THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON MONDAY, 29 JULY 2013.

REPRODUCTIVE HEALTH (ACCESS TO TERMINATIONS) BILL 2013 (NO.24) INQUIRY

Professor CAROLINE de COSTA WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - We thank you for the written submission you provided us. You may be aware or familiar with the processes of parliamentary committee. By appearing here, you are protected by parliamentary privilege for whatever comment you make within the confines of this hearing. In that regard, we suggest appropriate caution outside the precincts of this hearing in terms of your comments to media because if there was an actionable comment you may make you are not protected by parliamentary privilege, whereas in here, you are.

We have your submission and have had time to review it individually. We invite you to speak to the submission and expand on any matter you want to following that submission.

Prof de COSTA - First of all, thank you for asking me to come. I am very happy to come to Tasmania. I am an obstetrician and gynaecologist and have practised medicine in the area of women's reproductive health in Australia and elsewhere for more than 40 years, 15 years as an academic as well in the same discipline. In that time I have had great experience of caring for and talking to women in the early stages of pregnancy where the pregnancy was unplanned. As I have included in my submission, about half all pregnancies in Australia are unplanned. Of those, they are not necessarily unwanted, but still half of those do proceed to termination of pregnancy. So about one in four Australian pregnancies are terminated currently.

I have also had a lot of experience caring for women who are proceeding with a wanted pregnancy but who then make the very unfortunate discovery, usually towards the middle of the pregnancy, that they have a severe foetal anomaly or that there is some condition that has arisen in the mother that means she has to seriously consider terminating the pregnancy in order to go on treatment herself - for example, for a cancer. This has made me realise that abortion is an important issue for Australian women, and it is an important health issue. This is for women of all kinds, in my experience - young and old, employed, unemployed, married, single, little education, lots of education, from all ethnic groups, from all religions or no religion - and also women who have always thought they would never have a termination until it is a decision they have to make themselves. I think this is a health issue.

I have come from Queensland, and you might wonder what I am doing here lecturing Tasmanians, but I am concerned and have been for many years about providing abortion services and improving abortion law for all Australian women. We have in Queensland

almost exactly the same wording in our Criminal Code sections 224 and 226 as you have in sections 134 and 135 in your Criminal Code. These sections, as I am sure you are aware, date back not only to 1924 when your code was promulgated, or 1899 when ours was, but to 1861 in the United Kingdom and the Offences Against the Person Act. That was long ago done away with in the United Kingdom but we still have exactly the same wording in our criminal code and in yours.

I do not think it belongs in the twenty-first century. It does mean that doctors, when they decide that termination of pregnancy is appropriate for a woman, are aware they are committing a crime and they must have mentally a defence to that if they are prosecuted. There have not been many prosecutions but there has certainly been one in Queensland recently, as you would be aware. In 2009-10 a young couple was prosecuted for using drugs which are recognised as bringing about a medical termination. They went through a very difficult period of 18 months where they were widely discussed and exposed on the internet and in the media before the case was heard and they were acquitted. There has been very little change to our law in that time and no change to yours to prevent this kind of thing happening again.

So the message I have for you is that in the twenty-first century abortion is a health issue and an important issue for women.

Ms FORREST - Professor, have you worked in remote areas in Queensland?

Prof de COSTA - I have.

Ms FORREST - One of the concerns that has been raised is that the legislation we currently have, and even the legislation that is being proposed, requires an obstetrician to be one of the signatories to terminate beyond 16 weeks, as the bill currently sits, and is a barrier to women. Even though you may think Tasmania does not have any remote areas, we do in our scale of things, and access to obstetricians can be a challenge in those areas. Was that an issue for you in your practice?

Prof de COSTA - 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 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.

Ms FORREST - Did you hear our previous witness, Dr de Crespigny?

Prof. de COSTA - I didn't hear him speak but I know of him.

Ms FORREST - He was expressing concern about having any cut-off period for when the system changes. Currently women can, under the Criminal Code, have a termination of pregnancy up to term, basically. With this proposed legislation they still can, but the

circumstances as to how they access a termination - in the procedure, not where it's done because I accept your comments that after 10-12 weeks they have to go to a hospital anyway. Is this cut-off change and process that then requires after 16 weeks the consent of two practitioners and more rigour around that an issue for you and the way you see it?

Prof. de COSTA - 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 to be done by an experienced obstetrician-gynaecologist with commitment to the techniques.

Ms FORREST - I'm not sure what the situation is in Queensland but in Tasmania the current usual practice is that a woman will have a diagnostic ultrasound at 18-19 weeks. They most likely will have had scans before that but not diagnostic scans, and you say many things can't be detected that early anyway or can develop as the pregnancy proceeds. Is there any value at all in having any cut-off point to any change of procedure -

Prof. de COSTA - You mean an upper limit?

Ms FORREST - Yes, or do we just make it the same process right through?

Prof. de COSTA - I would have thought make the same process right through. There are going to be very few women presenting for termination after 20 weeks and they are going to be for major reasons.

Ms FORREST - And they're automatically going to see an obstetrician anyway.

Prof. de COSTA - Oh yes, because occasionally you see a woman who hasn't had an early ultrasound or even an 18-week one who nevertheless has a severe abnormality incompatible with life at 27 or 28 weeks, so it's appropriate to deliver that woman so she doesn't have to go through to the end of the pregnancy knowing she has a non-viable child.

I did my training in Ireland, where there is still no legal termination and yet that was one of the principles accepted by obstetricians there. If you make that kind of diagnosis for a woman at that time, many weeks before the baby is due but after 20 weeks, it's very sensible and logical to offer her an end to her distress.

Ms FORREST - There was a comment made that resuscitation of foetuses below 23 weeks is not generally done but there are cases where the cross-amnio and anencephaly and cases like that where they might not be detected until well after 23 weeks. Would it be your position not to attempt any resuscitation on babies like that after consultation with the parent?

Prof. de COSTA - I think it would be normal practice to discuss but take the example of an anencephalic. Anencephaly is where there is no development of the upper part of the brain, so it is completely incompatible with any kind of long life and certainly any kind of quality of life. Although the child can be born breathing and with a heartbeat for a

while, eventually this child with this very severe abnormality will die, usually sooner rather than later. I would recommend to parents in that situation that there be appropriate warmth and care for this infant but no resuscitation. That's after 24 weeks, and I think that would be normal practice in Australian hospitals. It doesn't happen very often these days and less than 24 weeks, it is most unlikely that an anencephalic is going to live very long. It is likely to be still-born in fact. These are things which the medical profession do pretty automatically anyway.

Mrs HISCUTT - Thank you very much for coming in. Along those same lines, for clarification, did you say that late-term abortions that you have witnessed or been part of or seen or whatever, have been for non-viable children?

Prof. de COSTA - Many of them, yes.

Mrs HISCUTT - Have you done any for other reasons, just an unwanted child or anything like that, past those 24 weeks?

Prof. de COSTA - No.

Mrs HISCUTT - You don't see that would happen?

Prof. de COSTA - It is not part of specialist obstetric and gynaecological practice.

Mrs HISCUTT - Would you see a need for economic and social circumstances to be in the bill? Do you have a comment on that?

Prof. de COSTA - At greater than 16 weeks?

Mrs HISCUTT - At any time.

Prof. de COSTA - Yes, because I think that social and economic circumstances do need, in some situations, to be considered.

Mrs HISCUTT - Even to a viable foetus past 24 weeks?

Prof. de COSTA - To a viable foetus, it is much more difficult past 24 weeks. It is not a question that arises, or certainly not very often, and certainly not in specialist obstetric and gynaecological practice.

Mrs HISCUTT - So there is probably not a need to have it in there?

Prof. de COSTA - No.

Mr VALENTINE - I wanted to see what your experience is with women having available to them all of the information about the risks associated with terminations and possibly in the earlier weeks I am talking about now as opposed to later. When they come in for termination, in your experience, do they have opportunities to get good information and is it likely that you would ever have a woman who goes to have an abortion without being presented with the risks associated with such a procedure?

Prof. de COSTA - I would certainly hope not and I think than in medical practice in Australia, the idea of informed consent is universal in all kinds of procedures. The clinics, for example Marie Stopes Australia - I don't know whether they are down here but they are certainly on the mainland - who provide many surgical and medical abortions early on and their counselling system, their informed consent system is excellent. I would think that in most other situations it is as well. Women need to be well informed about, first of all, the options for unplanned pregnancy, continuing with the pregnancy and considering keeping the child or having the child adopted as well as abortion. Those things need to be spelled out and the reasons for the woman seeking the termination need to be explored in case she doesn't know what options are available or what help is available to her. She must be quite sure of her decision before she is even told about methods of termination and what the risks are and what the advantages of the various types are and what she can expect and information about subsequent contraception and other things like that. There are a whole lot of things that she needs to know and I do believe that in general women are well-informed.

Mr VALENTINE - So you wouldn't see a need to put in compulsory counselling, for instance, in an act, to make that happen; it would happen as a course?

Prof. de COSTA - Yes, it most definitely should. Most women are able to make decisions for themselves and they are perfectly intelligent and able to do that.

Mr VALENTINE - Thank you.

Ms FORREST - Going back to the point that Leonie was asking a question on. I will read out a section of this bill because I want to put the context around it and I am not just picking out a couple of words. It refers to terminations by a medical practitioner after 16 weeks. It says:

> 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.
>
> It is clause 5 of the bill.

Prof. de COSTA - Yes.

Ms FORREST - It goes on. In subclause (2) it says it says: 'In assessing the risk referred to in subsection (1)', which I have just read, 'the medical practitioners must have regard to the woman's current and future physical, psychological, economic and social circumstances.' You said you didn't think that economic and social circumstances need

to be there but it is saying that those considerations are given after the medical practitioner believes that the physical and mental health of the woman is at greater risk if the pregnancy continues than if were terminated, and it also has to consider not just the economic and social circumstances but it has to consider the woman's current and future physical and psychological circumstances as well.

I am wondering what your views are. When you look at the whole picture, is it reasonable to have economic and social factors as part of that whole assessment regardless of the stage of gestation of the woman?

Prof. de COSTA - You mean having it in section 4 as well?

Ms FORREST - No, just in section 5. After 16 weeks, should it be part of the whole -

Prof. de COSTA - When I read it previously I understood that it was because it says under subclause (2) 'In assessing the risk referred to in subsection (1)' - is that not it?

Ms FORREST - That's right. That is what I am saying: it is contingent on the first test and the doctor having to give consideration to all aspects of the woman's health and wellbeing basically, including her social and economic circumstances.

Prof. de COSTA - Her physical and mental health is going to include her social and economic situation now but also in the future if she is going to bring up the child. Those things are very important.

CHAIR - If I could, even if it doesn't include it, it doesn't preclude that to be considered.

Prof. de COSTA - No, it doesn't.

Ms FORREST - Isn't it part of the full assessment of a woman, if you are making a decision with this woman as one of the medical practitioners involved, would you not consider all aspects of her wellbeing before making a decision?

Prof. de COSTA - Yes, I would.

Ms FORREST - It is appropriate to have it there then. Is that what you are saying? It is appropriate for all those things to be there.

Prof. de COSTA - Do you think it shouldn't be there?

Ms FORREST - I am not saying that; I am asking you. I tend to think it should be there because it is about the whole woman.

Prof. de COSTA - Yes, I would agree. I think it should be because her current and future socioeconomic situation is very much part of her physical and mental health.

Ms FORREST - Thank you, I wanted to clarify that.

Prof. de COSTA - No, I do.

Ms FORREST - In your clinical practice, professor, have you had any issues around the access zones? As you would be aware, this bill has a section that refers to exclusion zones or access zones so that people cannot actively protest, intimidate and harass women outside a clinic where they may be seeking a termination. Have you had any experience in that at all?

Prof. de COSTA - 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.

Ms FORREST - Directly. It doesn't stop people protesting in another place?

Prof. de COSTA - No, we live in a democracy. They can protest as much as they like in other situations but not directly where a woman is undergoing a procedure in the healthcare system.

Ms FORREST - Have you had any women who have had accessed your care who have been subjected to that harassment and intimidation?

Prof. de COSTA - Very few, really.

Ms FORREST - So it has not been a major problem?

Prof. de COSTA - It has not been a major problem where I have practised but I am aware that it is elsewhere in Australia.

Ms FORREST - Particularly in Victoria, in that clinic in East Melbourne.

Prof. de COSTA - Particularly in Victoria.

Ms FORREST - There have been some concerns with some of the medical practitioners, not so much the obstetricians and gynaecologists but more the general practitioners, about the conscientious objection section. I have read through RANZCOG's guidelines, which I am sure you are very familiar with, and the Medical Board of Australia's requirements as well. Do you see that this is a necessary part of the bill to have in there, and if so why, when you do have requirements within RANZCOG's code of ethics and AHPRA's code of practice now too?

Prof de COSTA - I think it is reasonable to acknowledge the existence of people who have conscientious objections. It is quite well worded in the Victorian legislation, which says that a doctor who does have such an objection must nevertheless make an effective referral. That means that he or she does not have to refer the woman who is requesting a termination to someone he or she knows will perform an abortion but to a service that will, for example, a family planning clinic or something like that, provide her with all the relevant information.

Ms FORREST - You use the term effective referral'. One of the concerns raised with me during the debate leading up to the introduction of the bill was that referral, in medical terms, tends to indicate, for example, that if you were going to refer me to somebody, you are referring me for a particular course of treatment, rather than just to get further information to make a decision. It was the word 'refer' that was causing the problem. So how does effective referral work in Victoria in such a way that it doesn't make doctors who have a contest objection fearful? Their concern is that if they are effectively referring, they are effectively saying, 'Sorry, I won't provide information about the effects and benefits of a termination, but Dr Smith down the road will'. Their comment to me is that they feel they are participating in the termination of that pregnancy by that referral process. So how does it work in Victoria - if it does work - such that those words do not create that problem for medical practitioners there?

Prof de COSTA - Yes, there is the idea of a general practitioner referring to a specialist; that is the way it was used most often. However, you can have somebody who doesn't do antenatal care, for example, a general practitioner who will say, 'I will refer you to my colleague down the road'. You might have plastic surgeon who doesn't do cosmetic surgery but who would say, I can refer you to my colleague', and go from there. I cannot think of another word, off the top of my head, which is more direct or something like that. There may need to be some spelling out of what is meant but I think the term 'an effective referral' is the appropriate one.

Ms FORREST - The AMA has informed the minister directly that referral in medicine is a very formal process. This is the wording they are proposing:

> When a personal moral judgment or religious belief prevents doctors from recommending termination of pregnancy they must so inform their patients. They must also inform patients that this option may be available elsewhere.

That is a long way of saying, 'You can seek someone else for information'.

Prof de COSTA - 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.

Ms FORREST - Or where to get the information.

Prof de COSTA - Yes; where do they go? 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.

Ms FORREST - In your opinion is the word 'refer' problematic and should we search for another word, or are they jumping at shadows?

Prof de COSTA - I wouldn't have thought it was problematic. I do not do private obstetrics anymore so I would refer patients to people who do, and I would use that word. It is

widely used by the medical profession both in that way and in the more formal process of writing a referral and putting your provider number on it and sending a patient to a specialist.

Mrs HISCUTT - Would it be better, if we are objecting to 'refer', to have something like 'provide a list of' people'? Would that save them having to refer and feeling like they are betraying themselves', if they provide a list of providers who would do if they are asked?

Prof de COSTA - I think the term 'effective referral' is quite -

Mrs HISCUTT - Is the same as, is it?

Prof de COSTA - Are you able to have footnotes or something to this legislation to explain what you mean by 'effective referral'?

Ms FORREST - Parliamentary Counsel is open to suggestions.

Mrs HISCUTT - Back onto the access zones and the haranguing that you have had to put up with, would they have been legal protests or illegal, because there is a procedure for protesting to go through the permits, et cetera?

Prof de COSTA - I think they are probably illegal.

Mrs HISCUTT - So this 150 metre access zone or whole access zone part, even if it was in law may still be cast aside for any would-be protesters.

Prof de COSTA - Possibly, but that is not a reason not to do it.

Mrs HISCUTT - So even though there is a process in place within the police department to put an application in, do you still think this would be more necessary, not just looking at the other one?

Prof de COSTA - I think it is a very worthy part of the legislation that is before you, useful and beneficial to the women undergoing that procedure.

Mrs HISCUTT - So you wouldn't think that the police department would say, 'No, you can't have one of these protests right outside a termination clinic'?

Prof de COSTA - It certainly doesn't seem to work in Victoria.

Mrs HISCUTT - It doesn't work here either.

Mr MULDER - You are saying that where doctors do inappropriately perform abortions that it is really appropriate that they be dealt with through medical councils and the appropriate professional bodies that deal with doctor malpractice, yet when it comes to the question of 'referring on' suddenly you want the criminal law involved if the doctors do not do what is required of their codes of practice. I am wondering why both couldn't be adequately handled by professional standards in the codes of conduct if it were, when it comes to a referral, simply made clear in the code of practice that referral simply doesn't mean it is available without indicating where it is available.

Prof de COSTA - But you have to make allowances for people who do have conscientious objections in this legislation. Those people have made clear that they want to be heard; their opinions need to be heard and respected. At the same time you have to balance the rights of the women who are seeking termination, so you must include something to that effect.

Ms FORREST - The medical code makes it pretty clear that the doctor has to refer when they can't provide that information themselves. Even RANZCOG made a statement that they are not to allow their moral or religious views to impede access to any legally available treatment. So whilst that is there, the penalty for doing so, I guess, would be investigation by AHPRA and the potential worst case outcome for the doctor would be deregistration. Are you saying that this strengthens it and is necessary to strengthen it, because it is there in a code?

Prof de COSTA - Yes, it is. In a way I would support your not having it but I do think that conscientious objectors to abortion have a strong point of view and will want to be included in this. At this point they probably do need to be, in that way.

CHAIR - Thank you for your time.

THE WITNESS WITHDREW

Mr MICHAEL STOKES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Michael, welcome to the committee and thank you for the submission under joint signatures. I suspect you know probably better than we do the provisions of parliamentary privilege. You are well aware of the privilege extended to you as result of appearing before the committee.

Mr STOKES - My major objection to this bill is that you cannot separate any aspect of health law from the criminal law. This bill does not do so, although it purports to do so to a certain extent. The reason why you cannot separate any aspect of medical law from criminal law is that most medical procedures, unless done without justification, are properly criminalised. If I amputate a limb of yours, no matter how skilfully done and things like that, without the proper legal justification, that is a maiming, grievous bodily harm, and is serious offence. Therefore at bottom the boundaries for any medical procedure - including medicines, which are often poisons - have to be the criminal law, and that is the case here.

What we find in this proposed bill is that the regulation of when terminations are lawful is in the proposed section 51A of the Criminal Code. There have been doubts that sections 4 and 5 of this bill - and this is where it gets very confusing - do anything at all. The Law Society had those doubts. I believe they put in a submission to that effect, and I certainly have those doubts. The bill seems to me, right at the beginning, to be based on an error - the idea that this area can be regulated by a health law, separate from the criminal law.

The key operative provisions are section 51A then the proposed sections 178D and 178E. As a consequence, it is not quite clear what sections 4 and 5 do. Maybe they are meant to operate, as they probably are in some way, as a level of regulation over and above the bottom, the floor, provided by the criminal law. But how that is to operate is not at all clear from the legislation. I know it has been said that is to be a matter of medical discipline. If that is the case, it should be very clearly stated so that people, when they read the act, know what it means. When you look at medical discipline, there are various levels of wrongful behaviour policed by medical boards. You have, for example, at the most extreme level, professional misconduct. Then you have unprofessional conduct and then there is a relative amorphous idea that there is conduct which is below the level of professionalism and expertise the public can reasonably expect. If sections 4 and 5 are to be subject to medical discipline, then it needs to be in the act and how seriously that is to be taken needs to be stated, otherwise we have these provisions and no-one is quite sure what they mean. Laws need to be clear.

Our opinion is that you should not be going down that route at all. It is not just a matter of medical interest and interest to medical practitioners when terminations are performed, but also a matter of public interest. Therefore, if we want to impose constraints on termination, particularly imposed by section 5, then they should be enforceable in some way in the public arena through the courts as a normal law. It seems to me that this part of the bill proceeds on a misconception. You cannot separate health law from criminal law.

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.

Section 7 seems to me to be unclear. The most obvious interpretation seems not really to improve access at all. The most obvious interpretation of section 7, obligations of medical practitioners and counsellors, the way it is worded would be that it only applies to a practitioner or counsellor who has an objection to all terminations, not to a practitioner or counsellor who has an objection to some terminations or perhaps to the termination in front of them. That is a fairly small percentage of practitioners and counsellors who have an objection to all terminations in every situation. So it is not really going to improve women's access all that much but of course it is quite discriminatory against people who have that objection. I know of two general practitioners who say that if this goes through they will have to cease general practice. They in conscience could not refer.

Also it seems to me that it is inconsistent with the codes of medial 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. I do not say that I have looked at them all but I did look at the ones that I was able to find. Dr Lord, who has also signed this, did not refer me to any others of which she was aware. So it seems to me that section 7 is very narrowly targeted and does not really improve access.

That raises another point which I have as a general objection to this legislation. I do not see it as particularly evidenced-based. Do we have any evidence that this is a serious

problem, that women are in practice being denied access by practitioners and counsellors with this conscientious objection? I have not seen any evidence presented and certainly none really in the information paper which was put out with the bill.

Section 8 I totally support. A provision order of that sort could be put into the Criminal Code very easily.

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.

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):

> 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.

This whole area of law seems to be extremely complex and difficult and needs a rethink. I am not sure we can resolve and get something sensible here. It seems we might have one of two alternatives. We might have to bite the bullet and choose one.

One means to allow infanticide, the killing of a live child after birth in some situations, the other is to place some restraints on late-term terminations. I know which I would do if I am right in that: I would place some restraints on late-term terminations and in particular I would say okay, a woman's control of her own body extends this far. If that is your position, that justifies an ending of the pregnancy but it does not justify the death of the child if the child could be viable outside the womb. It seems to me that the balance might be in those cases: all right, this child could be viable outside the womb; we really want to have termination right through more or less to the end as this allows us to say, you have to make reasonable efforts to resuscitate that child and then it would be adopted or whatever.

The other alternative seems to me that you are looking at the possibility of legalising, in some situations, infanticide, which is the killing of a child born alive.

Ms FORREST - Or allowing to die?

Mr STOKES - Allowing to die? If you allow it to die that could still be a homicide because, under the code, if you deny it the necessities of life, and necessities of life include reasonable medical treatment, and that is the cause of death, then that is a homicide under the code at the moment. So allowing it to die if it could have been resuscitated is not really an option as the law stands.

CHAIR - Just on that, are you relying on section 153(2), which talks about omissions?

Mr STOKES - That's right, yes. You have as well as that - don't tell me I didn't bring the section -

CHAIR - If you know what section it is we could get it for you.

Mr STOKES - Sorry, I have forgotten the section. I know it's in the chapter on omissions and it's basically the provision which makes it a homicide if someone within your charge dies as a result of a failure to provide the necessities of life. The necessities of life are then defined as including necessary medical treatment. If that child could have been resuscitated or saved with the provision of reasonable medical treatment, to allow it to die would then seem to be a homicide. So I'm not quite sure that gets us out of the bind, legally.

I'm sorry, I should have had that provision; I thought I had it here but I can certainly give you the section number.

CHAIR - Yes, if you wouldn't mind please, Michael, you could probably communicate that to Tom.

Mr STOKES - I will.

Mr VALENTINE - Can I ask a question on that?

Mr STOKES - Sure, that's basically what I wanted to say.

CHAIR - We will go with that on that very point at the moment.

Mr VALENTINE - Who has the capacity to bring that charge?

Mr STOKES - Who has the capacity to bring that charge?

Mr VALENTINE - Under these circumstances?

Mr STOKES - One thing I would have liked to have had and I haven't had the opportunity to do it unfortunately, is to look at the Coroners Act because unless a doctor can sign off as this death being of natural causes, which might be quite difficult in that situation, it would seem to me that there would have to be an inquest and then it would be up to the coroner to recommend whether anyone is charged or not. A lot would depend on the doctor there. If the doctor says it died of natural causes and puts that in a death certificate - I don't know whether the practice is actually to produce a death certificate in a situation of a late termination where the child is born alive but quite clearly there should be one. In my understanding of the Coroners Act, which is not great, is that a great deal depends upon the doctor signing the death certificate. If the doctor signs natural causes there is generally not an inquest, but people can still demand an inquest if they think that might have been a wrongful finding and then it becomes very much a political question.

Ms FORREST - Who would? That was your question before.

Mr VALENTINE - Yes, who would?

Mr STOKES - Let's say that there were some hospital staff there who were not happy with what happened. They might be in a position to do it. Without having gone - and I haven't done this - I haven't gone through the Coroners Act and it's certainly not an area where I have great expertise, but there is that potential, I think. At the end of the day, I suppose my own view is that even if there is no prosecution likely or it would be very difficult, I'm not sure that it's a good thing to have that possibility even in the law. I would say no.

Ms FORREST - You made a few claims in that last comment you made about this section and you said you would recommend restraint in late-term terminations where there could be a viable foetus outside the womb. What do you mean by 'viable'?

Mr STOKES - Viable, I would have thought, would be a foetus which could be resuscitated with reasonable medical treatment.

Ms FORREST - And live five minutes, five days or five years?

Mr STOKES - Not live five minutes, okay. Where there is a reasonable chance of a successful resuscitation, put it that way.

Ms FORREST - What does 'successful resuscitation' mean?

Mr STOKES - That the child is going to live. When you are getting into a situation, for example, of a child with deformities which might live for a short period of time or something like that, that is a very difficult question. I think in parts this bill is rushed. We need to have community conversations on these things. I don't claim to have all the answers and that one I find a very difficult moral problem.

Ms FORREST - There has been significant consultation with medical practitioners who understand this area much better than you, I suggest, because this is the area they work in. Babies with a range of anomalies that will see them not live very long, still can live for 24 hours. Trisomy 18 is one; an anencephalic child can live for a period of time. So by your definition, you are saying that those babies should be actively resuscitated. I know in practice that that doesn't happen. Currently out there now, when any of these babies are born, those of us who provide care - and I say 'us' because I have been there many, many times - do not actively resuscitate babies in those circumstances. You don't do it without consultation with the parents but we are talking about a termination of a pregnancy here and it is an abortion, if you want to call it that, but the baby is born alive.

Mr STOKES - Yes.

Ms FORREST - To put some sort of restriction as you are suggesting on this means that those women would then not be able to have a termination at all.

Mr STOKES - When I say that, if that baby is going to die of natural causes, then there is no problem. I think the law at the moment which raises the problem here is - first of all, let me say under this definition in this bill -

Ms FORREST - Let's go to the definition - that's where it was heading - and I do agree there is some confusion here and I have some concerns about that. In section 3, 'terminate means to discontinue a pregnancy'. If we took out 'so that it does not progress to birth' and just had 'by (a) ...; (b) ...; or (c) ...', then that would fix that problem.

Mr STOKES - That would fix that problem. Yes, I think that would largely fix that problem and that's the wording in the Victorian act.

Ms FORREST - That's relatively easily fixed.

Mr STOKES - That one is, yes.

Ms FORREST - I agree that 'progress to birth' does create that confusion perhaps around what we are talking about here.

Mr STOKES - That's right and on that I think we do need clarity as much as we can get it. We need clarity in these situations and clarity in the law.

Ms FORREST - If that definition was changed, that would remove a lot of those concerns you just had in the last comment?

Mr STOKES - That would remove a lot of those concerns, yes.

CHAIR - I am going to another area. That is, in your submission, Michael, on page 2 about the current legal position. You state some issues relating to assessing the risks of performing an abortion, where the doctors concerned may take into account any matter which they consider to be relevant, including the social and economic circumstances.

Mr STOKES - Yes.

CHAIR - Although social and economic circumstances are not specifically set out in the current section 164, they are nonetheless matters which competent medical opinion could take into account in assessing the impacts on the mother's mental health.

Mr STOKES - I think so, yes.

CHAIR - Whilst they are not specifically set out in the current section 164, they have been specifically set out in the bill, which obliges the medical practitioners to take into account those amongst other matters so listed. There has been some contention that social and economic circumstances ought not to be considerations. But I would put to you that the current section 164 allows that to be taken into consideration anyway because while they are not prescribed, any number of circumstances can be taken into consideration currently.

Mr STOKES - That's right. Anything which is relevant to the physical and mental health of a pregnant woman, if we assumed, as would probably be the case, it would be interpreted that physical and mental health includes long-term physical and mental health, not just the immediate physical and mental health, then we would be able to look at those things.

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

Ms FORREST - We have been informed that it's fairly clear that a woman seeking a termination beyond 16 weeks - certainly beyond 24 weeks - the first was the gestation, but a later stage termination will be under the care of an obstetrician and that is sensible. RANZCOG, the official code of ethics of the College of Obstetricians and Gynaecologists, under which all obstetricians and gynaecologists are required to practise, says:

> Doctors should recognise and respect the diversity of value and belief systems and understandings of health and illness in a multicultural society. They should endeavour to ascertain and respond sensitively to the needs of the individual, including her/his social and cultural needs.

It is already in RANZCOG's code of ethics and it's obstetricians who will be dealing with this. At least, one has to be an obstetrician when you read through that clause. Isn't that part of good care? When you go to the medical code, which talks about informed consent, 'informed consent' means ensuring that the patient has a full understanding of the risks and benefits of continuing or terminating a pregnancy. In getting that information to and from a woman to enable her to make an informed consent, wouldn't it be right and reasonable to consider all aspects of her health?

Mr STOKES - I'm not saying that it is not. I'm just saying that it struck me as rather odd to impose it as a legal duty at that point.

Ms FORREST - But isn't it about the total care of a patient as is required by the medical codes? It is just confirming what is in the medical codes, isn't it?

Mr STOKES - Probably 'must' is a bit stronger than 'should'. The other thing about this of course is again, the intention of section 5, which doesn't contain any penalty or anything like that, is to have it enforced as a matter of medical practice.

Ms FORREST - But it would be under AHPRA - Australian Health Practitioner Regulation Agency. That's the place for it, that's where the regulation occurs, in the regulations which are under AHPRA.

Mr STOKES - But if you are right, does subsection (2) really add anything to the existing medical codes? Is it needed?

Ms FORREST - Wouldn't you agree that it confirms the medical codes? It makes it very clear that the doctor can't just consider the economic needs. People seem to think or suggest that a woman will just turn up at 24 weeks and say, 'I can't afford to have this baby, I want you to terminate it'. That couldn't and wouldn't happen according to the experts that provide these services, and it wouldn't be able to happen because it would have to give regard to all of those other things as well. If there were implications for the woman's current and future physical and psychological circumstances, not just the economic ones, then they wouldn't meet the criteria either. So, isn't it a safeguard as opposed to a negative?

Mr STOKES - My point was, as much as anything else, I am not saying that these factors should be ignored. I am just not sure quite how the duty in section 2 fits in with the discretion of 'may' in subsection (1), as a matter of interpretation. That was all I was saying really about that.

Ms FORREST - You are not saying it shouldn't be there; you are just not sure how it fits together?

Mr STOKES - I am not sure how it fits together and I was saying that maybe it would be better to put it in 'may' rather than 'must'. I was only making that very minor point about that.

Ms FORREST - But subsection (1) basically has to be satisfied that both of the medical practitioners have made the determination, I am sure in consultation with the woman, that continuation of pregnancy would involve a greater risk, physically or mentally, to

the woman. They would have to establish that first before the next applies and if they have established that, then they must consider all aspects of the woman's mental, physical and psychological health and the circumstances before they can proceed any further. So, isn't that an added safeguard as opposed to a watering down? If you had 'may', then they could say, 'I may consider just her economic concern but I don't have to consider her current, future and physical and psychological health'. Isn't it better that they must consider all of it because it says 'and .... and .... and' not 'or'.

Mr STOKES - Yes, I know it says 'and ... and ... and'.

Ms FORREST - It's ensuring that decisions aren't made flippantly or lightly as some people seem to suggest; it actually creates a stronger test to ensure all of those things are considered, not just one or two but all of them so there is a greater requirement. It almost makes it more difficult but I don't think it does because it fits neatly within what the codes of practice say, particularly the RANZCOG code of ethics.

Mr STOKES - That was a very minor point and I don't want to spend a lot of time on it.

Ms FORREST - But it's in your submission and you've made quite strong comments about it so I think we do need to establish what you really are concerned about.

Mr STOKES - Okay. The concern really is that, in a way, under subsection (1), it is not clear that a medical practitioner has to go that way and this ties in with section 7 as well, in the sense that the medical practitioner might decide that, for various reasons, they don't want to treat that patient but then once they do decide to treat that patient, they will look at this and they have to consider these things.

Ms FORREST - Isn't it only those doctors then? Those who have a conscientious objection are not required to because section 7 gives them the out. I fully respect doctors who don't wish to participate and have the right to say, 'I don't wish to participate, but here is where you can get some information and make a decision on this'. Some women may decide not to proceed with a termination and come back to that doctor to continue care during the pregnancy, and that does happen. Section 5 only applies to doctors who don't have a conscientious objection and are willing to participate in it.

Mr STOKES - Looking at it on that basis, once the doctor undertakes that, as you say it is probably reasonable that they look at all these factors. It is certainly reasonable that they look at them. I wasn't denying the reasonableness of it, but it struck me as rather odd that that was a duty at that point.

Mrs HISCUTT - You went on about section 7, where the conscientious objection would apply to all doctors. You may get some doctors who do not wish to participate if they were getting in trouble, according to this, who may have that objection if they don't refer on, which is true if it comes to a later-term termination. If there is no health cause for the termination, it comes back to section 5(2). So if a doctor takes into consideration the future physical, psychological, economic and social circumstances, there is a good chance a termination could be wanted for three of them. If you're going to go for a termination because of your sudden change in economic circumstances, that is not a justification, or is it, for a termination? Is that what we're saying?

Mr STOKES - This is where I am not certain about the clarity of section 7. It seems to me that the most likely interpretation of section 7 is that it is referring to a practitioner who has a conscientious objection to all terminations. The other possible interpretation is that it applies to a practitioner who has a moral objection to some terminations, and in particular the one that is presenting right now. You do the assessment under section 5(2) -

Ms FORREST - After you've satisfied section 5(1).

Mr STOKES - In concert with; it is not a separate process. Subsection (2) has to be done while you are conducting the assessment under subsection (1). You cannot look at everything at once so you are probably going to go through it step by step. Some of the later things you could consider under section 5(1) would be social, economic and psychological. My concern is that if at any time you had a moral objection, does it at that point immediately fall under section 7? Even if you have no objection to most terminations, let us say it is a late-term termination - and we would hope this would not happen - for sex-selection purposes of a completely normal child. Although you are quite happy with most terminations, you have a moral objection to that one. Do you fall under section 7?

Ms FORREST - If someone was contemplating a termination for sex selection - it doesn't happen in Australia but I know it happens in other countries - sex can be determined very early and anyone with that in mind will have a CVS at about eight weeks and they will make a decision right there and then.

Mr STOKES - You would hope they would. I was just giving that as an example.

Ms FORREST - Let's think of realistic examples then.

Mrs HISCUTT - A realistic example would be a divorce, where you were pregnant and the man has gone. That would affect your social, income, psychological - even though you have a late-term pregnancy. How would that affect? You have a viable child and yet you satisfy three of the criteria already?

Ms FORREST - I would like to see the evidence of that actually occurring.

Mr STOKES - Section 7 needs to be clear as to exactly which cases it applies. You can imagine, for example, to take a much more realistic one, does it apply to the practitioner who has no objection, say, before 12 weeks, but objects after the first trimester, or has no objection before whatever period you want to name. You can imagine that is quite a defensible position to take. Do they fall under section 7?

Ms FORREST - If you look at that logically, though, I am eight weeks pregnant and rock up to the doctor and say, 'I want to discuss termination of pregnancy with you'. The doctor does not have any conscientious objection before 12 weeks, so they say to me, 'No worries, Ruth, I can talk to you about that', and they provide the information that I need to make my decision. I did not know I was pregnant until 12 weeks, so I turn up at 13 weeks and they say, 'I am sorry. I have an objection to terminations beyond 12 weeks so I cannot assist you here. Under section 7 I need to refer you to someone else who can provide that information to you.'

Mr STOKES - Okay. It is not clear that section 7 applies to that because if you look at the language 'conscientious objection to terminations' is not saying to classes of terminations or -

Ms FORREST - How do you name every one in legislation?

Mr VALENTINE - Is it possible to say 'objections to terminations or aspects of the termination'; does that fix your issue?'

Mr STOKES - My problem is that you could end up with a situation where it is difficult to probably imagine an absolutely plausible scenario because you may well if you, say, put in 'objections to termination or particular classes of termination' it may be that just about everyone will have some objection to some termination in a particular situation. Are we going to impose that duty to refer on to someone they believe may not have that objection?

CHAIR - I might just intervene there. Michael's submission says you are not posing solutions but you have raised some issues of concern and I do not think we should try to identify with you what those solutions might be.

Mr STOKES - That is fine.

CHAIR - If we are satisfied with your concerns we can seek solutions elsewhere to those matters, so we will stay with that issue for the moment.

Mr MULDER - This goes back to that issue with a doctor and basically criminalising the failure to refer something, against the conscientious objection. I think the point has been made this morning by yourself and by the member for Murchison that that sort of obligation already exists within the codes of practice. I particularly refer to the obstetrics and gynaecology ethical codes.

Mr STOKES - RANZCOG?

Ms FORREST - Yes.

Mr MULDER - It actually says 'doctors should offer a range of further opinion and/or ongoing care with suitable practitioners if' and one of the conditions is 'the therapy required is in conflict with the doctor's personal belief system'. Here you have a code of practice that makes the referral compulsory. The proponents of this bill have argued very strongly that we should decriminalise abortion on the fact that if it is a botched medical procedure, if the doctor does not do what he should do, then it should be taken out of the Criminal Code and handed to the professional bodies to deal with. It seems to me that in this particular case we are doing the reverse. We are criminalising something that is already covered by the codes of practice instead of decriminalising something that is covered by codes or practice.

Mr STOKES - The interesting thing about section 7, the one you are talking about, is that for medical practitioners here it is not specifying a penalty; it only specifies the penalty for counsellors. I must admit on law grounds I have strong objections to that. I don't think

that we should have different penalties for different classes of people who are essentially guilty of the same wrongdoing, and that seems to me to be extraordinarily discriminatory and basically wrong. It's denying equal treatment before the law to two classes of people so I have a strong objection to that difference.

Mr MULDER - What's your view then of the definition, on that same point? The department's own brochure, or it might be the Women's Legal Service's, is very strong on the point that the provision is in line with the current medical ethical codes of conduct so that is fine. Then it goes on to talk about the counsellors and the fact that they have no professional body's code of conduct, so therefore it might be appropriate to have a provision there when there is no code of conduct to cover their failure to refer. My other concern and from your legal position, you might like to explain to me what is a counsellor. The definition of a counsellor seems incredible: a person who holds themselves out to be a counsellor is a counsellor.

Mr STOKES - I think part of the reason why that is the case is, as you say, there is not the professional regulation of counsellors which there is of some other professions. But it is an extraordinarily broad definition in a way because it includes all sorts of people who are not receiving a fee or a reward and imposes that obligation on them.

You may be right about the interpretation of the RANZCOG code. I have referred to some of the codes that I found in that one. The RANZCOG code does contain the provision you read out but it also contains a principle, and the principle is that people - doctors, medical practitioners - should not be forced to act inconsistently with their conscience, to paraphrase it. How those two relate isn't a 100 per cent clear; it may be that the principle regulates the provision you have said so, yes, there is a duty to refer unless you have that conscientious objection to referring in that case.

Mr MULDER - In fact it does the opposite; it says that you have a duty to refer.

Mr STOKES - Yes, but that's subject to an interpretive principle, which is that a medical practitioner should not be forced to act against their conscience, to paraphrase it. That interpretive principle, you could argue, governs the interpretations of the provision you have read, in effect creating an exception to it.

Mr MULDER - I think this interprets the principle rather than the principle interpreting this. It simply says that you should refer if the therapy required is in conflict with your own personal value belief system. I think that's fairly clear and it's extremely pertinent.

Mr STOKES - By itself it is fairly clear but when you look at in the whole of the document in the light of the principle, it's not quite clear how those two relate. If I were making an argument, I would certainly make the argument that the principle governs the interpretation of that provision.

Mr MULDER - I am not about debating that, we could have a lengthy debate about that.

Mr STOKES - Sure.

Mr MULDER - You can't say, 'In principle I believe in murder, therefore the provisions of the Criminal Code don't apply to me on this'.

CHAIR - You are right, it's not the forum for such a debate as to interpretation but we will make judgments about that.

Mr MULDER - Thank you for that, that's all from me, Chair.

CHAIR - There is one area I want to go to before coming to Leonie on another question because we have been bouncing on that same matter. Michael, again in your submission under the heading of consent, you have raised the point that with the proposal to insert a new section 178E into the Criminal Code, that consent is required but that, because it is going to be under the Criminal Code, it will be consent as defined in the Criminal Code -

Mr STOKES - That's right.

CHAIR - And therefore, your contention is, because consent as the defined term in the Criminal Code embraces providing all the options, that we might have some conflict there with the insertion of that new section into the Criminal Code if the doctors don't give the broadest possible range of choices rather than just to proceed with an abortion.

Mr STOKES - My own view is that it's an easy route not to attempt to define 'consent' in this way in this area of law. 'Consent' in the Criminal Code, which will be the fallback definition, is defined as 'free agreement'. The problem with that provision is that it applies to a whole wide range of behaviours, including, say, consent to sexual intercourse and consent to medical treatment. 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. You put the options and make sure the person understands their options.

Also, in looking at this issue of consent, I have a concern here that under this legislation, not enough may be done to try to help women who are subject to all sorts of outside pressures to have a termination including, in some cases, quite violent coercion. I have talked with a colleague of mine at work, Terese Henning, who I believe will be giving evidence later and she doesn't think the law can do anything about that.

Mr VALENTINE - It can go both ways, can't it, the coercion?

Ms FORREST - They can do it the same way.

Mr STOKES - She said, the obvious solution, which I agree with, is to try to get the woman out of that environment. But that's not always going to feasible or workable. It seems to me that we may be taking greater concern to ensure that consent is fully informed, rational and considered in a lot of cases of major consumer decisions with cooling-off periods - and I'm not suggesting cooling-off periods are the answer here - than we are under this legislation with terminations.

I'm raising that as issue. I'm not sure that a cooling-off period is a sensible solution here and I don't pretend to have all the answers. But it is a concern that I have, that we are

doing very little at the moment, under existing law and under this, to try to deal with that issue.

Mrs HISCUTT - With regard to section 9, the access zones, in your legal view, do you reckon that the Police Offences Act provides enough protection already for legalising and restrictions and things on protests?

Mr STOKES - Under the Police Offences Act, you need to have a permit to hold a demonstration or a protest in a public street or public place. You can look at all the relevant considerations there. That seems to me to be a more sensible approach because it allows a more nuanced approach than this sort of blanket ban which, I suspect, if it were challenged in the High Court, would be found unconstitutional because in the second reading speech, the minister referred to a South Australian case that went to the High Court and that was a permit system, which this isn't. There, the controls were justified on traffic grounds and you can't use that justification here because the areas which are being regulated are not defined in any way by reference to traffic concerns; they are being defined by proximity to a clinic.

The only way this type of blanket ban in section 9 would survive High Court scrutiny is, if you had very strong evidence that demonstrations could have negative, permanent health outcomes for patients of the clinic. There is a test of proportionality; what the regulation is trying to achieve is its impact on freedom of speech disproportionate to what it's trying to achieve. The answer to that here is clearly yes, on current High Court authorities, unless you could really show that demonstrations close to a clinic are not just going to upset a person but are going to have a serious and ongoing negative impact on health.

Mrs HISCUTT - Are you saying that the police would not give a permit within the 150-metre or thereabouts zone? Is that what you reckon?

Mr STOKES - They wouldn't if it were unreasonable, they have that discretion but of course that discretion has to be read in the light of the fact that the current law with respect to freedom of speech allows insulting speech and allows abusive speech on political topics. Traffic concerns, for example, in giving or not giving a permit could be relevant. If you want to have a demonstration which would block the street then that might be a ground for refusing a permit but it's not a ground which relates to its being near a termination clinic. It's a ground which relates to its impact on traffic. This is not really about traffic, it's about proximity to a clinic. I see much of section 9 on that.

I don't think there was too much trouble in the definition of 'prohibited behaviour' in clause paragraph (a). I think the approach to the High Court will be that in 'besetting, harassing, intimidating', they are going to be looking for an element of coercion or intimation and they will read it down in the light of that, and that would survive on that ground.

Clause (b), 'able to be seen or heard by a person accessing, or attempting to access, premises at which terminations are provided' - I don't see that as having a snowflake's chance, realistically, in the High Court unless you can show that simply seeing that sort of demonstration is going to have an ongoing negative impact on health outcomes in the long term.

In (c), footpath interference, if the footpath interference had elements of intimidation it would survive but I suspect the High Court would say that then it wouldn't add much to (a) and they would tend to strike it down as going a bit too far.

CHAIR - Rather than work through any more, we have probably covered the nub of Michael's contention on that.

Ms FORREST - I want to take that one bit further then come back to another question.

CHAIR - We have gone 15 minutes past already.

Ms FORREST - This is a relevant question on this point.

CHAIR - We have laboured other points. My position is that we have gone 15 minutes over and that we have other people who have come early anyway, so I ask you to use your judgment on whether it's going to labour the point Michael has already made or it's to clarify something from where he has been coming.

Ms FORREST - In your view, Michael, would the police issue a permit for a group of people to go and sing outside in the street, not blocking the pathway, outside a building such as a clinic where terminations are provided? Would that be seen to be unlikely to gain a permit?

Mr STOKES - There is a reasonable chance it would gain permit, yes.

Ms FORREST - The other question I want to ask is going to back to informed consent which you were talking about. According to the medical code under AHPRA, informed consent is a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved. Information doctors need to give to patients is detailed in guidelines issued by the NHMRC. Good medical practice involves providing information to patients in a way that they can understand before asking for their consent. So to obtain an informed consent from any woman to continue her pregnancy or to terminate the pregnancy would require the discussion of both options, would it not?

Mr STOKES - Yes, under those codes. Whether it does under a provision like section 178E is not clear because whether you can read the definition of consent in the Criminal Code in the light of that AHPRA definition -

Ms FORREST - I'm not talking about the Criminal Code. I'm talking about the medical code here that the doctors are operating under and that would be operating assigned to a health act.

Mr STOKES - So you are saying, for example, in the interpretation of sections 4 and 5 where we don't have a definition of 'consent'?

Ms FORREST - No, because it's contained within the regulations, effectively.

Mr STOKES - Yes, but there is no cross-referencing between - that's one of my problems with proposed sections 4 and 5. If we really want those to link in to those guidelines -

Ms FORREST - Don't the regulations always link back to the principal act?

Mr STOKES - But this is not going to be the principal act for those regulations, is it?

Ms FORREST - No, but the doctors have to operate under the regulations they are provided with whether it's a termination of pregnancy, taking out someone's appendix or doing neurosurgery. The same rule applies. It's a medical procedure, no different from any other medical procedure in terms of what it is - obviously outcome is different - so why should we have different rules for different procedures?

Mr STOKES - It's not so much different rules for different procedures; my concern is, yes, you are now talking about not this bill so much. My understanding is - and correct me if I am wrong - that you are talking about regulations enacted under the national health professions law. If that's what is to govern terminations, okay, but what are proposed sections 4 and 5 then doing? If we want proposed sections 4 and 5 to link into that national legislation, let's put it in proposed sections 4 and 5 in some way so we get that linking-in. At the moment it's just not clear.

Ms FORREST - Okay. You mentioned, when you spoke initially to your submission, that you don't believe it's evidence-based; you don't believe there is a serious problem with access, or difficulty gaining access. On what do you base the claim that there is no evidence of that?

Mr STOKES - I believe there has been a reluctance to get evidence with terminations at all. Most of the evidence I have heard on most of these points has been anecdotal on both sides. I believe that's a real weakness, that we might rush into legislation.

Ms FORREST - But even if a small number of women, particularly from rural areas, find themselves unable to access termination when they want it and they end up proceeding with the pregnancy, they are very unlikely to come back and complain. Imagine how hard that would be, to have a baby and say, 'I didn't really want you and I'm going to complain about the process'. Realistically, that doesn't happen. You have to try to put yourself into the position of that woman involved. The doctors who are involved in this area, particularly the obstetricians in remote areas, clearly state that it is a major challenge for some women in these areas. To say there is no evidence, even if it's only a small number who may suffer life-long consequences emotionally, physically and psychologically that they can't articulate because they now have a child, makes it very difficult. Would you not agree with that?

Mr STOKES - Yes, if that is happening.

Ms FORREST - The evidence is that it is. We haven't spoken to those people in front of the committee as yet, but we hopefully will.

Mr STOKES - It seems to me there might be other ways of handling that sort of situation other than the provisions of proposed section 7. I have already pointed out that I think there are real problems in the drafting of proposed section 7 as it stands at the moment.

Ms FORREST - It's nothing to do with proposed section 7. You made the statement there is no evidence we even need this legislation

Mr STOKES - The whole legislation?

Ms FORREST - Yes.

Mr STOKES - There was nothing much in the way of evidence presented in the accompanying information paper which suggests the need for this legislation. That's where you would expect the evidence to be and it seemed to be to be fairly ideologically driven rather than evidence-based.

CHAIR - Michael, we have gone 25 minutes past our scheduled time. Thank you for both your time and your submission. We understand that, whilst you have raised a number of points, the duty rests with us to determine whether, as with every other submission, there is validity to that which is being presented to us.

Mr STOKES - Thank you.

THE WITNESS WITHDREW.

Mr DARREN CARR AND **Ms ELIDA MEADOWS**, MENTAL HEALTH COUNCIL OF TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATON AND WERE EXAMINED.

CHAIR - You are protected by parliamentary privilege while in this process and therefore all you say is protected by that process and you cannot be prosecuted in law for what you say. We encourage the exercise of caution when you speak to the media, if you do so, outside this process because there may be things you say in that environmental which are actionable.

Mr CARR - The summary message of our submission is in relation to the mental health impacts of abortion in looking at the terms of reference for this committee. Essentially what you are looking for is evidence on health impacts. What we have sought to bring here is the best quality evidence in relation to the mental health outcomes related to terminations of pregnancy. There is a broad range of information and research out there which has a variety of different findings and quality. As in any area of health research, there is good quality evidence and good research and poor quality evidence and poor research. What we are seeking to do is help you sort the wheat from the chaff in terms of the quality evidence.

If we had to sum up, the best quality research that has been replicated and subject to significant peer scrutiny shows that abortions do not cause adverse mental health outcomes for people who have abortions.

Ms MEADOWS - It is an incredibly difficult area to research in; there are so many variables. One of the issues is that a lot of research does not take into account the variables. Many years down the track someone might develop a mental illness but it could be related to their abuse as a child or their series of violent and abusive relationships, or something else that was not taken in to account. Funnily enough, mental health history is often not taken in to account when this research is being done.

We want to refer today to one of those researchers who is given quite a bit of credibility but is not in the paper - Dr Priscilla Coleman. She published an article in the British *Journal of Psychiatry Research* and it has been widely used by the pro-life lobby as evidence. She came up with the extraordinary number of 81 per cent of woman who have abortions end up with mental health issues. Subsequently, the editor-in-chief of that journal and the chief investigator of the database she used to present her findings, both discredited that research and went public in the same journal to say it was flawed. We thought we would use that as an example today.

Mr CARR - I do not have data to back this up but anecdotally I would say it is probably the most cited research.

Ms MEADOWS - That one and the New Zealand one - Ferguson.

Mr CARR - The Coleman study has been repeatedly debunked in the mental health literature. The flaws with the Coleman study are basically methodological errors, meaning that the research was not performed or designed well. Specifically, several factors that are shown to contribute to mental illness were not taking in to account in the

Coleman study - things like child abuse, domestic violence, stress and emotional problems. When you do research between two groups to try to find an association, you have to research confounders to show whether or not the association that will show up at the end is caused by what you are investigating or by some other external factor you have not taken into account. You have to take all the relevant factors in to account. This particular study did not take into account numerous well-known factors that are proven to cause mental illness.

Similarly, you have to compare like groups; another flaw with the Coleman study is that it did not compare like groups. The Coleman study compared woman who had had an abortion with those who had an unintended pregnancy. On the surface you would say, are they not the same group? What they should have compared to was an unwanted pregnancy, because pregnancies can be unintended but wanted, welcomed and proceeded with, so to compare the outcomes for that group, verses those who proceed with an unwanted pregnancy, you have to take the group of women that have an unwanted pregnancy and compare those who terminate against those who do not, and exclude people who have an unintended but wanted baby. There is research that has compared the relevant groups.

Similarly, when you conduct not just health research but any research, you should do so in a way that the results can be replicated that the study can be re-run to find if the results are replicated. The more studies that replicate a result the more weight you give to it. Numerous researchers were unable to replicate the findings of the Coleman study. Interestingly, and this is not widely publicised by those who cite the Coleman study, the editor-in-chief of the journal and the principal investigator who produced the data which the study was based on have both published rebuttals in the *Journal of Psychiatry Research*, the journal it was published in. The wording they used to describe it was quite damning.

Importantly, the Coleman study didn't distinguish between mental illness that occurred before the abortion or after the abortion. It took all mental illness and looked at an association with lifetime risk of mental illness. You cannot do that. It is not a valid outcome to look at all life events and then say, 'Well, abortion causes mental illness'. In many cases the mental illness actually occurred before the abortion; it would be equal as valid to say mental illness causes abortions. That is probably the biggest criticism that has been levelled.

The study design of Coleman was a retrospective approach where you get a whole lot of case histories. A prospective approach - which are more expensive and take a lot longer to do - would be to look at the population of women with unwanted pregnancies who present to a hospital or research institution and we are going to follow them through.

Ms MEADOWS - One such study has been done in England and Wales over an 11-year period. They have monitored more than 13 000 women - which is a huge sample - with unintended pregnancies and compared women who had abortions with those who delivered a baby. They controlled for history of mental illness. I don't know how reliable this is but it has been regarded as one of the best pieces of research in this area. The outcome was that among with women with no history of mental illness those who delivered a baby had a significantly higher risk of having psychotic episodes than those who had an abortion. I am not saying that lightly.

I am reading from a research paper, but my feeling is that sometimes we forget with issues of mental illness that being pregnant is a hormonal episode, a huge disruption. Some women who have babies do go on to develop a psychotic postnatal condition. That is one that can repeat with further pregnancies. So nobody goes through pregnancy, whether they terminate or have a baby, without some short-term, or even maybe long-term, consequences, but there is no evidence that having an abortion is going to increase those odds - absolutely none.

Mr MULDER - You made a very, very strong statement at the beginning along the lines that high-quality research shows abortions do not create adverse mental health outcomes.

Mr CARR - They do not increase your risk of mental illness. Arguments against abortion are commonly put on the grounds that this will cause mental illness amongst people who have abortions. The high quality research does not support that.

Mr MULDER - Simply being alive often creates adverse health outcomes, so I thought I would pick up the strength of that statement, because even if your research did not show any at all the most you could say was that our research did not show anything, not that there weren't any.

Mr CARR - No, certainly abortion is not protective in terms of people's mental health, although one study showed that proceeding with having children can be bad for mental health. You can go home and say to your kids -

Mr MULDER - Life is full of choices which have adverse health outcomes, mental or otherwise.

Mr CARR - But abortion does not increase your risk of mental illness.

Ms FORREST - This bill is to actually remove abortion from the Criminal Code into a health-related act. Have you done any work or are aware of any research that shows that having a termination of pregnancy as a criminal offence as opposed to a medical procedure has any impact on the way women see themselves in making a decision to have a termination as opposed to continuing? Would that flow through to this bill?

Ms MEADOWS - I have read some American research where they do not have it in their code. They were referring to New Zealand and Australia and this was an overview of research.

Ms FORREST - A meta-analysis?

Ms MEADOWS - Yes. They were very aware that in those jurisdictions the confounding factors are that women feel quite a stigma, so reporting is not going to be open - I am talking in terms of research - so women will not readily report.

Ms FORREST - Report a mental illness?

Ms MEADOWS - No, whether they had an abortion or not, whatever the circumstances around that. Also, the stigma would maybe result in women making decisions that were

not really what they wanted. There is now research starting to look at children of unwanted pregnancies and whether there is an effect on their mental illness in having been unwanted. In many cases once a child is born it becomes wanted, but there are cases where it does not. That does impact on mental health in children and their social and educational outcomes. There is a complexity there that we have not looked into fully. I have begun to read things that demonstrate some very poor results for women who are put into a position where they are frightened or stigmatised into not having an abortion when they really want one, and women who have children that they really do not want.

Mr CARR - The stigma issue is a really important one in terms of whether something is in the Criminal Code or not. We know two things: first, stigma is the reason where, in retrospective research where you are asking people 'have you ever had an abortion?', you can see under-reporting. Retrospective research can be flawed anyway because you are relying on someone's memory, but people can falsely report. That is why prospective research is the best type of research to look at any issue like this. We know that stigma and discrimination are really harmful to people's mental health, so whether we are talking about abortion or any other issue that sought to stigmatise a particular group in society, stigma and discrimination are really bad for people.

Ms FORREST - Let us talk about the stigma. I know from working as a midwife and booking in a women who is pregnant, giving her obstetric history, sometimes they will not tell you about a termination until after several visits. Obviously it is relevant at the first visit, but they do not feel comfortable enough, until they trust you, to reveal some of their obstetric history. By changing this out of the Criminal Code do you think that stigma will really disappear?

Mr CARR - It will reduce. Do I think stigma around any issue will disappear completely from our society? Not for some time. Do I think it would significantly reduce it? Yes. In terms of the Criminal Code changing stigma around something, if you looked at the attitude in the example I cited before where we have in living memory seen change to the Criminal Code, 20 years ago homosexuality was illegal and some fairly stigmatising attitudes were prevalent in the Tasmanian community. Now, the attitude of the majority of Tasmanians - not all and this would be equally applicable in any other setting - with that change in legislation has seen a reduction in stigma.

Again, we would see that the attitudes towards abortion have changed on this issue as well. If the time machine went back 50 years, attitudes were much more stigmatising towards women who had an abortion and towards unmarried mothers.

Ms MEADOWS - Let's not forget self-stigma, which does impact on people's mental health.

Mr VALENTINE - 'Did I do the right thing?'

Ms MEADOWS - Yes, 'I'm evil and I'm bad'.

Ms FORREST - Fifty years ago you had to have a backyard abortion, too, with all the inherent risks of that.

Mr VALENTINE - They had to leave the state, for the most part.

Mrs HISCUTT - Getting back to what your submission is about. You would say that, when I say 'normal' women I mean women without a pre-existing mental health problem as in child abuse and that sort of thing, the problems afterwards would be a grieving process which most normal people would go through with a loss, something that they would come to terms with and then cope with? Would you say it is grieving?

Mr CARR - Could I challenge the language of 'normal'?

Mrs HISCUTT - I did qualify myself by saying not having a pre-existing -

Mr CARR - I am comfortable with that language, so that's all right.

Mr MULDER - 'Usual' rather than 'normal' perhaps.

Mrs HISCUTT - I did say those 'without a pre-existing mental problem'.

Ms MEADOWS - Not every woman will go through an actual, full-on grieving; there are women who feel quite relieved judging by the research. All women, as I was saying before, most women, whether they go through full-term pregnancy or have an abortion will suffer some sort of baby blues anyway because of the physiological nature of pregnancy, which is a huge hormonal disruption of a woman's body. So they are going to be maybe sad for that reason, but there will be women who grieve and I don't see why that would be a big issue. If a woman makes a decision and is an adult, she will cope with the grieving, she will go through the process and she will cope with it. We are looking at debunking, in a way - well, it has already been debunked - the kind of research that says that abortion results in long-term, severe mental illness or ongoing mental illness and that clearly is not the case, judging by the research. We are not coming here with any particular point of view. We read the research and came up with these results.

Mr CARR - The Mental Health Council doesn't have a position on abortion. We have a position on mental health and what we are seeking to do is to give you the best quality evidence around the mental health impacts associated with abortion. You as our legislators are the ones charged with what to do with that evidence, but what I think you expect from us is that we will spell out to you what the evidence is.

In the Mental Health Council there is a variety of personal views, as there are on most issues and that's fine.

Mrs HISCUTT - Following on from that, would you say that the medical practitioners having to give regard to a woman's current and future physical, sociological and psychological circumstances is probably irrelevant to the actual abortion? The doctor would have to assess whether or not the patient has a pre-existing condition and how that abortion will affect that pre-existing condition - is that a fair statement or not?

Mr CARR - It is fair that for any person seeking a procedure, whether it was abortion or something else, the standard medical practice is that you will consider the person's full circumstances.

Mrs HISCUTT - So it's not specific to the abortion then, is that what you are saying? It's specific to anything and everything?

Mr CARR - It will vary. For something like an abortion obviously it is going to carry more weight than if you were going there with, say, a toothache or a chest infection and you need some antibiotics. Obviously there will different weight. In terms of abortion that does need to be taken into account.

Ms MEADOWS - You want to make sure that is really what the woman wants. If a man goes in and has a vasectomy, men can get very depressed after a vasectomy or feel that they are not manly enough anymore. Obviously a medical practitioner would talk through those issues before the vasectomy. I think that is reasonable. I think it's reasonable for a doctor not to be punitive or naysaying or whatever or push his own philosophy, but to talk through that you may feel a bit blue afterwards or whatever.

Mr CARR - Good health professionals will park aside their own view and do the best for their patient. Where health professionals do not do that, they should be held accountable according to their relevant registration board. 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.

Mr VALENTINE - A quick question and I don't know whether it is easy for you to answer or not. In the cohort of people who you work with, do you believe that the amount of information that's out there available to women who are considering abortion is sufficient or deficient in any way? Can you answer that, in terms of people with a mental disability or illness?

Mr CARR - People with mental illness are disadvantaged in terms of accessing information on most things, unfortunately. I don't have any research to back-up my answer but I suspect so. Are you aware of any research on that issue?

Ms MEADOWS - No. They are able to access what is out there for everybody. Most people living with mental illness are not in that extreme situation where they can't understand what is out there and how to get that information. There are organisations that provide very good information, like the Hobart Women's Health Centre, for instance and doctors, quite often, if you are able to speak to a doctor. Yes, I think, especially if this is taken out of the criminal justice system, people might be freer to provide more information and we do need information. It's important that people are aware of what choices are there and what it might mean for them. Whether they have an existing mental illness or not, on the whole, more information is a good thing.

Ms FORREST - Darren, you made the point about doctors held accountable under AHPRA under a health framework, which is where it should be for all medical care. The issue with the counsellors is they are not regulated. One of the issues that has been raised by others is that counsellors, under the act, have a penalty for failing to refer where they have a conscientious objection whereas clinical practitioners don't. That may change in

the future in that counsellors may become regulated but currently they are not. I don't think it's in AHPRA's gun to do it just yet.

Mr CARR - 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.

Mrs HISCUTT - Do you think there's a lot of them out there disproportionately?

Mr CARR - I don't know - there would be some.

Ms FORREST - Are you aware whether there is an issue of access to terminations and advice regarding terminations?

Mr CARR - Yes, there is in the disadvantaged communities. People who are living more rurally and remotely and people who are living in poorer areas have less access to information and services, including information services and terminations.

Ms FORREST - On what do you base that statement, Darren?

Mr CARR - The distribution of health professionals and health services - in health we have a thing called the inverse care log, whereby those with the greatest need usually have the least access. Sadly, that is true within Tasmania as well. I will use GPs as an example. The number of GPs in Sandy Bay per head of population is vastly greater than on the west coast. That's not unique to Tasmania, that's right across Australia and the world.

Mr MULDER - It's inverse proportionately to bulk billing, isn't it?

Mr CARR - It's called the 'inverse care log' and it applies to most health services.

Ms FORREST - With regard to the issues of grieving and sense of guilt and loss that happens after a miscarriage - a spontaneous abortion, from your experience, do women also grieve following a mastectomy, for example?

Mr CARR - Yes, grief is a normal part associated with any loss - it could be the loss of a job, loss following an abortion, following a mastectomy.

Ms FORREST - So the research indicates that is no different from a woman who proceeds with a pregnancy, the risk of having a sense of loss or grief in the loss of your freedom - loss of sleep, and sanity at times.

Mr MULDER - Don't forget the husband who has to get up in the middle of the night.

Mr CARR - Any major life adjustment, whatever it is, is associated with increased stress - moving house.

Mrs HISCUTT - Mr Mulder has just touched on a very pertinent point. With regard to all this, there is no reference to any fathers or fathers' wishes and that goes through the whole system, but then that's the way it is, isn't it? I don't agree with that.

Mr CARR - In our initial submission to the first inquiry we made notes - we circulated our submissions amongst our members and it's interesting that we had a response from our members pointing out that men didn't rate a mention. It's something we raised in our initial submission, that the voice of men is largely lost in this debate. The pragmatic reality is that men will suffer loss and grief associated with this issue as well.

Ms MEADOWS - I have found evidence that men suffer post-natal depression as well, especially if their partner is going through an episode.

Mr CARR - We do not believe that men should have a right of veto.

Mr VALENTINE - An overriding right, no.

Ms MEADOWS - No.

Mr CARR - Absolutely not. Thank you for raising the voice of men in that it is often missed.

Mrs HISCUTT - It worries for fathers who want the child yet the mother doesn't and aborts it, that he has no rights at all.

Mr CARR - That is a really difficult situation.

Ms MEADOWS - Or doesn't want a child and then is forced to pay for it, so there are issues there as well. Counselling should be offered to men as well in those situations.

Mr VALENTINE - Is it simply the case that perhaps the woman needs to be aware of the wishes of the father? Or is it more difficult than that?

Mr CARR - I think it's more difficult than that. As a society we need to be aware of this and need to raise the discussion so that men are more comfortable to discuss mental health issues and discuss their feelings, and in such a way - and I think every man will relate to this - that doesn't say we are bad for not doing it, we are just different. We need to create the discussion so it is comfortable for us to do so.

Ms FORREST - Isn't this, hopefully, part of the informed consent process? It does take two to make a baby, even though the fellow may have long disappeared into the mist. Part of the informed consent should be discussion around that as well, even though there is no power of veto.

Mr CARR - It would be entirely appropriate for informed consent as to whether the father is aware of the pregnancy and what his feelings are.

Ms FORREST - There could be coercion going on as well, either way.

Mr CARR - Absolutely.

Ms MEADOWS - Yes.

Mr VALENTINE - Or potential abuse if in fact the father found out, which might be of detriment to the woman.

Mr CARR - And a detriment to the relationship.

CHAIR - I think we have covered the matters. Darren and Elida, thank you very much.

Mr CARR - Can we say thank you for your interest in mental health outcomes, not just on this but on all the things we are frequently discussing with you.

THE WITNESSES WITHDREW.