit., p. 80.

> *understanding is that there is a varying level of understanding or acceptance as to what that word could mean for them. As a lawyer, I believe it is the best word for everybody because lawyers understand what the word 'refer' is, the general public understands what the word 'refer' is. The problem, obviously, is with the doctors where there is a varying level of understanding. If you felt you really needed to, you could put something in there to say, 'This is what "refer" means for the purpose of this bill'. I think that's overcomplicated and unnecessary. With a bit of education there could be better understanding of it. I don't believe it is problematic but it comes down to people's understanding of it. I accept that some medical practitioners have an issue with it. I do think the provision has to stay there, though*.'[112]

Dr Craig White also acknowledged the different meanings of "refer" but said it was the most appropriate word to use.

> '*I know there has been a bit of discussion about this over time. It may not be the perfect word, but it was seen to be the most useful and helpful one. The medical board's code of conduct distinguishes between three types of involvement of others in the care of the patient. It distinguishes between 'delegation', which is the doctor asking another provider to provide care on the doctor's behalf, whilst they retain overall responsibility for the patient's care. For example, a specialist in the hospital delegating day to day care to the more junior doctors. There is 'handover', which involves transferring all responsibility to another health care professional, such as would happen between doctors when they finish a shift, or a patient leaves a practice and they go to another practice - you would expect a handover at that transition point. The third category is to 'refer', which is defined as sending a patient to obtain opinion or treatment from another health care professional. It usually involves the transfer, in part, of responsibility for the patient's care, usually for a defined time and for a particular purpose*.'[113]

The Committee is aware that there has been one case dealt with in Victoria by the Performance and Professional Standards Panel of the Medical Council of Australia, where a medical practitioner was found to have breached the requirement to refer in the *Victorian Abortion Law Reform Act* 2008.

[112] Ibid.
[113] C. White, op. cit., pp. 19-20

According to a Victorian newspaper, another case of non-referral, in this case for sex selection, is currently being considered by the Panel in Victoria.[114]

The relevant section of the Victorian Act states:

> **'***8. Obligations of registered health practitioner who has conscientious objection*
>
> *(1) If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must-*
>
> *(a) inform the woman that the practitioner has a conscientious objection to abortion; and*
>
> *(b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.*
>
> *(2) Subsection (1) does not apply to a practitioner who is under a duty set out in subsection (3) or (4).*
>
> *(3) Despite any conscientious objection to abortion, a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.*
>
> *(4) Despite any conscientious objection to abortion, a registered nurse is under a duty to assist a registered medical practitioner in performing an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman*.'[115]

In the case that has been dealt with, a complaint was made against the doctor for stating that should a relevant situation present itself, due to his conscientious objection to terminations, he would not be able to comply with s 8 of the Act, although he would comply with the provisions of the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

The relevant section of that Code states:

> **'*2.4 Decisions 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:*

[114] M. Devine, *Herald Sun*, 5 October 2013, http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/story-fni0ffsx-1226733458187, viewed 6 November 2013.
[115] *Abortion Law Reform Act 2008* (Vic), s8.

…

2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.'[116]

The Performance and Professional Standards Panel found that the doctor had not, by his own admission, complied with the requirements of the law and cautioned him that he must meet his obligations under the law. It should be noted that the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* states that:

'*This code is not a substitute for the provisions of legislation and case law. If there is any conflict between this code and the law, the law takes precedence*.'[117]

According to the Victorian Branch of the Australian Medical Association, the Panel, concluded that:

'*… the word "refer" under the [Victorian] legislation requires that, 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 the doctor provides the patient with the name of a non-objecting medical practitioner or health service* ***such as an established family planning centre*** *or an appropriately accredited abortion clinic*.'[118] [emphasis added]

Finding 12:

The Committee finds that medical practitioner conscientious objection is also covered by codes of practice as established under the *Health Practitioner Regulation National Law Act* 2009.

[116] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, 1 July 2010, pp. 3-4.
[117] Ibid, p. 1.
[118] Australian Medical Association (Victoria), *Vicdoc*, June/July 2013, p. 15.

Finding 13:

The Committee finds that this clause differs from the AHPRA codes of practice as it obliges practitioners to facilitate access to further care rather than not impede access to treatments that are legal.

Finding 14:

The Committee finds that the Bill, as drafted, prevents a medical practitioner, with a conscientious objection to terminations, from referring a woman to anyone other than another medical practitioner.

Finding 15:

The Committee finds that it would be appropriate for a medical practitioner to be able to refer a woman to other prescribed services.

Counsellors

This clause attracted a large amount of evidence, with many witnesses expressing concern about one of more aspects in it. Some witnesses expressed reservations about the scope of the clause, especially in relation to the definition of counsellor which appears to include anyone who might counsel or provide advice to a woman, whether she is pregnant or not, about a termination or any pregnancy options. Others suggested that the clause was necessary because allegedly, some counsellors had used their position to harass and berate women who sought information about a termination, based on the counsellor's religious or moral views.

For example, Professor Nicholas Tonti-Filippini, representing the Ad Hoc Inter-Faith Committee said:

> '*Your question was about other people doing counselling and the issue of the unpaid and voluntary counsellors. The legislation seems to be incredibly broadened in that respect. It would pick up people like ministers of religion giving advice, which means that a woman might go to a minister of religion to hear what the minister of religion has to say, knowing full well the view that the minister of religion would have but wanting to hear that view. This now makes that minister of religion obliged to refer them straight on, so the woman doesn't get the range*

of views she might have been seeking. It is a very strange provision, I think, to interfere with relationships in that way.'[119]

Dean Richard Humphrey made a similar point in his evidence to the Committee:

'*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*.'[120]

He also said that:

'*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*.'[121]

Pastor Matiu Chamberlin, appearing on behalf of the Australian Christian Lobby, was also concerned about this issue.

' … *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*.'[122]

Dr Craig White told the Committee that priests would only be covered by the obligation to refer if they were providing pregnancy options advice.

'*It depends on the context of what they were doing. Providing information about pregnancy options advice would bring them under*

[119] N. Tonti-Filippini, *Transcript of Evidence*, 30 July 2013, p. 7.
[120] R. Humphrey, op. cit., p. 15.
[121] Ibid., p. 16.
[122] M. Chamberlin, *Transcript of Evidence*, 3 September 2013, p. 52.

> *the legislation. If they were counselling around issues of faith or religious beliefs, that would be completely separate. It is not intended in any way to cut across that relationship which has its own special qualities. If a parish priest said, 'I'm going to counsel you about your pregnancy options, terminations' and so on, it brings them under the act*.'[123]

His colleague, Ms Cherie Stewart, said:

> '*It might come down to how the priest is holding himself out because the definition of counsellor means a person who holds himself or herself out as a provider of a counselling service. There is a distinction between, 'Hello, I'm Mr Smith, a counsellor. I've got my shingle out the front, come and talk to me' versus, 'Hello, I'm Priest Smith, come and talk to me about the teaching of this faith'. I am not sure it could be said that the latter is holding themselves out to provide a counselling service as such. There is counselling that goes on but it is not the general. …. That hinges on the counselling. Have I put my shingle out saying, 'Hello, I am a counsellor come and talk to me about any issue and I will give you unbiased and impartial advice,' or am I hanging my shingle out to say, 'Hello, I am a priest of whatever and come and talk to me about.'*'[124]

Mr Eric Lockett raised his concern that the purported aim of ensuring a pregnant woman has access to advice about the full range of pregnancy options was undermined by solely focussing on those who have a conscientious objection to terminations.

> '*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*.'[125]

Mr Lockett also criticised the level of the penalty for counsellors with a conscientious objection who fail to refer clients to another counsellor:

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[123] C. White, op. cit., 23 September 2013, p. 12.
[124] C. Stewart, op. cit., 23 September 2013, pp. 12-13.
[125] E. Lockett, op. cit., p. 62.

> '*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*.'[126]

Mrs Pat Gartlan, representing the Catholic Women's League, spoke to the Committee on a similar theme.

> '*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*.'[127]

However, as mentioned previously, evidence was received that supported the clause as a means of ensuring women were given full and unbiased advice without any pressure or criticism from a counsellor.

Ms Georgie Ibbott told the Committee that:

> '*In our experience we have seen a number of clients who have not been provided with adequate information in relation to this, and their medical practitioner or counsellor has expressed a personal view which, in these terms, is a conscientious objection but has not been stated as such. This part of the bill is really crucial to make sure that women have the opportunity to receive all the information so they can be empowered to make their own decision. Again, we've seen women who have not been given all the information and don't feel empowered*

[126] Ibid., p. 61.
[127] P. Gartlan, op. cit., p. 34.

> *to make that decision. They have had the views of a medical practitioner or counsellor imposed on them*.'[128]

Similar evidence was given Ms Cait Calcutt, representing Reproductive Choice Australia and Children By Choice.

> *'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*.'[129]

Concern was expressed by other witnesses about the requirement for counsellors with a conscientious objection to refer to another counsellor who does not have such an objection. It was suggested that this referral must take placed immediately the counsellor becomes aware that the woman being counselled is considering a termination. There was also concern about the level of knowledge that counsellors would have about the beliefs and practices of other counsellors, particularly whether or not they held a conscientious objection to terminations.

Ms Pnina Clarke, Senior Counsellor with Pregnancy Counselling and Support Tasmania (**PCST**), told the Committee that the requirement to refer clients to another counsellor would cause the closure of their service.

> '*Should the current bill under inquiry become law, we would have to close our counselling service because we are a life pregnancy counselling agency and, as such, our counsellors hold a conscientious objection to referring directly to an abortion provider or indirectly to another counsellor who will do so. I want to stress that having a conscientious objection does not affect the professionalism or efficacy of our service to anyone considering an abortion*.'[130]

Ms Clark went on to explain why she held this view.

> '*I have shown this to someone who is no longer practising and she said, 'No, you can't counsel because according to this you have a conscientious objection'. It's not at the end of the counselling process that you have to refer, here it doesn't say that, or if you cannot counsel, full stop. Perhaps if we had legal advice that this was not so, we might be more comfortable*.'[131]

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[128] G. Ibbott, op. cit., p. 83.
[129] C. Calcutt, *Transcript of Evidence*, 3 September 2013, p. 71.
[130] P. Clarke, *Transcript of Evidence*, 30 July 2013, p. 17.
[131] Ibid., p. 33.

She also explained that current practice at PCST was for clients seeking a termination to be advised to contact a medical practitioner.

> '*At Pregnancy Counselling and Support we do not give advice. Our counsellors do counselling and this is a process. It takes into account the many issues that may be of concern to the woman. The only time we advise is when the woman has issues that are of a medical or legal nature. In these instances we do advise her to consult with a qualified and registered practitioner in these fields. Our counsellors do not have medical or legal training. The suggestion to seek the advice of those who are so trained is part of our duty of care to our clients. We consider that the abortion procedure is a medical issue and needs a qualified and registered medical practitioner's advice*.'[132]

Ms Clark said the requirements of this clause would not allow that to happen and he clause also requires referral to another counsellor who may not meet similar standards of care.

> '*If you consider that an abortion procedure is a medical issue, our current practice in keeping with our duty of care is to suggest that a woman who is seeking an abortion makes an appointment with a qualified medical practitioner of her choice. Such a practitioner is able to provide her with a medical assessment of her personal health situation, give her medical facts on abortion procedures, as well as any side effects and dangers, facilitating an informed consent. With section 7(3) being enacted, this process will no longer be in place. Counsellors will be required to refer women seeking abortions to other counsellors who may or may not uphold a similar standard of care for our clients as we do. So our counsellors would not be able to say, 'This requires a medical opinion'. We will have to just refer them to other counsellors and we don't know what their standards are. This is a concern for our duty of care to our clients*.'[133]

Dr Brigid McKenna, appearing on behalf of the Catholic Women's League, suggested that a woman seeking a termination should be referred to a medical practitioner by a counsellor, rather than to another counsellor.

> '*… 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*

[132] Ibid., pp. 17-18
[133] Ibid., p. 19.

> *even a referral; the only advice that ought to be given is that that woman goes back to see her general practitioner*.'[134]

The other significant concern raised in relation to counselling was the lack of legally enforceable regulation of counsellors. As Ms Lisa McIntosh, representing the Australian Health Practitioner Regulation Agency (**AHPRA**), told the Committee:

> '*That is where we come into some issue there because counsellors are currently not regulated, so they do not fall within the remit of the national law and I am not aware of any code. I am sure they probably have that but counsellors do not fall within the remit of the national law and medical practitioners do*.'[135]

Dr White explained why counsellors have been included in the Bill:

> '*I think the first time that we came to talk with the committee there was a discussion with someone who spoke before us, that counsellors are not one of the regulated professions. All psychologists can be counsellors. Psychologists are registered but not all counsellors are psychologists. Anyone can call themselves a counsellor. It was intended to place an obligation on anyone who held themselves up as providing a service which could be construed as counselling. That was the intent of that being so broad*.'[136]

Ms Terese Henning expressed the view that the requirement for counsellors to refer was a low level duty being imposed on them, especially as the profession was not regulated in the same way as medical practitioners:

> '*In this case the argument is that doctors are covered by a professional organisation and therefore this requirement in the legislation is not needed. For counsellors, on the other hand, there is no professional organisation which deals with them and their misconduct and therefore this is a requirement that we need to impose in law. That means that in this instance some form of discrimination is necessary and it's only a minor form of discrimination in fact because it doesn't require counsellors to actually participate in any kind of termination - they wouldn't anyway. It simply requires them to refer on to somebody who can provide the information that they are not willing to provide. It's a very low-level duty that we are imposing on them*.'[137]

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[134] B. McKenna, *Transcript of Evidence*, 3 September 2013, p. 43.
[135] L. McIntosh, *Transcript of Evidence*, 23 August 2013, p. 15.
[136] C. White, op. cit., 23 September 2013, p. 12.
[137] T. Henning, op. cit., p. 4.

However, Mr Darren Carr told the Committee that counsellors did have a professional organisation that required a certain standard of conduct.

> '*No, I do not think it is in AHPRA's gun but there are counselling professional bodies and one of my closest friends, godfather to my children, is a Christian counsellor and there are professional bodies, there are standards and ethical standards to which they can and should subscribe. Counselling is a skill like others and people providing counselling should be appropriately credentialed and appropriately qualified. We are promoting the significant training in the community sector so that community mental health workers are appropriately skilled and credentialed. Likewise people counselling in such a difficult area as this, we believe, should be governed by a regulation and set of ethical standards to which they are held accountable. It's not appropriate for organisations to be doing counselling per se or to call something 'counselling' where people have no qualifications or standards to which they have no training*.'[138]

Finding 16:

The Committee finds that "counsellors", as a collective group, are not regulated under any national or state-based regulatory body.

Finding 17:

The Committee finds that the definition of "counsellor" is broad and, despite assertions to the contrary, unintended classes of persons may fall within its parameters.

Finding 18:

The Committee finds that the maximum penalty applying to counsellors, as currently prescribed, may be excessive.

Finding 19:

The Committee finds that the Bill, as drafted, prevents a counsellor, with a conscientious objection to terminations, from referring a woman to anyone other than another counsellor.

[138] D. Carr, op. cit., p. 34.

Finding 20:

The Committee finds that it would be appropriate for a counsellor to be able to refer a woman to other prescribed services.

Finding 21:

The Committee notes that the comparable Victorian legislation, the *Abortion Law Reform Act* 2008 (Vic), does not regulate counsellors in any way.

Referral in practice

There was also contention among witnesses on exactly how medical practitioners and counsellors with a conscientious objection to terminations could refer to another practitioner who does not have such an objection. It was suggested that this requirement could contravene freedom of conscience by requiring a doctor or counsellor to be complicit in a termination.

For example, Dr Brigid McKenna told the Committee that '*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*.'[139]

Dr McKenna explained further:

> '*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*.'[140]

Dr Helen Lord expressed a similar view.

> '*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*.'[141]

However, Ms Audrey Mills said a referral to another medical practitioner, or in the case of a counsellor, to another counsellor, would not necessarily result in a termination being carried out.

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[139] B. McKenna, op. cit., pp. 38-39.
[140] Ibid., p. 41
[141] H. Lord, op. cit., p. 86.

> '*Remember that we are talking about not necessarily a referral which will result in the procedure; it is referral to a medical practitioner who will then have to discuss whether in fact this is the right option for you. There has been much emphasis on informed consent in the last 10-15 years for medical practitioners; they are now very aware, because they have been sued numerous times for other procedures, that if they don't carefully go through informed consent outlining all the options and outlining all the risks, that they won't have informed consent and that they could be liable to civil legal action and of course it is confirmed in the codes that apply to them. Referral in these circumstances may not necessarily result in the procedure being undertaken but it does result in at least the woman being given information about what are the risks, what are her options which then enable her to make a decision, and a decision which the doctor is part of, too. In some circumstances they might not be prepared to do the procedure*.'[142]

Ms Mills went on to point out that:

> '*The referral in the bill, subsection (2), refers to 'must refer the woman to another medical practitioner who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations'. The reality is, this will be played out by doctors referring to services like a planning service. But the provision itself means that the doctor who is referring needs to be at least of the view that the doctor at Family Planning or whatever other services referred to, doesn't have the same conscientious objection*.'[143]

Prof. Caroline de Costa told the Committee that:

> '*I don't think the doctor fulfils their obligations if they simply say, 'I think that you can find this information elsewhere'. Particularly for women in remote and rural areas, it may be very difficult to know what they should do next. Now they have been turned away from this doctor, and they are not sure what the situation is because they have never had to think about it before. …. They need to be referred, at the very least, to some telephone counselling service or some place which will give them the information that is available to the women of the particular state or area. These services are legally and safely available and you can make your decision yourself about whether you are going to choose someone*.'[144]

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[142] A. Mills, op. cit., pp. 13-14.
[143] Ibid., p. 14.
[144] C. de Costa, op. cit., p.8.

Dr Craig White said:

> '*The writing of a referral is, as much as anything, a requirement of the Health Insurance Commission, so that Medicare benefits are payable for reimbursement. That's not an issue we're trying to deal with in here. We are saying if there is an aspect of care you're unable, for whatever reason, to provide - your skills don't extend that far, your hands have gotten too shaky, whatever the reason - but you have a patient who would benefit from something you can't provide, then you would tell them where they could get that service. It is a relatively low threshold for someone to get over, particularly when you're not sending someone to a 'termination' clinic, where all they do is talk about terminations - where they greet you with, 'Hi, you're here for your termination'. There are no services like that. They're all about, 'What are your options?'. I feel, on balance, that it's an appropriate thing to do*.'[145]

Ms Susan Fahey also said that a referral did not mean that the person making the referral would be complicit in a termination:

> '*If a doctor has a conscientious objection and is having to refer to another medical practitioner that they reasonably know or think would not have a conscientious objection and you wondered about the inclusion of the word 'service' instead. What I would say to that is that you can feasibly give someone a pamphlet to Family Planning because they have counsellors, they have medical practitioners. The reason that you need to refer to someone that you reasonably think would not have a conscientious objection because if you have an objection - say I'm a doctor who has a conscientious objection and I refer to Ben who I know has a conscientious objection, the patient winds up still in the same situation. They do not have someone who can speak to them objectively. I think sometimes there is an assumption that a doctor who does not have a conscientious objection to termination of pregnancy is therefore somehow pro-abortion and that is not generally the case. It is just someone who feels that they can actually discuss it*.'[146]

She went on to say that:

> '*If a doctor has a conscientious objection to referring to Family Planning it means that service will not provide the terminations, that absolves them from the direct link, which is what some of the doctors*

[145] C. White, op. cit., p. 20.
[146] S. Fahey, op. cit., p. 76.

> *have expressed, and because Family Planning has doctors who work there, then that covers both bases because a lot of the nurse practitioners are very adept and able and make it a practice to provide that advice, but sometimes you need that medical advice as well*. *… It is very clear. What doctors are being asked to do in this legislation is nothing outside of what they should be doing. If they are doing what they are supposed to do in practice, they would be doing it*.'[147]

Finally in relation to this clause, concerns were expressed regarding the requirement for a medical practitioner or a counsellor with a conscientious objection to conclude a consultation immediately they became aware that the woman was seeking a termination or information about a termination. It was suggested that they would also be required to immediately refer the woman to another medical practitioner or counsellor, as the case may be.

The Victorian Branch of the Australian Medical Association has advised its members that its policy position is that a conscientious objection should be considered a conflict of interest. It states that:

> '*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 you have a conflict. At this point, it would seem that you can refer the patient to a Family Planning clinic*.'[148]

Dr Helen Lord was one who raised this matter:

> '*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*

[147] Ibid., p. 78.
[148] Australian Medical Association (Victoria), op. cit., p. 15.

> *to take action against a doctor, even though the doctor is abiding by AHPRA's own code of conduct*.'[149]

However, this interpretation of the clause was disputed by Dr Craig White who told the Committee that:

> '*There is no one standing over anyone's shoulder saying that the moment that you become aware, you must do this and three milliseconds is too late. How far an individual practitioner can engage with the kind of helpful discussion you have described - because it is an important relationship - is also going to be a personal choice. There will be some who hold stronger views than others and they may not be prepared to go as far as people who hold a set of views less tightly. So there is a degree of personal choice on the part of the practitioner about whether they see themselves as having conscientious objection and how far that plays out*.'[150]

As Dr White explained earlier in his evidence at that hearing:

> '*To come at this from another perspective that may or may not be helpful, we are trying to make sure that a woman doesn't get caught thinking she is being exposed to all the options with all the implications laid out in an even-handed way, when she is only getting part of the picture. If women know what sort of advice or counselling they are going to get from their priest and they are happy with that, that is fine. We are just trying to protect those who find themselves at risk of being caught*.'[151]

Finding 22:

The Committee finds that the word "refer" has a particular meaning for medical practitioners, but, the word "refer" in this Bill has the ordinary meaning of the word.

Finding 23:

The Committee finds that the obligation to refer would be satisfied by a counsellor or a medical practitioner providing the contact details of a service or provider e.g. in the form of a prescribed list or pamphlet.

[149] H. Lord, op. cit., p. 86.
[150] C. White, op. cit., 23 September 2013, p. 17.
[151] Ibid., p. 16.

Finding 24:

The Committee finds that the obligation to refer does not require such referral to be made immediately upon the woman raising the issue of termination. Accordingly, the practitioner/counsellor is not precluded from discussing other pregnancy options with the woman prior to referring her.

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Clause 9 Access zones

(1) In this section –

access zone means an area within a radius of 150 metres from premises at which terminations are provided;

distribute includes –

(a) communicate, exhibit, send, supply or transmit to someone, whether to a particular person or not; and

(b) make available for access by someone, whether by a particular person or not; and

(c) enter into an agreement or arrangement to do anything mentioned in paragraph (a) or (b); and

(d) attempt to distribute;

prohibited behaviour means –

(a) in relation to a person, besetting, harassing, intimidating, interfering with, threatening, hindering, obstructing or impeding that person; or

(b) a protest in relation to terminations that is able to be seen or heard by a person accessing, or attempting to access, premises at which terminations are provided; or

(c) footpath interference in relation to terminations; or

(d) recording, by any means, a person accessing or attempting to access premises at which terminations are provided without that person's consent; or

(e) any other prescribed behaviour.

(2) A person must not engage in prohibited behaviour within an access zone.

Penalty: Fine not exceeding 500 penalty units or imprisonment for a term not exceeding 12 months, or both.

(3) A person must not publish or distribute a recording of another person accessing or attempting to access premises at which terminations are provided without that other person's consent.

Penalty: Fine not exceeding 500 penalty units or imprisonment for a term not exceeding 12 months, or both.

(4) If a police officer reasonably believes a person is committing or has committed an offence –

(a) under subsection (2) that involves recording, by any means, a person accessing or attempting to access premises at which terminations are provided without that person's consent; or

(b) under subsection (3) –

the police officer may –

(c) detain and search that person; and

(d) seize and retain the recording and any equipment used to produce, publish or distribute the recording found in the possession of that person.

(5) If a person is convicted or found guilty of an offence under subsection (2) or (3), any item seized under subsection (4) is forfeited to the Crown and is to be destroyed or disposed of in a manner approved by the Minister administering the *Police Service Act 2003*.

(6) If a police officer reasonably believes a person is committing or has committed an offence under subsection (2) or (3), the police officer may require that person to state his or her name and the address of his or her place of abode.

(7) A person must not fail or refuse to comply with a requirement under subsection (6) or, in response to such a requirement, state a name or address that is false.

Penalty: Fine not exceeding 2 penalty units.

(8) A police officer making a requirement under subsection (6) may arrest, without warrant, a person who fails or refuses to comply with that requirement or who, in response to the requirement, gives a name or address that the police officer reasonably believes is false.

This clause was another which was contentious and which attracted comment from a number witnesses. Those who supported the clause asserted that it would protect women accessing termination clinics to undergo a medical procedure that is currently legal in Tasmania from abuse, harassment and stigmatization.

Those who opposed it suggested it was an attack on freedom of speech and that police already had sufficient powers to deal with such offences.

Prof. Caroline de Costa told the Committee that she had been subject to harassment and was aware that it was a major problem in Victoria.

> *'Personally I have been harassed at times, although it has not been a big problem in Queensland anyway, I think. I am certainly aware it has been a major problem since the fertility clinic in East Melbourne opened since 1972 and I would very much like to see you passing this exclusion zone legislation because it is very inappropriate that women who have made a health decision for themselves are subjected to any kind of criticism from people who know nothing about them.'*[152]

Ms Terese Henning told the Committee that the aim of the clause was to protect women seeking a termination.

> '*As far as access to access zones are concerned, and we are now dealing here with the situation where we are trying to protect women who are accessing a facility to obtain a termination and we want to protect them from harassment, from abuse, from intimidation when they are attending these facilities, we say that the current provisions in the Police Offences Act don't go far enough and that we do need specific - and we have set out why clearly in our paper - protection for these women. I'm sure you have heard from women and from organisations who have dealt with women who have been harassed and intimidated when they have attempted to access facilities, and it is not something that they deal with easily after the event. It makes an event - and decisions which are incredibly hard and often very painful to make - far, far worse and way more difficult to live with. Let's face it, the point of the protest action outside these facilities is to try to prevent women from accessing them, is to try to prevent women from feeling safe in accessing those services. That is the point and people should not be able to behave in that pointed, intimidatory fashion and this legislation prevents that from happening. It does not prevent protests from occurring, it simply constrains their location. The High Court is not going to overturn that. It's on all fours with its earlier decision in the Adelaide case. That would be on all fours. Factually it might be slightly different - it doesn't matter. The courts are dealing all the time with slightly different fact cases, they apply the same principles and*

[152] C. de Costa, op. cit., p. 7.

> *exactly the same principles would apply here. That's very clear. I do not think that there would any constitutional difficulties with this law*.'[153]

Ms Georgie Ibbott said the clause did not infringe people's right to demonstrate.

> '*Section 9 in relation to access zones - any woman dealing with an unplanned pregnancy and facing a decision on how to address her unplanned pregnancy, and one who decides to proceed with a termination, is obviously already going through a very difficult and traumatic time and is particularly vulnerable. This section of the legislation is very important to make sure that that woman is free from harassment and stigma as she attempts to exercise her decision around her own sexual and reproductive health. Importantly, it doesn't remove the right to protest but it does ensure that we have some protections for women at a particularly vulnerable and distressing time, and we see that as really crucial to protect those women as much as possible*.'[154]

Assoc. Prof. Jo Wainer told the Committee that she had been subjected to harassment and threats and gave examples of other incidents.

> '*I want to turn now to why access zones are needed. The reason I spoke about my experience of being harassed and threatened is to set the background for why access zones are needed, because what goes on outside clinics and providers is really horrific. I would love for you to have experienced what goes on so you know what you're dealing with, and I'm probably one of the people who can tell you that because it has happened to me. When I was working in rural Victoria there were two gynaecologists at that hospital which was the regional health centre, and neither of them wanted to do terminations but occasionally they would. Rural communities are small and word would get out and the hospital would be picketed. The staff were really intimidated by that because there was nowhere else for them to go. This was their community turning against them. It was very difficult for the staff and the consequence was a shutdown of any access to services, similar to what happened in Bendigo*.'[155]

Assoc. Prof. Wainer elaborated on her personal experiences.

> '*I have been at the fertility control clinic when it has been surrounded by protestors. …. We've had that clinic blockaded so that women had*

[153] T. Henning, op. cit, pp. 4-5.
[154] G. Ibbott, op. cit., p. 89.
[155] J. Wainer, op. cit., p. 40.

> *to scramble across the bodies of the people in the blockade. I have seen, and I'll never forget this, a young couple who had driven to Melbourne from the country. This was probably the biggest thing they had ever done in their life. They'd found out they were pregnant, found out what to do about it, had come to Melbourne on their own, parked the car outside the clinic and were early for their appointment. We didn't have any security in place and their car was surrounded by demonstrators who were banging on the windows with placards and shouting, 'You're a murderer'. This couple were terrified and I was watching that man; he tried to care for his girlfriend and he couldn't protect her from that level of violence and hatred - people were spitting on them*.'[156]

She also pointed out that similar restrictions had been successful in other places.

> '*It has worked in Canada, it worked for the Royal Women's Hospital and it will work here as well so I beg you, please, keep your access zones*.'[157]

Mr Anthony Reckin, representing Marie Stopes International Australia, also gave evidence of similar protests at clinics operated by the organisation.

> '*As I said, we have 15 clinics and we get various levels of protesters. At Bowen Hills in Queensland, every day they have 40 people standing outside the clinics and that is very well publicised. In our Fairfield and Penrith clinics we have very young Muslim men that are very aggressive. They paint and use graffiti and put pamphlets all over people's cars and letter boxes and we have an AVO out against - … We have very good relationships with the police in most of our clinics and most of the time if we ring up and say we have an issue they will come and issue 'moving on' orders. But it is a big grey area. Certainly if other things are going on with the police at the time, it may not look like it is a priority but it is something that we struggle with. We spend a lot of our own time and legal resources to see how we, as a company, can stop it. …. We had an incident in Victoria about two months ago where envelopes of white powder were sent to head office and two of the clinics on operating days, so we had to shut down the clinics, and remove all of the staff and our clients. We had to have the drug people and the infectious diseases control people out. That was a pre-meditated act and, after September 11, to put something like white powder into an envelope is quite extreme*.'[158]

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[156] Ibid.
[157] Ibid., p. 41.
[158] A Reckin, Transcript of Evidence, 19 August 2013, pp. 65 & 66.

Ms Susan Fahey said protests were also taking place in Tasmania.

> '*We urge you to maintain the access sites. We think that the evidence is certainly there through Susie Allinson's research. I think her research found that just under 80 per cent of women who had crossed through or passed any form of protest, whether it was silent or not, had long-term lasting emotional and psychological impacts. We would urge you to maintain that. We think that it is a necessary inclusion. Just because we do not have hundreds of people standing outside the clinic - I think we have all seen the photos of the protestors - albeit silent but wrapped around the street around Michelle O'Byrne's office when the bill was first introduced. It is not necessarily something that will not happen to the clinic here. It was not something I would have expected to have seen - children on lawns with signs and people wrapped around, albeit silently, in Tasmania, but we have seen it and so I do not think it is a long stretch to say that could happen to a clinic here*.'[159]

Ms Tania Penovic also supported the clause, saying it struck a reasonable balance.

> '*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*.'[160]

Dr Helen Lord acknowledged the need to protect women from harassment but raised questions about the effectiveness of access zones.

> '*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*

[159] S. Fahey, op. cit., p. 76.
[160] T. Penovic, op. cit., p. 78.

> *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*.'[161]

Others rejected the clause on the grounds that it curtailed freedom of speech and it was also suggested that the clause may be unconstitutional. For example, Mr Michael Stokes told the Committee the clause was an attack on freedom of speech and that police had sufficient powers to deal with such behaviour.

> '*Section 9, access zones, is unnecessary in my opinion and in the opinion of my co-signatories because the Police Offences Act regulates most of these behaviours already. You have a particular problem here with the one about making a record, particularly a photographic record. If this bill goes through, police will not be able to use cameras to collect evidence where there is the likelihood they will photograph someone entering a clinic. You will not be able to use, as far as I can see, closed-circuit television. It is a blanket prohibition on making these records. The one in the Police Offences Act which seems to me to be much more sensible, is subject to sensible exceptions to allow police to use recording devices to gain evidence, to allow news to report and some other exceptions as well, but there is none here. My final objection to section 9 is that I think much of it is going to be held unconstitutional. There is an implied guarantee in the federal Constitution of freedom of political communication. I don't think there is any doubt at all that what a protestor is doing, considering terminations are a hot potato in the political issue, that a demonstration or a protest against termination would be a political communication. In a number of cases the High Court has been quite strong on the grounds that political communications can be offensive. They can be designed to insult and cause emotional distress, within reasonable limits. In the last case on that the court split 3:3 - three judges finding political communication can be offensive without any limits. The other three held that extremely offensive communications might be prohibited. It seems to me that that type of blanket ban on protest and demonstrations within a prescribed area is going to fail on any test as unconstitutional*.'[162]

[161] H. Lord, op. cit., p. 87.
[162] M. Stokes, op. cit., p. 13.

Archbishop Adrian Doyle said the clause infringed on freedom of speech.

> '*It is the right to have freedom of speech. The right to protest is one I think we all hold dearly, even though we may not be happy with the people who are taking up this right. People need to behave with respect and treat other people with dignity. Here in Hobart, I believe the Church of St Joseph's is within 150 metres of one of the locations where these practices take places. Father Gerald Quinn over many years has been one of the greatest defenders of human life protection. If he were to speak out in that church, according to the way I understand it, he could be in difficulty with the law. If the law is not going to be implemented or never going to be put into practice, I do not believe that is a very satisfactory state either. It is quite a unique situation that has developed here. It probably has no parallel anywhere else. It is our belief that if we uphold the right of freedom of speech and freedom to protest, then this should not be part of this law in this particular case*.'[163]

Dean Richard Humphrey presented a similar view on behalf of the Anglican Church of Tasmania.

> *'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.'*[164]

[163] A. Doyle, op. cit., p. 6.
[164] R. Humphrey, op. cit., p. 17.

Finding 25:

The Committee finds that access zone provisions are justified because women and staff have been subject to harassment, physical violence, vilification and intimidation when attending premises at which terminations are provided.

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Clause 10 Proceedings

(1) Proceedings for an offence against this Part may only be instituted by –

(a) a police officer; or

(b) the Secretary of the Department or a person authorised in writing to institute proceedings by the Secretary of the Department.

(2) Proceedings for an offence under this Part must be instituted within 12 months after the date on which an offence is alleged to have been committed.

The Committee questioned the Department of Health and Human Services in relation to the period within which proceedings must be instituted, suggesting three years might be more appropriate. Ms Cherie Stewart responded to the suggestion by saying '*I have no objection to it being three years*.'[165]

The Health Complaints Commission in Tasmania allows for complaints in relation to health matters to be made within two years of the incident.[166]

Finding 26:

The Committee finds that the appropriate timeframe in which to allow the institution of proceedings is that generally allowed for health complaints, being two years.

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[165] C. Stewart, op. cit., 23 September 2013, p. 27.
[166] http://www.healthcomplaints.tas.gov.au/making_a_complaint/frequently_asked_questions#four accessed on 5 November 2013

Clause 11 Infringement notices

(1) In this section –

infringement offence means an offence against this Part that is prescribed by the regulations made under this Act to be an infringement offence.

(2) A person referred to in section 10(1) may issue and serve an infringement notice on a person if he or she reasonably believes that the person has committed an infringement offence.

(3) An infringement notice may not be served on an individual who has not attained the age of 16 years.

(4) An infringement notice is to be in accordance with section 14 of the *Monetary Penalties Enforcement Act 2005*.

(5) The regulations made under this Part –

(a) may prescribe, for infringement offences, the penalties payable under infringement notices; and

(b) may prescribe different penalties for bodies corporate and individuals.

The Committee questioned the Department of Health and Human Services in relation to the implementation of this clause.

Dr Craig White told the Committee that:

> '*You would hope very rarely. It seems to have become standard drafting practice to include a provision for infringement notices in primary legislation. Giving effect to that would require making a regulation that permits the issuing of infringement notices. It is hard to say how many there are, because we do not know what the final shake of the legislation looks like, but the issue that inevitably would give everyone reassurance, is that they would have to come back through parliament and be tabled, before they became part of the regulations. That is the downstream issue for consideration. …. From my perspective, no, and I am not aware of anyone rushing around saying, let us order ten thousand infringement notices to use in the first year*.'[167]

[167] C. White, op. cit., 23 september 2013, pp 27-28.

Ms Cherie Stewart said:

> *'If the bill was passed in its current form there are only four offences in it, because we do not issue infringement notices for crimes under the criminal code. You have your counsellor failing to refer, a person engaging in prohibited behaviour in an access zone, publishing or distributing the recording, or failing to provide a name and address to a police officer. It would not be inappropriate for all of those to appear in regulations, allowing the issuing of an infringement notice. Bearing in mind, that does not necessarily mean an infringement notice will issue, but it is with the discretion of the enforcement officer to issue one, if it is at the lower end of the spectrum of offending. If somebody were a persistent offender, a decision might be to take the matter through the courts rather than deal with it via an on-the-spot fine. All regulations need to be tabled before the parliament, who can disallow, so there are checks and balances there. …. I suppose that the contentiousness of the issues might be a matter of perspective, but as I understand it, the issuing of infringement notices is also a less costly way of moving forward with an enforcement action, rather than commencing proceedings in court. The other thing to bear in mind is that a person can argue against an infringement notice and fight against it. The Monetary Penalties Enforcement Act regulates it and once you have paid it, you are effectively saying yes, I admit to this offence. If you decide to fight it, you can go down that path. It does not essentially shut off the option of it.'*[168]

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[168] C. Stewart, op. cit., 23 September 2013, p. 28.

PART 3 – CRIMINAL CODE ACT 1924 AMENDED

Clause 13 Principal Act

In this Part, the *Criminal Code Act 1924** is referred to as the Principal Act.

Clause 14 *Criminal Code* amended

….

(f) by inserting the following sections after section 178C:
….

….

178E. Termination without woman's consent

(1) A person who intentionally or recklessly performs a termination on a woman without the woman's consent, whether or not the woman suffers any other harm, is guilty of a crime.

Charge: Termination without woman's consent.

(2) No prosecution is to be instituted against a medical practitioner who performs a termination on a woman if the woman is incapable of giving consent and the termination is –

(a) performed in good faith and with reasonable care and skill; and

(b) is for the woman's benefit; and

(c) is reasonable having regard to all the circumstances.

(3) For the purposes of this section, ***woman*** means a female person of any age.

The Committee raised with the Department of Health and Human Services the meaning of the term "consent" in light of new Clause 178E Termination without woman's consent to be added to the *Criminal Code*.

Dr Craig White told the Committee that:

> '*The committee would like to discuss the rationale of the removal of informed consent from earlier drafts of the clause. Not through having been involved in earlier drafts but just from talking with people it appears that it was seen as a tautology, it was redundant to have the*

word 'informed', there was no change or shift in policy, it was just seen as 'consent' is by definition, 'informed' in the context of what we are talking about, and if you draw on the Criminal Code definition of consent, that implies free agreement, and if you look at the medical understanding you do not have consent unless it is informed. It is a key feature of the consenting process. The Medical Board's code of conduct takes you to the National Medical Research Council's guidelines on consent, and all about being informed. Something that my colleague advised me about is that referring to consent as 'informed consent' is the more common drafting approach, so that was a new fact, from my memory. The only time you move away from using 'consent', for example, in section 164 framework, is when you are trying to give a very different meaning to 'consent'. In section 164(5) of the Forensic Procedures Act, where it means consent after a police officer has made a certain request to provide certain information. We have gone back simply to the term 'consent' because we feel that it covers the need to provide information.'[169]

Ms Cherie Stewart told the Committee that:

'The definition of consent in the criminal code still sits with this framework because it is about free agreement. Any time that there is a free agreement you will not have that consent there for the criminal code. The medical understanding may or may not go a little further than the criminal code. The criminal code specifically provides that it is not free agreement if a person is reasonably mistaken about the nature or the purpose of the act, or if they are unable to understand the nature of the act. That probably draws in with it the element of being informed about what the act is about. Even if that were not the case in the medical context, you have the extra information here. At least as far as the criminal code goes, it has to be free agreement. From our perspective that still works, and we have the definition already in the criminal code for those, so that will come into play. It means informed in the medical context, so if it is under duress, and do not understand the nature of the act, that is not consent.'[170]

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[169] C. White, op. cit., 23 September 2013, p. 6.
[170] C. Stewart, op. cit., 23 September 2013, p. 7.

PART 5 – MISCELLANEOUS

Clause 17 Administration of Act

Until provision is made in relation to this Act by order under section 4 of the *Administrative Arrangements Act 1990* –

(a) the administration of this Act is assigned to the Minister for Health; and
(b) the department responsible to that Minister in relation to the administration of this Act is the Department of Health and Human Services.

Access to terminations in the public hospital system

A number of witnesses were highly critical of the fact that there was limited access to terminations in Tasmania's public hospital system. In relation to the numbers of terminations within the public hospital system, Mr Michael Pervan noted that:

> '*Around 70-80 TOPs* [terminations of pregnancies] *are done across the state every year on average and an additional 30 also in the private sector. Whether that is on par with comparable populations elsewhere, we don't know. It's not data that is easily attainable through public sources and it's not generally reported on because of the sensitivity surrounding it, and because of the presence of private clinics and accessing that private health service data in other states*.'[171]

Ms Kim Boyer, representing The Link Youth Health Service, was among those critical of the limited access to terminations in the public hospital system.

> '*I think you just heard from the previous witnesses that the issue of the failure of the public health system to provide access to women to terminations of pregnancy is a major issue and has been well before the formation of the state health organisations. I used to work in the health system and it's been an issue for quite a long time. It started with an issue of conscientious objection but it has become almost in the area of cost-cutting. It is regarded as a superfluous service. Our strong view is that the change in the legislation will further enable the health system to provide access to abortions or termination and appropriate counselling and clinical support that surrounds those, which at the moment is not available. I think we are the only*

[171] M. Pervan, *Transcript of Evidence*, 14 October 2013, p. 1.

> *jurisdiction in Australia where it isn't available and we think that is not appropriate*.'[172]

Ms Robin Banks told the Committee women were disadvantaged in relation to health care as a result of this limited access:

> '*Those disadvantages flow from the current significant barriers to the availability of pregnancy terminations locally and in the public health system. The fact that a person may need to go interstate or to access a private clinic certainly disadvantages women on low incomes and those who find it difficult to travel to the major urban areas*.'[173]

Ms Banks went on to say:

> '*If you remove* [terminations from the Criminal Code] *and put it into the proposed framework I would anticipate - and it has been the case elsewhere - that there is greater willingness to provide information and the medical procedures at a broader range of healthcare providers, including public hospital and elsewhere. There is less need for a women then to go to a private clinic or interstate to access the same healthcare services. Criminalisation has a stifling effect. People are afraid of being prosecuted and there have been prosecutions, not so much here but interstate, where people had anticipated it wouldn't happen and then somebody was prosecuted which then makes everybody afraid. Even people who have been operating well within the law and the current restrictions become more fearful of the consequences of participating in terminations. So it's a broader impact than just the difference between the 16 weeks or not. The fact that it is within criminal law has a particular effect on people's behaviour*.'[174]

Mr Michael Pervan also told the Committee that fear of prosecution among medical practitioners was a factor within public hospitals:

> '*I know from my time at the Royal that the problem wasn't so much funding or access to a theatre or appropriate facility. It was more the concerns of the staff and, once again, that comes in two directions. The first is that there is a cultural fear or a concern that they might be liable to prosecution. There is probably some evident mythology around people who have been prosecuted. …. There is also a very strong conscientious objection for religious and other reasons why staff and, in my limited experience, particularly nursing staff, object to participating in the procedure. It's quite a complex social and medical issue to try to have delivered in a large teaching hospital,*

[172] K. Boyer, *Transcript of Evidence*, 19 August 2013, pp. 16-17.
[173] R. Banks, op. cit., p. 40.
[174] Ibid., p. 48.

> *notwithstanding it's one of those procedures which has to be balanced with a funding cap and an activity cap so the more TOPs are done the less of something else would have to be done. That would be my general observation of the situation*.'[175]

However, Mr Pervan also stated that a policy direction from the Minister for Health and Human Services would allow terminations to be carried out in Tasmanian public hospitals.

> '*That would be as straightforward as a policy direction from the minister. There is provision under the Tasmanian Health Organisations Act to provide such direction. My advice to the minister would be that that would be entirely appropriate but I prefer to see the procedure as part of a plan that would include all sorts of allied services around the counselling necessary for a therapeutic environment. Given the nature of the procedure, I would be reluctant to go ahead and just purchase an increased number of TOPs at the Royal and have it managed in the same way as a remediation of a hernia.*'[176]

Mr Pervan also suggested that the State could contract private clinics to undertake terminations on behalf of the public system.

> '*It would depend on the price and the volume that you are talking about for the procedure and the management of the case as opposed to just the procedure specifically. I can tell you from data that the cost of the procedure is about the same as dialysis, but that is not the service that is needed for the patient. There is certainly provision within the act to purchase from the private sector. I have been speaking to my old colleagues in Western Australia, who say that for the early-term terminations they have done much better in the private sector. The buildings are purpose built and they can have psychology and social work staff up on site. There is a need to link some of the mums in with social services for other medico-social support, so that can all be done within those environments. As the pregnancy progresses and can become more medically complex, you need a more complex and safe environment. Ultimately some have to be delivered within a teaching hospital and others can be delivered in a day surgery-type environment*.'[177]

Ms Kim Boyer also supported the need for terminations to be carried out in the most clinically appropriate setting.

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[175] M. Pervan, op. cit., pp. 1-2.
[176] Ibid., p. 2.
[177] Ibid., p. 3.

> '*In the distant past when they were provided in the public system they were provided in the gynaecology wards but in particular sessions, which enabled people who had conscientious objections not to be part of those sessions, and that seemed to be quite good. I'm not a specialist at organising clinical services but my view would be that you would let those providers determine which would be the best quality, best accessible, best type of service that could be provided from both the client's perspective particularly but also the clinician's perspective*.'[178]

Assoc. Prof. Jo Wainer told the Committee that the South Australian public hospital model for terminations was an effective system, but may not be appropriate for Tasmania.

> '*They are very complex questions about how public service and the public hospital does deliver that level of care and I think each hospital and health network will come up with its own solutions but there probably is not a single model that fits other than the model in South Australia which has had mandated public hospital delivery of abortion services since they changed their law in 1972. Their model was to set up a free-standing clinic within the hospital grounds and that way staff could self-select to work in that clinic and they would not encounter staff who would be hostile or in any way not supportive; that seems to have worked. It does concentrate services, though, and in Tasmania they do not have enough abortions to support a service like that properly*.'[179]

Ms Susan Fahey also supported the view that access to terminations should be available in the public hospital system.

> '*That, obviously, would be a matter for the health department because in any given time you could have a doctor in, say, the Royal who has a conscientious objection and they won't want to do it. Obviously, that should be supported, but then there should also be people employed who do not have that view because otherwise we have heard plenty of evidence of people being sent by organisations who are paying for people to go interstate and have terminations because they cannot access them here and that is a problem*.'[180]

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[178] K. Boyer, op. cit., p. 22.
[179] J. Wainer, op. cit., p. 46.
[180] S. Fahey, op. cit., p. 85.

Data collection and reporting

Doctors Michelle Williams and James Brodribb raised in their evidence the lack of data available in relation to terminations in Tasmania and the problems this caused.

Dr Brodribb told the Committee that:

> '*We don't have any data in Australia on the reasons for termination of pregnancy across the reproductive spectrum. In the United Kingdom there is a thing called 'extended perinatal mortality', where in fact they all register terminations at any stage because we need to know what is happening to the pregnancies and why they are failing. There is a whole cohort of pregnancies that fail. The reality is, as we said earlier on, the vast majority of terminations are under 12 weeks for social reasons, but once you get beyond 12 weeks, where you can get your first diagnoses from very good ultrasound, we are seeing pregnancies terminated for medical conditions and we have no data on that. I think one of the submissions that we put from the council was that all termination data should be collected so we actually know what we are dealing with*.'[181]

He went to explain further

> *'The prenatal data forms are filled in through the maternity units whereas terminations are done - as you know - inside and outside hospital, and the ability to get data is hard enough now and to check that the data is valid. If you go that step, Professor Joe Correy started doing - in fact, he started the first natal data collection in Australia and he did gynaecology as well, which really emphasised the difficulty of getting data outside the maternity setting. He emphasised that the data wasn't filled in. If it was filled in, it was incomplete and a lot of his time was spent sending forms back to doctors and hospitals to get the data. He was particular, a bit like a dog with a bone, with it. If we were to do we would have trouble.'*[182]

Later in his evidence, Dr Brodribb explained why this was a concern for the medical community.

> '*There is no formal collection process. The difficulty is that we are identifying major abnormalities at 12 weeks, particularly of the brain, and those pregnancies will be terminated because we know what the outcomes of those anomalies are, even at 12 weeks. To get any*

[181] J. Brodribb, op. cit., p. 22.
[182] Ibid., p. 23.

> *temporal trend about what is happening within the community in terms of abnormalities and given the interaction of the environment with reproduction, as we understand very well now, we have no data about that unless it is collected from the point at which we identify this*.'[183]

Dr Williams told the Committee that there were difficulties in collecting data, including the need to protect the privacy of those individuals to whom the data related.

> *'I think the one concern would be harassment potentially of people having terminations who are identifiable. For example, if you had a genetic disease that ran in your family and you chose to terminate an infant who was found to have the same serious abnormality, there would be the risk if we had identifiable data that you could go back and identify patient data. That's why we do not do it under COPMM because we are bound to keep patient confidentiality. It would need to be within your act, but we would need to have provisions for patient privacy. …. My take on it is more for a medical and public health type of thing. If we are getting a big jump in spina bifida cases, do we have enough folate in the community? It is really to add to the live born data. We know there are concerns, for example about gastroschisis, which is an abnormality of the anterior abdominal wall where the intestines are out and there is some question as to whether that is related to increasing cannabinoid exposure. Knowing that sort of data across a community would be incredibly useful for us if we had the live born and the termination data. I do not know how much good it would serve the community generally, but the community loves watching things like Big Brother. They love living other people's lives*.'[184]

The Committee notes that data along the lines sought by Drs Williams and Brodribb is routinely collected in South Australia and Western Australia, a matter it raised with representatives of the Department of Health and Human Services.

Mr Michael Pervan, Deputy Secretary System Purchasing and Performance with the Tasmanian Department of Health and Human Services, also expressed concern about privacy issues in data collection.

> '*It is not so much about the collection of that because we collect data automatically from the time that we first meet you. It is more about what you do with that data and how it is publicly reported. There is a whole body of work on ethics in reporting. There are specialists at the Menzies* [Menzies Research Institute Tasmania] *who can talk us through or help us work our way through the issues. I think that there should be public reporting on it because that is one way that mothers*

[183] Ibid., p. 25.
[184] M. Williams, op. cit., p. 24.

> *who need to access these sorts of procedures will know that we do them. Care needs to be taken in reporting issues around foetal abnormality to make sure individuals are not identified. I do not think many people comprehend the trauma associated with one of those events and it is not the job of the public system to make that trauma worse. Certainly we should be collecting data, which could show that we need to do more about a particular profile of cases in terms of how we perform the operations and what follow-up is required, or indeed it could identify some issue that might be causal. My overriding concern would be not to publish data which would identify individuals or add to their trauma*.'[185]

In response, Dr Craig White told the Committee that:

> '*Data is always attractive when you want to have a rational debate about things. I do not know how many times someone says, 'I wish we had the data on this'. We are a long way from having perfect data. In an ideal world, I think not a problem. In the circumstances we are in at the moment, I wonder about whether the value of having the data outweighs the difficulties in collecting it, and whether in an environment where we are trying to make the procedure more normal - in a clinical setting - it will cause anxiety in women to know that their data will be reported. Indeed, but not everyone is reassured by that. De-identification is a lot harder in Tasmania than it is in even in South Australia, where the population of Adelaide alone is a lot bigger than the whole of Tassie. In theory, it would be great to have the data, but I see it as potentially complex. I am not sure that we are able to legislate getting data from interstate, because our legislation would not have jurisdiction on reporting of interstate procedures. You cannot ask women as they come off the plane, 'Did you have a termination while you were outside Tasmania?'. I wonder how useful it would be, given the dynamics of the way women in Tasmania access terminations, which includes a lot of them, we believe, going outside Tasmania. I should not say 'a lot' because we do not know, but I think it is more likely to change, with more of them doing it here, if they do not feel it is being reported centrally. This might be something that comes up in the review of the legislation on terminations*.'[186]

Mr Michael Pervan said the data collection system used in Western Australia may be a useful model for Tasmania.

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[185] M. Pervan, *Transcript of Evidence*, 14 October 2013, p.10.
[186] C. White, op. cit., 23 September 2013, pp. 29-30.

> *'I think the data WA is recording is a reasonable model to follow. I always squirm a bit when people come from elsewhere and say what they do there is much better than what we do here and that we should do that. It is a good model but I think it would have to be assessed on its merits for Tasmania because of the much smaller population. There is a difficulty in reporting small numbers because it is so easy to identify individuals or locations and that is not what the job of reporting is*.'[187]

Dr White also suggested that the collection of some data was probably more appropriately undertaken as part of a dedicated medical research project.

> '*The foetal abnormalities question would probably be better answered by a carefully constructed research approach, rather than legislated reporting of a clinical practice, because I am not even sure you would even know. You do not know, for example, of the abnormalities that happen in the setting of spontaneous abortion. You do not really know, even if you measure this, how many abnormalities are happening. It may be that there are no more, but for nutritional reasons women are able to carry them longer than in a less well-nourished society. It is a bit problematic to even draw conclusions from that information. Absolutely, there are so many unknowns. It is taking us more into the area of research and I wonder how much value you would really get from the data. And, what sort of abnormalities are we talking about - are you going to send every DNA sample off for DNA analysis*?'[188]

Ms Cherie Stewart also pointed out there was potential for gaps in the data without some form of compulsion on the women undergoing terminations.

> '*But you will still have a gap in the data unless you force all women who have a termination to undergo further screening or testing to determine if there is a foetal abnormality. It may not be known, and the woman may be seeking a termination for reasons other than foetal abnormality, particularly in early gestation*.'[189]

[187] M. Pervan, op. cit., pp. 83-84.
[188] Ibid., p. 30.
[189] C. Stewart, op. cit., 23 September 2013, p. 31.

Finding 27:

The Committee finds that terminations of pregnancies could be available in the public sector, or purchased from the private sector, through a Ministerial Policy Direction or by decision of a Tasmanian Health Organisation.

Finding 28:

The Committee finds that a barrier to early terminations being performed in the public hospital system is the fear of a criminal prosecution currently felt by some medical practitioners.

Finding 29:

The Committee finds that there is a lack of comprehensive data regarding terminations in Tasmania.

Finding 30:

The Committee finds that there is limited publicly available data in Tasmania because of privacy concerns.

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Appendix A Public Submissions*

Name	***Organisation***
Mr Malcolm Nicholson	
Mr Francis W Crane	
Ms Naomi Dieckfoss	
Mr John Rowlings	
Ms Vanessa Matthews	
Ms Donna Hill	
Mr Martin Fitzgerald	
Mr Tim Ross	
Ms Maree Triffett	
Mr Tony Steven (CEO)	Australian Medical Association Tasmania
Ms Marcia Riordan	Ad Hoc Interfaith Committee
Rabbi Dr Shimon Cowen (Director, Institute for Judaism and Civilization Inc, Chai, Social Policy Committee, Organisation of Rabbis of Australasia, Senior Adjunct Research Associate, Monash University)	Institute for Judaism and Civilization
Sister Christina Wood	
Mrs Marilyn and Mr Paul Jacques	
Ms Peggy Bernard	
Dr Elizabeth Sypkes	
Ms Julie A. Bowe	
Mrs Elisabeth Heckscher	
Dr Lachlan de Crespigny Professor Julian Savulescu (Uehiro Chair in Practical Ethics, University of Oxford and Editor of the Journal of Medical Ethics)	

Name	***Organisation***
Ms Triet Le	
Ms Katrina Dunlop	
Ms Mai-Ann Le	
M P Gill	
Professor Kate WarnerMs Terese Henning, Senior Lecturer	
Ms Bridget Mathewson (Counsellor and Office Co-ordinator)	Pregnancy Counselling & Support Tas. Inc
Ms Marina Fusescu	
Professor Caroline de Costa (Professor of Obstetrics and Gynaecology, School of Medicine and Dentistry, James Cook University)	
Ms Kate Wilde (Sexual Health Nurse and Midwife)	
Ms Lisa McIntosh (Director Notifications, Tasmania)	Australian Health Practitioner Regulation Agency (AHPRA)
Ms Beatrice Clayton	
Ms Mishka Gora and Ms Clare Smith	Human Rights for the Unborn – Tasmania
Ms Kate Cann	Real Choices
Mr Victor Prados-Valerio	
Mr Andrew Roberts	
Mr Piet and Ms Jeltje Verdouw	
Mr Hans and Ms Jackie van Tuil	
Mr Angela Galamai	
Dr Anna Ritchie (GP)	
Ms Kate Marsh (Convenor)	Pro Choice Qld
Ms Joanne Dilorenzo	

Name	***Organisation***
Ms Joanna Siejka and Ms Rebekka Gale	Youth Network of Tasmania
Mr Owen Wilkins	
Ms Diny Van Galen and Ms Cecily Van Galen	
Mr Josh and Ms Charmagne Downes	
Ms Rosemary Wells	
Mr Matthew Day (Secretary)	Department of Health and Human Services
Dr Louis Rutman, Dr Kathy Lewis, Dr Greg Levin and Dr Susie Allanson	Fertility Control Centre
Ms Tania Penovic and Dr Ronli Sifris	Castan Centre for Human Rights Law
Mr Jeremy Orchard	Introfish Incorporated
Mr Gareth, Mr Joseph and Mrs Elizabeth Higgins	
Ms Fiona Witcomb	
Rev. Dr. Peter Ferwerda	
Dr Michelle Williams (Chair- Council of Obstetric and Paediatric Mortality and Morbidity)	Council of Obstetric and Paediatric Mortality and Morbidity
Adjunct Associate Professor Jo Wainer (Adjunct Associate Professor, Monash University Faculty of Medicine, Nursing and Health Sciences)	
Ms Yvonne Wilkins	
Ms Anna Matuszek	
Mrs Margaret Day	
Mrs Betty Roberts	
Ms Leah Armand	
Ms Maureen Susan Playdon	
Ms Gemina Atkinson	

Name	***Organisation***
Mr Martin and Ms Penny Webb (Life & Family Advocates, Cornerstone Presbyterian Church)	
Ms Sally Dare	
Ms Anne Sherston (Tasmanian Director and New Site Coordinator)	Rachel's Vineyard Program
Ms Shaelene Craddock	
Mrs Fiona Haynes	
Ms Cecilia and MrMichael O'Connell	
Mrs Lola Phillips (State President) and Dr Brigid McKenna	Catholic Women's League Tasmania Inc.
Mr Eric Lockett (Public Questions Officer, Tasmanian Baptists)	Tasmanian Baptist Churches
Mr Guy Manley and Mrs Barbara Manley	
Mr Shaun Kelly	
Ms Jenny Ejlak (Secretary, Reproductive Choice Australia)	Pro Choice Tasmania
Mr Gavin Boneham	
Dr Leslie Cannold (President and Spokeswoman, Reproductive Choice Australia) and Ms Jenny Ejlak (Secretary)	Reproductive Choice Australia
Ms Debbie Garratt (Executive Director)	Real Choices Australia
Ms Trish Norton	
Mrs Rachel Walter	
	Women's Legal Service Tasmania
Mrs Maria A Kuilenburg	
Clinical Associate Professor Boon Lim (Director of Obstetrics & Gynaecology) and Clinical Associate Professor John Daubenton (Director of Paediatrics)	Women's, Adolescent & Children's Services, THO South

Name	***Organisation***
Ms Marilyn Beaumont (Chairperson, National Board)	Australian Women's Health Network
Ms Anna Greener and Ms Rita Joseph	
Ms Diana Hutchinson	
Mr Guy Barnett	
Ms Emily Thomas	
Dr Beth Mulligan	
Dr Clare Roberts (SMO, Family Planning Tasmania)	
Ms Georgie Ibbott (Acting General Manager)	Family Planning Tasmania
Ms Shelley Smith	
Eris Smyth	
Mr Michael Stokes, Dr Jeremy Pritchard, Dr Helen Cockburn and Dr Helen Lord	
Mr David Harridine	
Dr Sally Cockburn	
Ms Jane Hutchinson (Director)	Hobart Community Legal Service
Mrs Margaret and Mr Wayne Williams	
Ms Clare Williams	
Dr Caroline Harvey (Medical Director)	Family Planning Queensland
Father Gerald Quinn, Catholic Chaplain, Royal Hobart Hospital	
Ms Claire Morgan	
Dr Gerald Fogarty (President, Solidarity!)	Solidarity!
Mr Anthony Horton	
Dr Helen Lord	
Dr Richard Lord	

Name	***Organisation***
Ms Mary McVilly	
Mr Brian Bennett	
Ms Marie McGuire (President)	Pregnancy Help Australia Limited
Rt. Revd. John Harrower (Bishop)	Anglican Diocese of Tasmania
Mr David and Ms Sherrin Drew	
Ms Linda Seaborn	
Ms Jamila Fontana	
Mr Michael Moore (CEO), Dr van der Mei (Tas President), Dr Catherine McKenzie (Co-convenor Women's Heath SIG)	Public Health Associate of Australia
Ms Madryn Sanderson (Communications Director)	Marie Stopes International
RANZCOG Board	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Ms Diana Sangue (Manager)	Pregnant Alternatives Inc
Mr Michael Watts	
Ms Krystyna Shepherd	
Ms Lynne Jordan (CEO) and Dr Kathy McNamee (Medical Director)	Family Planning Victoria
Senators Carol Brown, Lin Thorp and Anne Urquhart	
Archbishop Adirian L. Doyle	Archdiocese of Hobart
Ms Melanie Fernandez (Chair)	Women's Electoral Lobby (Aust)
Father Terry Southerwood	
Ms Alex West (State President)	Tasmania University Union
Ms Louise Tighe	
Very Reverend Richard Humphrey (Dean of Hobart, Anglican Church of Tasmania)	

Name	***Organisation***
Mr David Perez (CEO)	The Link, Youth Health Service
Ms Marita Johnstone	
Mr Frederick Christopher Brohier and Ms Elizabeth Mews	Wilberforce Foundation
Ms Petra Begnell (Policy and Health Promotions Manager)	Women's Health Victoria
Ms Marie-Claire Sykes	
Mr Greg Donnelly MLC (Parliament of New South Wales)	
Ms Melanie Ross	
Ms Briony Kidd	
Ms Erin Woolley	
Mr Mark Brown (Tasmanian Director)	Australian Christian Lobby
Dr Christopher Middleton	
Mr Darren Carr (CEO)	Mental Health Council of Tasmania
Mr Benedict Bartl (Policy Officer)	Community Legal Centres Tasmania
Dr Steve Hambleton.	Australian Medical Association
Ms Mary Anne Ryan	Tasmanian Women Lawyers
Ms Audrey Mills	
Mr Vincent Sierwruk	
Mr Michael Links	
S M Morrison	
Ms Robin Banks (Anti-Discrimination Commissioner)	Anti-Discrimination Commission
	Human Rights Law Centre

***Please note: in addition to the above, the Committee also received a number of written submissions which requested confidentiality.**

Appendix B

HEARINGS AND WITNESSES ATTENDING

DETAILS	ORGANISATION	WITNESSES
29 July 2013, Hobart		Dr Lachlan De Crespigny Professor Julian Savulescu (both via teleconference)
		Professor Caroline De Costa
		Mr Michael Stokes
	Mental Health Council of Tasmania	Mr Darren Carr Ms Elida Meadows
30 July 2013, Hobart		Ms Terese Henning, Senior Lecturer at UTAS Ms Audrey Mills, Barrister & Solicitor
	Pregnancy Counselling and Support	Ms Bridget Mathewson, Counsellor and Office Co-ordinator Ms Pnina Clark, Senior Counsellor
	Department of Health and Human Services	Dr Craig White, Chief Medical Officer Ms Cherie Stewart, Legal Policy Officer

DETAILS	ORGANISATION	WITNESSES
	Ad Hoc Interfaith Committee (via phonelink)	Ms Marcia Riordan, Life, Marriage and Family Office, Catholic Archdiocese of Melbourne Ms Marlene Pietsch, Lutheran Church of Australia, Victorian District Professor Nicholas Tonti-Filippini, Associate Dean and Head of Bioethics, John Paul II Institute, Melbourne
	Anti-Discrimination Commissioner	Ms Robin Banks
	THO South	Clinical Associate Professor Boon Lim Director of Obstetrics & Gynaecology
	Family Planning Tasmania	Ms Georgie Ibbott, General Manager, Family Planning Tasmania Dr Clare Roberts, Senior Medical Officer, Family Planning Tasmania Ms Kate Wilde, Registered Nurse, Midwife and Senior Nurse, Family Planning Tasmania
19 August 2013, Hobart	Department of Health and Human services	Dr Craig White, Chief Medical Officer Ms Cherie Stewart, Legal Policy Officer Ms Susan Diamond, Director – Strategy, Program Development and Evaluation
	The Link	Mr David Perez, Chief Executive Officer Ms Judy Hebblethwaite, President Ms Kim Boyer, Vice President Ms Marianne Wyrsh, Youth Health Fund Coordinator

DETAILS	ORGANISATION	WITNESSES
	Australian Women's Health Network	Ms Marilyn Beaumont, Chairperson
		Associate Professor Jo Wainer
		Dr Sally Cockburn
	Marie Stopes International Australia	Mr Anthony Reckin and Ms Mina Barling
	Community Legal Centres Women's Legal Centre	Mr Ben Bartl Ms Susan Fahey
	RANZCOG	Professor Michael Permezel, President
23 August 2013, Hobart	Archdiocese of Hobart	Archbishop Adrian Doyle Ms Belinda Clarke, Director of Mission at Calvary Health Care Tasmania
	AHPRA	Ms Lisa McIntosh
	Council of Obstetric and Paediatric Mortality and Morbidity	Dr Michelle Williams Dr James Brodribb

DETAILS	ORGANISATION	WITNESSES
		Dr Beth Mulligan
	Public Health Association of Australia	Mr Michael Moore (via phone link) and Dr Ingrid van der Mei
	Tasmanian Women Lawyers	Ms Mary Anne Ryan
3 September 2013, Hobart	Hobart Women's Health Centre	Ms Glynis Flower
	Anglican Church	Dean Richard Humphrey
	Catholic Women's League	Mrs Pat Gartlan Dr Brigid McKenna
	Australian Christian Lobby	Mr Mark Brown Mr Matiu Chamberlin
	Tasmanian Baptists	Mr Eric Lockett
	Pro Choice Tasmania / Reproductive Choice Australia	Ms Jenny Ejlak Ms Cait Calcutt (via phonelink)
	Human Rights Law Centre/ Castan Centre for Human Rights Law	Ms Rachel Ball and Ms Emily Howie (HRLC) Ms Tania Penovic and Dr Ronli Sifris (CCHRL) (all appearing via teleconference)
		Dr Helen Lord

DETAILS	ORGANISATION	WITNESSES
4 September 2013, Hobart	Private Hearing	
23 September 2013, Hobart	Department of Health and Human Services	Dr Craig White, Chief Medical Officer Ms Cherie Stewart, Legal Policy Officer
14 October 2013, Hobart	Department of Health and Human Services	Mr Michael Pervan, Deputy Secretary System Purchasing and Performance, Department of Health and Human Services.
18 October 2013, Hobart	Private Hearing	